REQUEST FOR CASHLESS HOSPITALIZATION FOR HEALTH INSURANCE

POLICY PART-C (Revised)

(TO BE FILLED IN BLOCK LETTERS**)**

DETAILS OF THE THIRD PARTY ADMINISTRATOR/INSURER/HOSPITAL

a. Name of TPA/Insurance company: ----------
b. Toll free phone number: ----------
c. Toll Free Fax: ----------
d. Name of Hospital: ----------
   i. Address ----------
   ii. Rohini ID ----------
   iii. E-mail id ----------

TO BE FILLED BY INSURED/PATIENT

A. Name of the patient: ----------
B. Gender: ☐ Male ☐ Female ☐ Third Gender
C. Age: (Years)/(Month)
D. Date of birth: (DD/MM/YYYY)
E. Contact Number: ----------
F. Contact Number Of attending relative:----------
G. Insured card ID number: ----------
H. Policy Number /Name of corporate:----------
I. Employee ID: ----------
J. Currently do you have any other mediclaim/health insurance: ☐ Yes ☐ No

   i. Company name: ----------
   ii. Give details: ----------

K: Do you have a family physician: ☐ **Yes** ☐ **No**

L: Name of the family physician: ----------

M: Contact Number If any: ----------

N: Current Address of Insured patient: ----------

O: Occupation of Insured patient; ----------

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(PLEASE FILL UP COMPLETE DECLARATION OF THIS FORM)

TO BE FILLED BY TREATING DOCTOR/HOSPITAL

A. Name of the treating doctor: ----------
B. Contact number: ----------
C. Nature of illness/Disease with presenting complaints: ----------
D. Relevant Critical Findings: ----------

E. Duration of the present ailment ----------Days

i. Date of first consultation : DD/MM/YYYY

ii. Past history of present ailment ,if any----------

F: Provisional diagnosis: ----------

i. ICD 10 codes ----------

G: Proposed line of treatment:

i. Medical Management ( )
ii. Surgical Management ( )
iii. Intensive care ( )
iv. Investigation ( )
v. Non-allopathic treatment ( )

H: If Investigation and/or Medical management provide details ----------

i. Route Of Drug Administration ----------

I: If Surgical, Name Of Surgery ----------

i. ICD 10 PCS Code ----------

J: If other treatment, provide details ----------

K: How did injury occur ----------

L: In case of accident

i. Is it RTA: ☐ Yes ☐ No
ii. Date of Injury: (DD/MM/YYYY) (------/------/----------)
iii. Report to police ☐ Yes ☐ No
iv. FIR NO ----------
v. Injury/disease caused due to substance abuse/Alcohol Consumption ☐ Yes ☐ No
vi. Test conducted to establish this (if yes. Attach report) ☐ Yes ☐ No

M: In case of Mater G ☐ P ☐ L ☐ A ☐

i. Expected date of delivery(DD/MM/YYYY) (----/----/--------)

DETAILS OF PATIENT ADMITTED

A. Date of admission (DD/MM/YYYY) ----------
B. Time of admission (HH:MM) ----------
C. Is this an emergency/planned hospitalization event: Emergency ☐ Planned ☐
D. Mandatory past history of any chronic illness If yes(Since Month/Year)
i. Diabetes ----------
ii. Heart disease ----------
iii. Hypertension ----------
iv. Hyperlipidemias ----------
v. Osteoarthritis ----------

vi. Asthma/COPD/Bronchitis ----------
vii. Cancer ----------
viii. Alcohol/Drug abuse ----------
ix. Any HIV/or STD Related ailment ----------
x. Any other ailment, Give details ----------

E. Expected number of days/stay in hospital ----------
F. Days in ICU ----------
G. Room Type ----------
H. Per day room rent+ Nursing and Service charges + patients diet ----------
I. Expected cost of investigation + diagnostic ----------
J. ICU Charges ----------
K. OT Charges ----------
L. Professional fess surgeon + anesthetist fees + consultation charges: ----------
M. Medicines+ consumables + cost of Implants (if applicable please specify) ----------
N. Other Hospital expenses if any ----------
O. All-Inclusive package charges if any applicable ----------
P. Sum total expected cost of hospitalization ----------

DECLARATION

(Please read very carefully)

We confirm having read understood and agreed to the declarations of this form

a. Name Of the Treating doctor ----------
b. Qualification: ----------
c. Registration Number With State code ----------

Hospital seal
(Must includes Hospital ID)

Patient/Insured Name and Sign

DECLARATION BY THE PATIENT/REPRESENTATIVE

a. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the insurer/T.P.A after the discharge. I agree to sign on the final bill & the discharge summary, before my discharge.
b. Payment to hospital is governed by the terms and condition of the policy. In case the Insurer/T.P.A is not liable to settle the hospital bill, I undertake to settle the bill as per the terms and condition of the policy.
c. All non-medical expenses and expenses not relevant to current hospitalization and the amounts over & above the limit authorized by the insurer/T.P.A not governed by the terms and conditions of the policy will be paid by me.

d. I hereby declare to abide by the terms and conditions of the policy and if at any time the facts disclosed by me are found to be false or incorrect I forfeit my claim and agree to indemnify the Insurer/T.P.A
e. I agree and understand that T.P.A is in no way warranting the services of the hospital & that the Insurer/T.P.A is in no way guaranteeing that the services provided by the hospital will be of a particular quality or standard
f. I hereby warrant the truth of the forgoing particulars in every respect and I agree that if any I have made or shall make any false or untrue statement, suppression or concealment with respect to the claim, my right to claim reimbursement of the said expenses shall be absolutely forfeited.
g. I agree indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer/T.P.A
h. "I/We authorize Insurance company/TPA to contact me/us through mobile/email for any update on this claim"
    a) Patient's/Insured's name: ----------
    b) Contact Number: ----------
    c) e-mail id(optional): ----------
    d) Patient's/Insured's Signature: ----------

Date: ---------- Time: ----------

HOSPITAL DECLARATION

a. We have no objection to any authorized TPA/Insurance company official verifying documents pertaining to hospitalization.
b. All valid original documents duly countersigned by the insured/patient as per the checklist below will be sent to TPA/Insurance company within 7 days of the patient's discharge.
c. We agree that T.P.A/Insurance company will not be liable to make the payment in the event of any discrepancy between the facts in this form and discharge summary or other documents.
d. The patient declaration has been signed by the patient or by his representative in our presence.
e. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications.
f. We shall abide by the terms and conditions agreed in the MOU.
g. We confirm that no additional amount would be collected from the insured in excess of agreed package rates except costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility/choosing separate line of treatment which is not envisaged/considered in package.)
h. We confirm that no recoveries would be made from the deposit amount collected from the insured except for costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility/choosing separate line of treatment which is not envisaged/considered in package.)
i. In the events unauthorized recovery of any additional amount from the insured excess of agreed package rates the authorized TPA/Insurance company reserves the right to recover the same from us (The network provider) and /or take necessary action, as provided under the MOU or applicable laws.

Hospital seal Doctor's Signature

Date: Time: