A Max India Joint Venture

Max Bupa Health Insurance

Pre-Authorization Form (Cashless)

HOSPITAL ID | | | | | | |

MEMBERSHIP NUMBER | | | | | | | | | | |

DETAILS OF THE THIRD PARTY ADMINISTRATOR (To be filled in block letters)

a) Name of TPA/Insurance company:

b) Toll free phone number: c) Toll free fax:

TO BE FILLED BY THE INSURED / PATIENT

a) Name of the Patient

b) Gender ☐ Male ☐ Female c) Age Years Y Y Months M M d) Date of birth D D M M Y Y

e) Contact no. f) Insured card ID no.

g) Contact number of attending relative: h) Employee ID

i) Policy no. / Name of corporate

j) Currently do you have any other Mediclaim / Health insurance ☐ Yes ☐ No Company name

Give details

k) Do you have family physician ☐ Yes ☐ No l) Name of the family physician

m) Contact number if any

(PLEASE COMPLETE DECLARATION ON THE REVERSE SIDE OF THIS FORM)

TO BE FILLED BY THE TREATING DOCTOR / HOSPITAL

a) Name of the Treating Doctor b) Contact no.

c) Name of illness / disease with presenting complaints d) Relevant clinical findings

e) Duration of the present ailment Days 1) Date of first consultation D D M M Y Y 2) Past history of present ailment if any

f) Provisional diagnosis 1) ICD 10 code

g) Proposed line of treatment ☐ Medical management ☐ Surgical management ☐ Intensive care ☐ Investigation ☐ Non allopathic treatment

h) If investigation & / or Medical Management provide details 1) Route of drug administration

i) If Surgical, name of surgery 1) ICD 10 PCS Code

j) If other treatments provide details k) How did injury occur

l) In case of accident 1) Is it RTA ☐ Yes ☐ No 2) Date of injury D D M M Y Y 3) Reported to police ☐ Yes ☐ No 4) FIR no.

5) Injury / Disease caused due to substance abuse / alcohol consumption ☐ Yes ☐ No 6) Test conducted to establish this (if yes attach reports)

l) In case of Maternity ☐ G ☐ P ☐ L ☐ A Date of delivery D D M M Y Y

Details of patient admitted

a) Date of admission D D M M Y Y b) Time H H M M

c) Is this an emergency / a planned hospitalization event? ☐ Emergency ☐ Planned

d) Expected no. of days in hospital Days e) Room type

f) Per Day Room Rent + Nursing & Service Charges + Patient's diet Rs.

g) Expected cost of investigation + diagnostics Rs.

h) ICU charges Rs.

i) OT charges Rs.

j) Professional fees surgeon + Anesthetist Fees + consultation charges Rs.

k) Medicines + Consumables + Cost of Implants (if applicable please specify). Other hospital expenses if any. Rs.

l) All inclusive package charges if any applicable Rs.

m) **Sum total expected cost of hospitalisation** **Rs.**

Mandatory: Past history of any chronic illness

If yes, since (month / year)

- ☐ Diabetes M M Y Y
- ☐ Heart Disease M M Y Y
- ☐ Hypertension M M Y Y
- ☐ Hyperlipidemias M M Y Y
- ☐ Osteoarthritis M M Y Y
- ☐ Asthma / COPD / Bronchitis M M Y Y
- ☐ Cancer M M Y Y
- ☐ Alcohol or drug abuse M M Y Y
- ☐ Any HIV or STD / Related ailments Any other Ailment give details M M Y Y

(Please read very carefully)

DECLARATION

We confirm having read understood and agreed to the Declarations on the reverse of this form

a) Name of treating doctor S U R N A M E F I R S T N A M E M I D D L E N A M E

b) Qualification c) Registration No. with State code

Hospital Seal (Must included Hospital ID)l

Patient / Insured Name & Signature

Email us: pre.auth@maxbupa.com Fax No: 1800 3070 3333

(Important Please Turn Over for documents checklist)

DECLARATION BY THE PATIENT / REPRESENTATIVE

1. 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.
2. Payment to hospital is governed by the terms and conditions of the policy. In case the Insurer / TPA is not liable to settle the hospital bill, I undertake to settle the bill as per the terms and conditions of the policy.
3. 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.
4. 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
5. I agree and understand that T.P.A is in no way warranting the service of the hospital & that the Insurer / TPA is in no way guaranteeing that the services provided by the hospital will be of a particular quality or standard.
6. I hereby warrant the truth of the forgoing particulars in every respect and I agree that if 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.
7. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer / TPA.
8. I also consent & authorize TPA / insurance company, to seek details about any past consultation, prescription or treatment, necessary medical information / documents from any hospital / Medical Practitioner who has attended on the person against whom this claim is made. A copy of this authorization shall be considered as effective and valid as the original.

a) Patient's / Insured's Name:_____

b) Contact number:_____ c) Patient's / Insured's Signature: _____

DOCOUMENT CHECKLIST: FOR FASTER PRE-AUTHORISATION

- ☑ Photo ID proof (Mandatory document for pre-authorisation)
- ☑ Past illness records (With duration of stay in hospital mentioned)
- ☑ Complete medical history with medical investigation reports
- ☑ All documents mentioned above submitted along with the completed pre-auth form

Insurer may require further documents to process the request

HOSPITAL DECLARATION

1. We have no objection to any authorized TPA / Insurance Company official verifying documents pertaining to hospitalization within 7 days of the patient's discharge.
3. All non medical expenses, OR expenses not relevant to hospitalization or illness, OR expenses disallowed in the Authorization Letter of TPA / Insurance Co, OR arising out of incorrect information in the pre-authorisation form will be collected from the patient.
4. We agree that TPA / 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.
5. The patient declaration has been signed by the patient or by his representative in our presence.
6. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications.
7. We will abide by the terms and conditions agreed in the MOU.

Hospital Seal

Doctor's Signature

DOCUMENTS TO BE PROVIDED BY THE HOSPITAL IN SUPPORT OF THE CLAIM

1. Detailed Discharge Summary and all Bills from the hospital
2. Cash Memos from the Hospitals / Chemists supported by proper prescription.
3. Receipts and Pathological Test Reports from Pathologists, supported by note from the attending Medical Practitioner / Surgeon recommending such pathological Tests.
4. Surgeon's Certificate stating nature of operation performed and Surgeon's Bill and Receipt.
5. Certificates from attending Medical Practitioner / Surgeon that the patient is fully cured.

Email us: pre.auth@maxbupa.com Fax No: 1800 3070 3333

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