

TO BE FILLED BY TREATING DOCTOR/HOSPITAL

A: Name of the treating Doctor: -----

B: Contact number: -----

C: Nature of Illness/Disease with presenting complaint: -----

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 code -----

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 Maternity 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 ----- Days
- F. Days in ICU ----- Days
- 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 fees Surgeon + Anaesthetist 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 include 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 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.
- 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 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.
- f) 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.
- g) I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer / TPA.
- 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: ----- 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 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.
- 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 will 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 event of unauthorized recovery of any additional amount from the Insured in 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:



**Cashless Authorization Letter
(Part-D)**

Claim Number(Please quote this number for all further correspondence)

Date DD/MM/YYYY

ABC Hospital	Name of Insurance Company	:
	Name of TPA	:
Address	Proposer Name	:
.....	Patient's Member	:
.....	ID/TPA/Insurer Id of Patient	:
	Relation with Proposer	:
Rohini Id:		

Dear Sir/Madam,
This has reference to the pre-authorization request submitted on We hereby authorize cashless facility as per details mentioned below:

Patient Name :	Age:	Gender :
Policy Number:	Expected Date of Admission:	
Policy Period :	Expected Date of Discharge:	
Room Category: Eligible Room: Category as per T&C of Policy Contract:	Estimate length of Stay :	
Provisional Diagnosis :	Proposed Line of Treatment :	

Authorization Details:-

Date & Time	Reference number	Amount	Status
dd/mm/yyyy - hh:mm			
dd/mm/yyyy - hh:mm			

Total Authorized Amount:- Rs(In Words)

Authorization Remarks:

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Hospital Agreed Tariff:

1. Package Case
 - i. Agreed Package Rate

2. Non-package Case

- i. Room Rent/day
- ii. ICU Rent/day.....
- iii. Nursing Charges/day.....
- iv. Consultant visit Charges / day
- v. Surgeon's Fes/OT/Anaesthetist.....
- vi. Others(specify)

Authorization Summary

Total Bill Amount	:	(INR)
* Other Deductions	:	(INR) (At time of Final Authorization)
Discount	:	(INR) (At time of Final Authorization)
Co-Pay	:	(INR)
Deductibles	:	(INR)
Total Authorized Amount	:	(INR)
Amount to be Paid by Insured	:	(INR) (At time of Final Authorization)

Other Deduction Details:

S.No.	Description	Bill Amount	Deducted Amount	Admissible Amount	Deduction Reason

Terms & Conditions of Authorization:

- 1.Cashless Authorization letter issued on the basis of information provided in Pre- Authorization form. In case misrepresentation/concealment of the facts, any material difference/ deviation/ discrepancy in information is observed in discharge summary/ IPD records then cashless authorization shall stand null & void. At any point of claim processing Insurer or TPA reserves right to raise queries for any other document to ascertain admissibility of claim.
- 2.KYC (Know your customer) details of proposer/employee/Beneficiary are mandatory for claim payout above Rs 1 lakh.
- 3.Network provider shall not collect any additional amount from the individual 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).
- 4.Network Provider shall not make any recovery 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).

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5. In the event of unauthorized recovery of any additional amount from the Insured in excess of Agreed Package Rates, the Authorized TPA / Insurance Company reserves the right to recover the same or get the same refunded to the policyholder from the Network Provider and/or take necessary action, as provided under the MoU.
6. Where a treatment/procedure is to be carried out by a doctor/surgeon of insured's choice (not empaneled with the Hospital), Network Provider may give treatment after obtaining specific consent of policyholder.
7. Differential Costs borne by policyholder may be reimbursed by insurers subject to the terms and conditions of the Policy.

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. Diagnostic Test Reports and Receipts supported by note from the attending Medical Practitioner / Surgeon
Recommending such Diagnostic supported by note from the attending Medical Practitioner / Surgeon recommending such diagnostic tests.
4. Surgeon's Certificate stating nature of operation performed and Surgeon's Bill and Receipt.
5. Certificates from attending Medical Practitioner / Surgeon giving patient's condition and advice on discharge.
6. Original Claim Form B duly Signed
7. PPN Declaration letter form duly signed
8. Pre-Auth Form Part –C & D in Original.

The Hospital is requested to submit the claim within 7 days from the date of discharge or else it will be deemed as this Authorization Letter has not been used & company holds no responsibility for payments from insurance company.

Name of the Product and UIN No : - Important Policy terms & conditions sub-limits/co-pay/deductible etc)

**Authorized signatory :
(Insurer/TPA)**

Address: