Pre-Authorization Form

HDFC ERGO

PLEASE FAX/SCAN PAGE 1 ONLY

REQUEST FOR CASHLESS HOSPITALISATION FOR MEDICAL INSURANCE POLICY

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

a. Name of the TPA/Insurance Company :

b. Toll free phone no : c. Toll free FAX :

TO BE FILLED BY INSURED/PATIENT

a. Name of the patient :

b. Gender : Male □ / Female □ c) Age (YY/MM) : Y Y M M d) Date of birth (DD/MM/YYYY) : D D M M Y Y Y Y

e. Contact Number : f) Insured Member ID card no :

g. Policy No./Corporate Name : h. Employee ID :

i. Currently do you have any Medicliam/Health Insurance : Yes □ / No □ j. Company Name :

Give details :

k. Do you have a family physician : Yes □ / No □ l. Name of the family physician :

m. Contact No, if any :

PL COMPLETE DECLARATION ON THE REVERSE SIDE OF THE FORM

TO BE FILLED BY TREATING DOCTOR /HOSPITAL

a. Name of treating doctor : b. Contact No :

c. Nature of illness/ Disease with presenting complaints : d. Relevant clinical findings :

e. Duration of resent ailment : Days f. Date of first consultation : D D M M Y Y Y Y

g. Past history of present ailment, if any : h. Provisional Diagnosis :

i. ICD Code :

j. Proposed line of treatment : Medical Management □ Surgical management □ Intensive Care Unit □ Investigation □ Non allopathic treatment □

k. Investigational &/or Medical Management provide details : l. Route of drug administration :

m. If surgical name of surgery : n. ICD 10 PCS code :

o. If other treatment provide details : p. How did injury occur :

q. In case of Accident : i) Is RTA : Yes □ / No □ ii) Date of injury : D D M M Y Y Y Y iii) Reported to policy : Yes □ / No □ iv) FIR No.

v) Injury/Disease caused due to substance abuse/alcohol consumption : Yes □ / No □ vi) Test conducted to establish this : Yes □ / No □ If yes, attach report

r. In case of maternity : Gravida □ Para □ Living Children □ Abortions □ Date of delivery : D D M M Y Y Y Y

Details of patient admitted

a. Date of admission : D D M M Y Y Y Y b. Time : H H M M

c. Is this a emergency/a planned hospitalisation event? Emergency □ Planned □

d. Expected no of days stay in hospital Days e. Room Type :

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

g. Expected cost for 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 hospitalization Rs.

Mandatory:

Past history of any chronic illness — If yes, since (month/year)

i. Diabetes M M Y Y

ii. Heart Disease M M Y Y

iii. Hypertension M M Y Y

iv. Hyperlipidemia M M Y Y

v. Osteoarthritis M M Y Y

vi. Asthma/ COPD/Bronchitis: M M Y Y

vii. Cancer M M Y Y

vii. Alcohol or drug abuse M M Y Y

vii. Any HIV or STD / Related ailments M M Y Y

Any other Ailment give details:

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DECLRATION

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

a. Name of the treating doctor :

b. Qualification :

c. Registration no with state code :

Hospital Seal (Must include Hospital ID)

Patient I Insured Name & Signature

DECLARATION BY THE PATIENT/ REPRESENTATIVE

1. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Insurer/TPA 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/TPA 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 / TPA
5. I agree and understand that TPA 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, 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.

Patient's/ Insured's Name :

Patients/insured's Signature :

Phone Number :

HOSPITAL DECLARARTION

1. We have no objection to any authorized TPA / Insurance Company official / Authorised representative verifying documents pertaining to hospitalization.
2. All valid original documents duly countersigned by the insured / patient as per the checklist mentioned in the claim form will be sent to TPA / Insurance Company within 15 days of the patient's discharge.
3. All non–medical expenses OR expenses not relevant to hospitalization or illness, OR expenses disallowed in the Authorisation Letter of the 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 I 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.