

REQUEST FOR CASHLESS HOSPITALISATION FOR HEALTH INSURANCE POLICY

(TO BE FILLED IN BLOCK LETTERS)



DETAILS OF THE THIRD PARTY ADMINISTRATOR/ INSURER/ HOSPITAL:

a. Name of TPA/Insurance company: **HEALTHINDIA INSURANCE TPA SERVICES PVT. LTD.**
(IRDA LICENCE No .022)

Cashless Request E-mail Id : crm@healthindiatpa.com

b. Toll free phone number : 1800-2201-02

c. Toll free fax: 07666136699

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 _____ Months

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: _____

(PLEASE 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 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 ()

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 + 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 include Hospital ID)

Patient/Insured Name and Sign

