REQUEST FOR CASHLESS HOSPITALIZATION FOR MEDICAL INSURANCE POLICY

IFFCO TOKIO GENERAL INSURANCE COMPANY LIMITED

CIN: U74899DL2000PLC107621

IFFCO-TOKIO GENERAL INSURANCE Muskurate Raho

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

a) Name of TPA:

b) Name of Insurance company:

c) Toll free phone number: d) Toll free Fax:

e) E-Mail ID

TO BE FILLED BY THE INSURED / PATIENT

a) Name of Insured

b) Name of the Patient:

c) Gender Male ☐ Female ☐ c) Age : years (Y Y) months (M M) DOB: (D D M M Y Y) d) Relationship to Primary insured:

e) Name of the person attending the patient: f) Relationship to patient: i) Contact No:

g) Address:

City: State:

Pin Code: Phone No. E-Maid ID:

h) Insured ID number: i) Policy number

j) Policy Type: Individual ☐ Corporate ☐ k) Corporate Name : l) On the date of hospitalization, are you an employee/member of the group Yes ☐ No ☐

m) Employee ID: m) Currently do you have any other Mediclaim / Health Insurance: ☐ Yes ☐ No If Yes, i) Policy No.

ii) Company Name : iii) Sum Insured Rs.

n) Name of the family physician: o) Contact Number:

p) Are you covered under any similar health scheme. If yes, Give Details:

TO BE FILLED BY THE TREATING DOCTOR / HOSPITAL

a) Name of the treating doctor: b) Contact Number:

c) Nature of ILLNESS / Disease with presenting complaints d) Relevant clinical findings:

e) Duration of the present ailment : i) Date of first consultation: ii)Past history of present ailment if any:

f) Provisional diagnosis: l) ICD 10 Code:

g) Proposed line of treatment : ☐ Medical Management ☐ Surgical Management ☐ Intensive care ☐ Investigation ☐ Non Allopathic treatment

h) If investigation & / Medical Management provide details i) Route of drug administration:

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

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

l) In case of accident: II) Is it RTA: ☐ Yes ☐ No III) Date of Injury: (D D M M Y Y) iv) Reported to police: ☐ Yes ☐ No 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 reports)

l) In case of Maternity: ☐ G ☐ P ☐ L ☐ A LMP (D D) (M M) (Y Y)

Details of the patient admitted

a) Date of admission: (D D M M Y Y) b) Time: (H H) : (M M) c) Room No.:

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

e) Expected no. of days stay in hospital: ☐ Days f) Room Type:

g) Per Day Room Rent: Rs.

h) Nursing & Service Charges + Patient's Diet: Rs.

i) Expected cost for investigation + diagnostics: Rs.

j) ICU Charges: Rs.

k) OT Charges: Rs.

l) Professional fees Surgeon: Rs.

m) Professional fees Anesthetist: Rs.

n) Professional fees Consultation: Rs.

o) Medicines+Consumables. Other hospital expenses if any: Rs.

p) Cost of Implants: (If applicable please specify): Rs.

q)) All inclusive package charges if any applicable: Rs.

r)) Sum Total expected cost of hospitalization: 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	(M M)	(Y Y)

Any other Ailment give details:

HOSPITAL DETAILS

a) Name of the Hospital: b) Hospital ID:

c) Address of the Hospital:

City: State: Pin Code:

Phone No. (S T D C O D E) (P H O N E) E-Mail ID

d) Name of Key contact person: Mobile No.

e) Qualification of a treating doctor: Reg. No. of the Doctor: Rx/test done so far:

DECLARATION

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

a) Name of the treating doctor:

b) Qualification:

c) Registration No. with state Code:

Signature of treating doctor	Hospital Seal (Must include Hospital ID)	Patient / 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 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. In case any clarification is needed on admissibility of a particular item, I shall contact TPA Toll Free Number on this form.
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 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, my right to claim reimbursement of the said expenses shall be absolutely forfeited. I further declare that, in respect of the above treatment, no benefits are admissible under any other Medical Scheme or Insurance.
7. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer / TPA.
8. I authorize Insurer/TPA to view my medical & nursing records, investigation reports, medicines given, their bills etc.; and to collect their photocopies.

Patient's / insured's Name:		**Contact Number**	
Patient's/ insured's signature:			

HOSPITAL DECLARATION

1. We have no objection to any authorized TPA/ Insurance company official verifying documents pertaining to hospitalization.
2. 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.
3. All non–medical expenses OR expenses not relevant to hospitalization or illnesses OR expenses disallowed in the Authorization Letter of the TPA/ Insurance Co. OR arising out of incorrect information in the pre-authorization 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 IN ORIGINAL BY THE HOSPITAL IN SUPPORT OF CLAIM (DURING CLAIM SUBMISSION)

1. Detailed Discharge Summary and all Bills from the hospital <<In IRDA prescribed format>>
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.