Preauthorization Form

Request For Cashless Hospitalisation For Medical Insurance Policy

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

a. Name of TPA/Insurance company: Aditya Birla Health Insurance Company Limited.

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: Y Y M M Years Months

d. Date of birth: D D M M Y Y Y Y

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

k. Company Name: Give details

l. Do you have any family physician: Yes No

m. Name of the family physician:

n. 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 number:

c. Nature of ILLNESS / Disease with presenting Complaints:

d. Relevant clinical findings:

e. Duration of the present ailment: Days

Date of first consultation: D D M M Y Y Y Y Past history of present ailment if any:

f. Provisional diagnosis:

g. ICD 10 Code:

h. Proposed line of treatment: Medical Management Surgical Management Intensive care Investigation Non allopathic treatment.

I. If Investigation &/or Medical Management provide details:

j. Route of drug administration:

k. If Surgical, name of surgery:

l. ICD 10 PCS Code:

m. If other treatments provide details:

n. How did injury occur:

o. In case of accident: i. Is it RTA – ☐ Yes ☐ No ii. Date of injury: D D M M Y Y Y Y

iii. Reported to Police: ☐ Yes ☐ No iv. FIR No:

p. Injury /Disease caused due to substance abuse/alcohol consumption: ☐ Yes ☐ No

Test conducted to establish this: ☐ Yes ☐ No (if Yes attach reports)

q. In case of Maternity : ☐ G ☐ P ☐ L ☐ A Date of Delivery: D D M M Y Y Y Y

Details of the patient admitted

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

c. Is this an emergency /a planned hospitalization 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

g. Expected cost of investigation + diagnostics:

h. ICU Charges: i. OT Charges:

j. Professional fees Surgeon+ Anaesthetist Fees + consultation Charges:

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

l. All inclusive package charges if any applicable:

m. Sum total expected cost of hospitalisation:

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 absuse: M M Y Y

☐ Any HIV or STD/Related ailment: M M Y Y

Any other Ailment give details:

(PLEASE READ VERY CAREFULLY)

DECLARATION

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 / Insured Name & Signature

(IMPORTANT PLEASE TURN OVER)

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 authorised 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 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.

Patient's/Insured's Name:

Patient's/Insured's Signature

Contact Number:

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 mentioned below will be sent to TPA / Insurance Company within 7 days of the patient's discharge.
3. All nonmedical 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.

CENTRAL KYC REGISTRY | Know Your Customer (KYC) Application Form | Individual

Important Instructions:

A) Fields marked with '*' are mandatory fields.
B) Please fill the form in English and in BLOCK letters.
C) Please fill the date in DD-MM-YYYY format.
D) Please read section wise detailed guidelines / instructions at the end.
E) List of State / U.T code as per Indian Motor Vehicle Act, 1988 is available at the end.
F) List of two character ISO 3166 country codes is available at the end.
G) KYC number of applicant is mandatory for update application.
H) For particular section update, please tick (✓) in the box available before the section number and strike off the sections not required to be updated.

For office use only
(To be filled by financial institution)

Application Type* ☐ New ☐ Update
KYC Number ________ (Mandatory for KYC update request)
Account Type* ☐ Normal ☐ Simplified (for low risk customers) ☐ Small ☐ OTP based E-KYC

☐ 1. PERSONAL DETAILS (Please refer instruction A at the end)

	Prefix	First Name	Middle Name	Last Name
☐ Name* (Same as ID proof)				
Maiden Name				
Father / Spouse Name				
Mother Name				

Date of Birth* D D – M M – Y Y Y Y

PHOTO

Gender* ☐ M- Male ☐ F- Female ☐ T-Transgender
Marital Status* ☐ Married ☐ Unmarried ☐ Others
Citizenship* ☐ IN- Indian ☐ Others (ISO 3166 Country Code ☐☐)
Residential Status* ☐ Resident Individual ☐ Non Resident Indian ☐ Foreign National ☐ Person of Indian Origin
Occupation Type* ☐ S-Service (☐ Private Sector ☐ Public Sector ☐ Government Sector)
☐ O-Others (☐ Professional ☐ Self Employed ☐ Retired ☐ Housewife ☐ Student)
☐ B-Business
☐ X- Not Categorised

Signature / Thumb Impression

☐ 2. TICK IF APPLICABLE ☐ RESIDENCE FOR TAX PURPOSES IN JURISDICTION(S) OUTSIDE INDIA (Please refer instruction B at the end)

ADDITIONAL DETAILS REQUIRED* (Mandatory only if section 2 is ticked)
ISO 3166 Country Code of Jurisdiction of Residence*
Tax Identification Number or equivalent (If issued by jurisdiction)*
Place / City of Birth* ISO 3166 Country Code of Birth*

☐ 3. PROOF OF IDENTITY (PoI)* (Please refer instruction C at the end)

(Certified copy of any one of the following Proof of Identity[PoI] needs to be submitted)

☐ A- Passport Number Passport Expiry Date D D – M M – Y Y Y Y
☐ B- Voter ID Card
☐ C- PAN Card
☐ D- Driving Licence Driving Licence Expiry Date D D – M M – Y Y Y Y
☐ E- UID (Aadhaar)
☐ F- NREGA Job Card
☐ Z- Others (any document notified by the central government) Identification Number
☐ S- Simplified Measures Account - Document Type code Identification Number

4. PROOF OF ADDRESS (PoA)*

☐ 4.1 CURRENT / PERMANENT / OVERSEAS ADDRESS DETAILS (Please see instruction D at the end)

(Certified copy of any one of the following Proof of Address [PoA] needs to be submitted)

Address Type* ☐ Residential / Business ☐ Residential ☐ Business ☐ Registered Office ☐ Unspecified
Proof of Address* ☐ Passport ☐ Driving Licence ☐ UID (Aadhaar)
☐ Voter Identity Card ☐ NREGA Job Card ☐ Others (please specify)
☐ Simplified Measures Account - Document Type code

Line 1*
Line 2
Line 3 City / Town / Village*
District* Pin / Post Code* State / U.T Code* ISO 3166 Country Code*

☐ 4.2 CORRESPONDENCE / LOCAL ADDRESS DETAILS * (Please see instruction E at the end)

☐ Same as Current / Permanent / Overseas Address details (In case of multiple correspondence / local addresses, please fill 'Annexure A1')

Line 1*

Line 2

Line 3 City / Town / Village*

District* Pin / Post Code* State / U.T Code* ISO 3166 Country Code*

☐ 4.3 ADDRESS IN THE JURISDICTION DETAILS WHERE APPLICANT IS RESIDENT OUTSIDE INDIA FOR TAX PURPOSES* (Applicable if section 2 is ticked)

☐ Same as Current / Permanent / Overseas Address details ☐ Same as Correspondence / Local Address details

Line 1*

Line 2

Line 3 City / Town / Village*

State* ZIP / Post Code* ISO 3166 Country Code*

☐ 5. CONTACT DETAILS (All communications will be sent on provided

Tel. (Off) — Tel. (Res) — Mobile —

FAX — Email ID

☐ 6. DETAILS OF RELATED PERSON (In case of additional related persons, ple ase fill 'Annexure B1') (please refer instruction G at the end)

☐ Addition of Related Person ☐ Deletion of Related Person KYC Number of Related Person (if available*)

Related Person Type* ☐ Guardian of Minor ☐ Assignee ☐ Authorized Representative

Name* Prefix First Name Middle Name Last Name

(If KYC number and name are provided, below details of section 6 are optional)

PROOF OF IDENTITY [PoI] OF RELATED PERSON* (Please see instruction (H) at the end)

☐ A- Passport Number Passport Expiry Date D D — M M — Y Y Y Y

☐ B- Voter ID Card

☐ C- PAN Card

☐ D- Driving Licence Driving Licence Expiry Date D D — M M — Y Y Y Y

☐ E- UID (Aadhaar)

☐ F- NREGA Job Card

☐ Z- Others (any document notified by the central government) Identification Number

☐ S- Simplified Measures Account - Document Type code Identification Number

☐ 7. REMARKS (If any) Mobile no. / Email-ID) (Please refer instruction F at the end)

8. APPLICANT DECLARA TION

- I hereby declare that the details furnished above are true and correct to the best of my knowledge and belief and I undertake to inform you of any changes therein, immediately. In case any of the above information is found to be false or untrue or misleading or misrepresenting, I am aware that I may be held liable for it.
- I hereby consent to receiving information from Central KYC Registry through SMS/Email on the above registered number/email address.

Date : D D — M M — Y Y Y Y Place :

[Signature / Thumb Impression]

Signature / Thumb Impression of Applicant

9. ATTESTATION / FOR OFFICE USE ONLY

Documents Received ☐ Certified Copies

KYC VERIFICATION CARRIED OUT BY	INSTITUTION DETAILS
Date D D — M M — Y Y Y Y	Name
Emp. Name	Code
Emp. Code	
Emp. Designation	
Emp. Branch	
[Employee Signature]	[Institution Stamp]

BREACH CANDY HOSPITAL TRUST

Cashless Consent Form – Third Party Administrator (TPA)

- I have been explained in details about the cashless facilities at Breach Candy Hospital Trust. I undertake not to hold the hospital responsible for any delay in getting approval or extensions from TPA.
- I have understood that such approvals are my responsibility and the hospital renders this service as a value addition only.
- I will be admitted on the basis of authorization letter received from the insurance Co / TPA which is only a provisional authorization.
- In the absence of an authorization letter, I would be admitted as a "Cash" patient. I would be required to pay the requisite deposit on admission & subsequently clear all hospital bills.
- In case of emergency admission, if the authorization is not received from the insurance Co. / TPA, then I would undertake to clear the bills of the hospital.
- I would have to clear all bills related to exclusions as stated by the Insurance Co. / TPA
- I am aware that subsequent to the pre-authorization and admission a request for confirmation of claim payable is sent to TPA. Only on confirmation from TPA, I will be treated as TPA (Cashless Facility)
- In case I undergo treatment for which the Insurance Co / TPA withdraws authorization or rejects the claim, then I would clear all hospital bills of the hospital.
- I would be required to pay security deposit 48 hrs before the admission. The same will be refunded on settlement from the Insurance Co/ TPA.
- The hospital is not responsible for refusal on part of TPA for reimbursement of my claims.
- I am aware that the original reports and original discharge card are handed over to the Insurance Co/ TPA.
- I am aware that I have to show the copy of the pre-authorization form at the reception on the day of admission to get the cashless benefit.
- I am aware that in planned admission I have to submit the pre-authorization form one week prior to admission and in emergency within 24 hrs. of admission.
- I agree to pay the over and above bill of the approval amount and that I will not seek reimbursement for the same.

Signature of the Patient ________________ Signature of the Relative ________________

Name of the Patient ___________________ Name the of Relative ___________________