

CASHLESS FORMPLEASE FAX/SCAN PAGE 1 AND 2 ONLY
REQUEST FOR CASHLESS HOSPITALISATION FOR MEDICAL INSURANCE POLICY**DETAILS OF THE PROVIDER**

Hospital Name/nursing Home Name: _____

City Name: _____ Pin Code:

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State Name: _____ Hosp Id:

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Landmark: _____

Hospital Contact No: _____ Fax No: _____ TPA desk No _____ Email id: _____

TO BE FILLED BY THE INSURED/PATIENT

a) Name of the Patient: _____

b) Gender: Male Female c) Age: Years

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 Months

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 d) Date of birth:

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e) Name of the Attendant: _____ f) Contact number, if any:

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g) Contact number:

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 h) Insured card ID number:

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i) Policy number | Name of corporate: _____

j) Employee ID:

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k) Currently do you have any other Mediclaim / Health insurance: Yes No

Company Name: _____

Give details: _____

l) Do you have a family physician: Yes No m) Name of the family physician: _____n) Contact number, if any:

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o) Insured E-mail id _____ **(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:

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c) Nature of ILLNESS / Disease with presenting complaints _____

d) Relevant clinical findings: _____

e) Duration of the present ailment:

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 Days i. Date of first consultation:

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i. Past history of present ailment if any: _____

f) Provisional diagnosis _____ i. ICD 10 Code:

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

h) If Investigation & I or Medical Management provide details _____

i) Route of drug administration: _____

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

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j) If other treatments provide details: _____

k) How did injury occur: _____

l) In case of accident: i. Is it RTA: Yes No ii. Date of injury:

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

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v. Injury/Disease caused due to substance abuse/alcohol consumption: Yes Novi. Test conducted to establish this: Yes No (If Yes attach reports)l) In case of Maternity: G P L A Date of Delivery:

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 LMP:

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SECTION A

SECTION B

SECTION C

Details of the patient admitted

- a) Date of admission: 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: 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
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)

- Diabetes
- Heart Disease
- Hypertension
- Hyperlipidemia
- Osteoarthritis
- Asthma / COPD / Bronchitis
- Cancer
- Alcohol or drug abuse
- Any HIV or STD / Related ailments

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

DECLARATION BY THE PATIENT / REPRESENTATIVE

1. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Bajaj Allianz General Insurance Company Limited 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 Bajaj Allianz General Insurance Company Limited 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 Bajaj Allianz General Insurance Company Limited 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 Bajaj Allianz General Insurance Company Limited
5. I agree and understand that Bajaj Allianz General Insurance Company Limited is in no way warranting the service of the hospital & that the Bajaj Allianz General Insurance Company Limited 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 Bajaj Allianz General Insurance Company Limited
8. I Agree to be abide by the AML guidelines issued by IRDA*

a) Patient's / insured's Name: _____

b) Contact number:

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c) Patient's / Insured's Signature:

HOSPITAL DECLARATION

1. We have no objection to any authorized Bajaj Allianz General Insurance Company Limited official verifying documents pertaining to hospitalization.
2. All valid original documents duly countersigned by the insured I patient as per the checklist below will be sent to Bajaj Allianz General Insurance Company Limited within 7 days of the patient's discharge.
3. All non medical expenses, OR expenses not relevant to hospitalization or illness, OR expenses disallowed in the Authorization Letter of the Bajaj Allianz General Insurance Company Limited, OR arising out of incorrect information in the pre-authorisation form will be collected from the patient.
4. WE AGREE THAT BAJAJ ALLIANZ GENERAL INSURANCE COMPANY LIMITED 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.

*As per IRDA circular Ref: IRDA/SDD/GDL/CIR/020/02/2013 Anti-Money Laundering /Counter Financing of Terrorism (AML/CFT)-Guidelines for General Insurers All general insurance companies are required to carry out KYC norms at the settlement stage where claim payout crosses a threshold of ` One lakh per claim. In cases where payments are made to third party service providers such as hospitals, the KYC norms shall apply on the customers on whose behalf service providers act.

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 _____