

PRE-AUTHORIZATION REQUEST FORM

Please use Reliance Provider Portal to communicate with us - <https://provider.reliancegeneral.co.in/>

Part 1 Insured Details	Insured Name: _____ Claim No _____	
	Mobile No.: _____	Policy No.: _____
	E-mail Id _____	
	If Group Policy, Company Name: _____ Employee id _____	
	PAN No. _____	UID Aadhar No. _____
	Source of Funds <input type="checkbox"/> Business <input type="checkbox"/> Profession <input type="checkbox"/> Salary <input type="checkbox"/> Agricultural Income <input type="checkbox"/> Savings <input type="checkbox"/> Others	
	Monthly Income: <input type="checkbox"/> Upto ₹ 20,000 <input type="checkbox"/> ₹ 20,001 to ₹ 50,000 <input type="checkbox"/> ₹ 50,001 to ₹ 1,00,000 <input type="checkbox"/> ₹ 1,00,001 and above	
Part 2 Patient Details	Patient Name: _____	
	Patient UHID _____	Age: _____ yrs DOB: _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
	Patient Mobile No.: _____ Patient Email id: _____	
	Relation with insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Others _____	
	Address: _____	
	City: _____	Pin Code _____
	Attendant Name: _____	
Attendant Mobile no.: _____ Attendant email id _____		
Part 3 Service Provider Details	Hospital Name: _____ Hospital Code: _____	
	Hospital Address: _____	
	City: _____ Pin Code _____	
	Contact Details (Hospital Employee)	
	Treating Doctor Detail	
	Name: _____	Name: Dr. _____
	Telephone no./Mobile no. _____	Qualification: _____
Fax No.: _____	Registration No.: _____	
E-mail Id _____	Mobile No.: _____	
Part 4 Case Information (filled by treating doctor)	Presenting Complaint _____	
	Duration _____	Date of first onset/Consult _____
	H/O of past illness related to present complaint _____	
	Relevant Clinical findings _____	
	Investigation findings _____	
	Provisional Diagnosis _____	Past Medical History
	Treatment Plan : <input type="checkbox"/> Medical <input type="checkbox"/> Surgical	Duration/Details
	In case of Maternity	HTN <input type="checkbox"/> Y <input type="checkbox"/> N _____
	Obstetric History G _____ P _____ L _____ A _____	IHD/CAD <input type="checkbox"/> Y <input type="checkbox"/> N _____
	LMP _____ EDD _____	Diabetes <input type="checkbox"/> Y <input type="checkbox"/> N _____
	In case to Injury/RTA/Self Injury	Asthma/COPD/TB <input type="checkbox"/> Y <input type="checkbox"/> N _____
	Under Influence of Alcohol/Drug abuse <input type="checkbox"/> Yes <input type="checkbox"/> No	Paralysis/CVA/Epilepsy <input type="checkbox"/> Y <input type="checkbox"/> N _____
Attached Copy of <input type="checkbox"/> MLC <input type="checkbox"/> FIR <input type="checkbox"/> PI	Arthritis <input type="checkbox"/> Y <input type="checkbox"/> N _____	
MLC/FIR Number: _____ Place: _____	Cancer/Tumor/Cyst <input type="checkbox"/> Y <input type="checkbox"/> N _____	
	STD/HIV <input type="checkbox"/> Y <input type="checkbox"/> N _____	
	Alcohol/Drug abuse <input type="checkbox"/> Y <input type="checkbox"/> N _____	
	Psychiatric condition <input type="checkbox"/> Y <input type="checkbox"/> N _____	
	Others <input type="checkbox"/> Y <input type="checkbox"/> N _____	

An ISO 9001:2008 Certified Company

RCare Health: Reliance General Insurance, No.1-89/3/B/40 to 42/ks/301, 3rd floor, Krishe Block, Krishe Sapphire, Madhapur, Hyderabad 500081.

IRDAI Registration No. 103. Reliance General Insurance Company Limited. Registered Office: H Block, 1st Floor, Dhirubhai Ambani Knowledge City, Navi Mumbai - 400710. **Corporate Office:** Reliance Centre, South Wing, 4th Floor, Off. Western Express Highway, Santacruz (East), Mumbai - 400 055. Corporate Identity Number U66603MH2000PLC128300. Trade Logo displayed above belongs to Anil Dhirubhai Ambani Ventures Private Limited and used by Reliance General Insurance Company Limited under License. RGI/MCOM/CO/MI-14/PRE-AUTHORIZATION REQUEST FORM /VER. 1.4/301017.

Part 5 Billing details (filled by hospital)	Room Type: <input type="checkbox"/> Single AC <input type="checkbox"/> Single NON AC <input type="checkbox"/> Twin Sharing AC <input type="checkbox"/> Twin Sharing NON AC <input type="checkbox"/> Multi-bed <input type="checkbox"/> Others	If Package not applicable,
	Hospital Room Name.: _____	Room Rent + Nursing Charges _____
	Type of Admission: <input type="checkbox"/> Planned <input type="checkbox"/> Emergency	Surgeon/Assistant Surgeon Charges _____
	Expected DOA: <input type="text"/> dd/mm/yy Length of Stay: <input type="text"/> Days	Anesthesia/Anesthetist Charges _____
	Package Rate: <input type="checkbox"/> Yes <input type="checkbox"/> No	Operation theatre Charges _____
	If Yes, Package Charges _____	Doctor's Visit Charges _____
	Implant Charges _____	Investigation Charges _____
	Remarks (if Any) _____	Pharmacy Charges _____
	_____	Implant Cost(if any) _____
	_____	Total Cost of Hospitalization _____

Please note: In case the Health Gain Policy under which the cashless claim is being lodged has been taken on installment basis then in the event of cashless claim being admissible, the company will deduct the balance installments due if any, from the claim approved amount and pay the balance due to the Policyholder. In the event of the claim assessed amount being lower than the Balance installment due then the Policyholder is liable to pay the balance premium installments due immediately by cheque or DD, failing which the said Claim would be treated as inadmissible and the Policy shall stand cancelled immediately and no liability shall be admissible under the Policy for any Claims liability in future or in period elapsed.

Consent by the Patient/Insured/Beneficiary: I/We understand that Cashless facility is not automatically guaranteed by RGICL. I/We have no objection to RGICL RCare Health Officials visiting the Hospital/Nursing Home to check the details of treatment and are authorized to collect documents pertaining to my treatment from the Hospital/Nursing Home.

I/We have provided the necessary information accurately to the best of my/our knowledge. I/We agree to pay the cost of the hospitalization, if authorization given by RGICL RCare Health becomes null and void, due to wrong and incorrect information.

Patient Signature: _____

Treating Doctor's Signature: _____

Date & Place: d d m m y y y y

Stamp of Hospital: _____

Declaration	I hereby agree, affirm and declare that, the statements/information given/stated by me/us in this claim form is true, correct and complete. No material information which is relevant to the processing of the claim or which in any manner has a bearing on the claim has been withheld or not disclosed. If I have given/made any false or fraudulent statement/information, or suppressed or concealed or in any manner failed to disclose material information, the policy shall be void & that I shall not be entitled to all/any rights to recover there under in respect of any or all claims, past, present or future. The receipt of this claim form/other supporting/related documents does not constitute or be deemed to constitute an agreement by the Company of the claim and the Company reserves the right to process or reject or require further/additional information in respect of the claim.
	I hereby provide my consent and authorize Reliance General Insurance Company Ltd to seek any medical information from any hospital/Medical Practitioner who has at any time attended on the insured person.
	Place: _____ Date: <input type="text"/> d <input type="text"/> d <input type="text"/> m <input type="text"/> m <input type="text"/> y <input type="text"/> y <input type="text"/> y <input type="text"/> y

(Signature of Claimant)

IMPORTANT INFORMATION FOR HOSPITALS:

- The Pre-authorisation Request Form should be filled with due care including the unique number received by the Insured/member/beneficiary. All columns are required to be filled in block letters.
- Completed Pre-authorization Request Form should be faxed to RCare-Health on 1800 3010 3001, or emailed at rgicl.rcarehealth@relianceada.com by the provider hospital. It should reach us at least 4 days prior to likely date of admission. In case of emergency admission Pre-Authorisation Request Form should be sent within 4 hours of admission.
- Authorisation may be denied if complete information is not provided or queries are not replied to.
- Discrepancy in the information provided by the hospital records found at the time of claim may render the authorisation given null and void and the amount claimed by the hospital would have to be settled by the Insured to the hospital.
- Any changes in Diagnosis/Treatment plan should be intimated before discharge of the patient.
- All queries raised by us need to be replied at the earliest & maximum within 24hrs.
- Request for authorisation/enhancement will not be entertained after discharges of the patient.
- We shall share the authorization denial letter to the concerned hospital within 24 hours of complete and correct information being provided.
- If clinical details provided are insufficient, there may be a delay in the authorisation or denial for cashless.
- As per IRDAI any claimed amount above 1lac, copy of PAN card/form 60 of the insured/Policy holder/Proposer is mandatory and for below 1lac, Photo identity proof (For eg- Aadhar card, Driving license, Election card, Passport etc) is mandatory.

Email: rgicl.rcarehealth@relianceada.com, Help line: 1800 3009 (Toll free) 022 - 39898282 (Charges Apply)

Fax No.: 180030103001 (Toll free)

IRDAI Registration No. 103. UIN of Reliance HealthGain Policy: IRDA/NL-HLT/RGI/P-H/V.I/318/13-14.

UIN of Reliance HealthWise Policy : IRDA/NL-HLT/RGI/P-H/V.I/315/13-14

UIN of Group Mediclaim: UIN: IRDA/NL-HLT/RGI/P-H/V.I/317/13-14.

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 _____