Liberty Videocon General Insurance

PRE-AUTHORISATION FORM

PLEASE FAX / SCAN PAGE 1 ONLY

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 :

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 ☐ d d y y m m d) Contact number :

e) Insured card ID number : f) Policy number / Corporate :

g) Employee ID : h) Currently do you have any other Mediclaim / Health Insurance : Yes ☐ No ☐

i. Company Name ii. Give :

iii. Policy No. : iv. Sum Insured :

I) Name of the family physician : j) Contact number :

(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 : I) Date of first consultation : d d m m y y II) Past history of present ailment if any :

f) Provisional diagnosis : I) ICD 10 Code :

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

h) If Investigation & / or Medical Management provide details I) Route of drug administration :

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

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

I) 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)

I) 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 Time: h h m m b) Date of Surgery / Delivery : d d m m y y Time: h h m m

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

d) Expected no. of days stay in hospital : d d m m y y 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 (If applicable please specify): Other hospital expenses if any : Rs

I) 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	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

(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 :

Signature of treating doctor

Hospital Seal (Must include Hospital ID)

Patient / Insured Name & Signature

(IMPORTANT : PLEASE TURN OVER)