PRE – AUTHORIZATION FORM

REQUEST FOR CASHLESS HOSPITALIZATION FOR HEALTH INSURANCE POLICY / TO BE FILLED IN BLOCK LETTERS

GOOD HEALTH INSURANCE TPA LIMITED

Tel :1860 425 3232
Fax :1860 425 4242
Email : preauth@ghpltpa.com
Web : www.goodhealthtpa.com

1 DETAILS OF THIRD PARTY ADMINISTRATOR AND HOSPITAL

NAME OF THE TPA: GOOD HEALTH INSURANCE TPA LTD.

TOLL FREE PHONE NO.: 18004253232 TOLL FREE FAX NO.: 18604254242

HOSPITAL NAME

HOSPITAL LOCATION: AREA CITY

HOSPITAL ROHINI ID HOSPITAL TPA ID

HOSPITAL FAX NO. HOSPITAL PHONE NO.

HOSPITAL EMAIL ID

2 TO BE FILLED IN BY INSURED/PATIENT : DETAILS OF INSURED/PATIENT (Please also sign the declaration on last page of this form)

PATIENT NAME

GENDER MALE FEMALE THIRD GENDER AGE YEARS / MONTHS DATE OF BIRTH DD / MM / YYYY

CONTACT NO. CONTACT NO. OF ATTENDING RELATIVE

OCCUPATION TPA CARD ID

POLICY NO./CORPORATE NAME

EMPLOYEE ID

ADDRESS OF THE INSURED PATIENT

DO YOU HAVE ANY OTHER MEDICLAIM YES / NO

POLICY NO.

INSURANCE CO. NAME

DO YOU HAVE A FAMILY PHYSICIAN YES / NO

PHYSICIAN NAME

CONTACT NO.

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3 TO BE FILLED IN BY TREATING DOCTOR / HOSPITAL (Please also sign the declaration on last page of this form)

TREATING DOCTOR NAME CONTACT NO.

NATURE OF ILLNESS / DISEASE WITH PRESENTING COMPLAINT

RELEVANT CRITICAL FINDINGS

PAST HISTORY OF PRESENT AILMENT

DURATION OF PRESENT AILMENT DAYS

DATE OF 1ST CONSULTATION D D / M M / Y Y Y Y

PROVISIONAL DIAGNOSIS

ICD 10 CODE

PROPOSED LINE OF TREATMENT (PLS TICK)

- ☐ MEDICAL MANAGEMENT
- ☐ SURGICAL MANAGEMENT
- ☐ INTENSIVE CARE
- ☐ INVESTIGATION
- ☐ NON-ALLOPATHIC TREATMENT

PLEASE PROVIDE DETAILS OF (IF ANY)

INVESTIGATIONS	MEDICAL MANAGEMENT	NAME OF SURGERY	OTHER TREATMENT
	ROUTE OF DRUG MANAGEMENT	ICD 10 PCS CODE	

HOW DID INJURY OCCUR

IN CASE OF ACCIDENT : IS IT RTA YES / NO

REPORT TO POLICE YES / NO

DATE OF INJURY D D / M M / Y Y Y Y

FIR NO.

INJURY/DISEASE CAUSED DUE TO SUBSTANCE ABUSE/ALCOHOL CONSUMPTION YES / NO

TEST CONDUCTED TO ESTABLISH THIS (IF YES, ATTACH REPORT) YES / NO

IN CASE OF MATERNITY G P L A

EXPECTED DATE OF DELIVERY D D / M M / Y Y Y Y

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DETAILS OF PATIENT ADMITTED

DATE OF ADMISSION D D / M M / Y Y Y Y

TIME OF ADMISSION M M / H H

EXPECTED NO. OF DAYS / STAY IN HOSPITAL _____ DAYS

ROOM TYPE _____

IS THIS AN EMERGENCY / PLANNED HOSPITALIZATION EVENT EMERGENCY / PLANNED

DAYS IN ICU _____ DAYS

	COST IN INR / RS.
PER DAY ROOM RENT + NURSING & SERVICE CHARGES + PATIENTS DIET	
EXPECTED COST OF INVESTIGATION + DIAGNOSTIC	
ICU CHARGES	
OT CHARGES	
PROFESSIONAL FEES SURGEON + ANESTHETIC FEES + CONSULTATION CHARGES	
MEDICINES + CONSUMABLES + COST OF IMPLANTS (PLS SPECIFY)	
OTHER HOSPITAL EXPENSES, IF ANY	
ALL-INCLUSIVE PACKAGE CHARGES IF APPLICABLE	
SUM-TOTAL EXPECTED COST OF HOSPITALIZATION	

MANDATORY PAST HISTORY OF ANY CHRONIC ILLNES

	IF YES, SINCE
DIABETIES	M M / Y Y Y Y
HEART DISEASE	M M / Y Y Y Y
HYPERTENSION	M M / Y Y Y Y
HYPERLIPIDEMIAS	M M / Y Y Y Y
OSTEOARTHRITIS	M M / Y Y Y Y
ASTHAMA/COPD/BRONCHITIS	M M / Y Y Y Y
CANCER	M M / Y Y Y Y
ALCOHOL/DRUG ABUSE	M M / Y Y Y Y
ANY HIV OR STD RELATED AILMENT	M M / Y Y Y Y
ANY OTHER AILMENT, GIVE DETAILS	M M / Y Y Y Y

4 DECLARATION

WE CONFIRM HAVING READ, UNDERSTOOD AND AGREED TO THE DECLARATION OF THIS FORM

NAME OF THE TREATING DOCTOR _____

QUALIFICATION _____ REGISTRATION NO. WITH STATE CODE _____

HOSPITAL SEAL INCLUDING HOSPITAL ID _____

PATIENT / INSURED NAME AND SIGN _____

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DECLARATION BY THE PATIENT / REPRESENTATIVE :

a. 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.
b. Payment to the 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.
c. All non-medical expenses and expenses not relevant to current hospitalization and the amount over & above the limit authorized by the Insurer / TPA not governed by the terms and conditions of the policy will be paid by me.
d. 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 Insurer / TPA.
e. 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.
f. 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.
g. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer / TPA.
h. "I/We authorize Insurance Company / TPA to contact me / us through mobile / email for any update on this claim."

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

b) Contact Number:_____

c) e-mail Id (Optional):_____

d) Patient's / Insured's Signature:_____

Date:__D D / M M / Y Y Y Y____ Time: ___H H / M M_____

HOSPITAL DECLARATION :

a. We have no objection to any authorized TPA / Insurance Company official verifying documents pertaining to hospitalization.
b. All valid original documents duly countersigned by the insured / patient as per the checklist below will be sent to the TPA / Insurance Company within 7 days of the patient's discharge.
c. 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.
d. The patient declaration has been signed by the patient or by his representative in our presence.
e. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications.
f. We will abide by the terms and conditions agreed in the MOU.
g. We confirm that no additional amount shall be collected for the insured in excess of the Agreed Package Rates except costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility / choosing separate line of treatment which is not envisaged / considered in package).
h. We confirm that no recoveries would be made from the deposit amount collected from the insured except for costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility / choosing separate line of treatment which is not envisaged / considered in package).
i. In the event of unauthorized recovery of any additional amount from the Insured in excess of Agreed Package Rates, the authorized TPA / Insurance Company reserves the right to recover the same from us (the Network Provider) and / or take necessary action, as provided under the MOU or applicable laws.

HOSPITAL SEAL INCLUDING HOSPITAL ID

DOCTOR'S NAME AND SIGN