Request for Cashless Hospitalisation for Health Insurance Policy Part - C

Details of the Third Party Administrator/ Insurer/ hospital: (To be filled in block letters)

a) Name of Insurance company: MAX BUPA HEALTH INSURANCE

b) Customer helpline number: 1860 500 8888

c) Fax no./email Id:

d) Name of Hospital:

i. Address

ii. ROHINI ID

iii. E-mail Id

TO BE FILLED BY INSURED/PATIENT

A. Name of the Patient:

B. Gender: Male ☐ Female ☐ Third Gender ☐ C. Age: Year (YY) Month (MM)

D. Date of Birth: (DD MM YYYY) E. Contact number:

F. Contact number & name of attending relative:

G. Insured Card ID number:

H. Current Address of Insured Patient

I. Occupation of Insured Patient

J. Policy number/Name of Corporate:

K. Employee ID:

L. Currently do you have any other mediclaim /health insurance: ☐ Yes ☐ No

Company Name:

Give Details:

M. Do you have a family Physician: ☐ Yes ☐ No

N. Name of the Family Physician:

O. Contact number, if any: (Please complete declaration of this form)

TO BE FILLED BY TREATING DOCTOR/HOSPITAL

A. Name of the treating Doctor:

B. Contact number:

C. Nature of Illness/Disease with presenting complaint:

D. Relevant critical findings:

E. Duration of the present ailment ☐☐☐ Days (i) Date of first consultation: (DD MM YYYY)

(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 code:

J. If other treatment, provide details

K. How did injury occur

L. In case of accident (i) Is it RTA: Yes NO (ii) Date of Injury: D D M M Y Y Y Y

(iii) Report to Police Yes NO (iv) 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 report)

M. In case of Maternity G P L A (i) Expected date of Delivery D D M M Y Y Y Y

Details of patient admitted

A. Date of admission D D M M Y Y Y Y

B. Time of admission H H M M

C. Is this an emergency/planned hospitalization event: Emergency Planned

D. Mandatory Past History of any chronic illness
If yes (Since month/year)

Diabetes	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
Asthma/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

E. Expected number of days stay in hospital: (Days)

F. Days in ICU

G. Room Type

H. Per Day Room Rent + Nursing and Service Charges + Patients Diet: (INR)

I. Expected cost of investigation + diagnostic: (INR)

J. ICU Charges (INR)

K. OT charges (INR)

L. Professional fees Surgeon + Anesthetist Fees + Consultation Charges: (INR)

M. Medicines+ Consumables+ Cost of Implants (if applicable please specify)

N. Other hospital expenses if any

O. All-inclusive package charges if any applicable

P. Sum Total expected cost of hospitalization

DECLARATION

We confirm having read understood and agreed to the Declarations of this form

a. Name of the treating Doctor S U R N A M E F I R S T N A M E M I D D L E N A M E

b. Qualification: c. Registration number with State code

Hospital Seal
(Must include Hospital ID)

Patient/Insured Name and Sign

DECLARATION BY THE PATIENT/REPRESENTATIVE

a. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Insurer/ T.P.A after the discharge. I agree to sign on the Final Bill & the Discharge Summary, before my discharge.
b. 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.
c. All non-medical expenses and expenses not relevant to current hospitalization and the amounts over & above the limit authorized by the Insurer/ T.P.A 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 the Insurer/ T.P.A
e. I agree and understand that T.P.A 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".

1. Patient's/Insured's Name:
2. Contact number:
3. e-mail Id (optional)
4. 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 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 respons1b1hty 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 would be collected from the insured in excess of 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

Doctor's Signature

Date D D M M Y Y Y Y Time H H M M

ANNEXURE FOR PREAUTH CLAIMS

Dear Policyholder,

Please fill the following information along with the cashless form for your medical insurance policy.

Policy No.

Membership Number

Hospital Id
(To be filled by hospital)

DOCUMENT CHECKLIST:

I. Copy of Photo ID, address proof and recent photo of patient. (for Valid proof of documents kindly refer KYC documents list) KYC documents list includes PAN Card/Driving License/Voter Id. Card/ Aadhar Card
II. Past illness records (With duration of symptoms) if any
III. First and subsequent consultation paper along with admission note.
IV. Complete medical history along with supporting investigation reports.
V. In case of accident, MLC/FIR copy (if applicable)
VI. Claim consent letter

All documents mentioned above to be submitted along with the completed filled cashless form. Insurer may require further documents to process the request.

Name of the Proposer/insured SURNAME FIRST NAME MIDDLE NAME

Contact No.

Signature

Name of the TPA coordinator SURNAME FIRST NAME MIDDLE NAME

Date: DDMMYYYY

Place:

Signature

Consent Letter

To,

Date___/___/____

Medical Superintendent

_____

_____

_____

I, Mr./Ms _____ Age _____ Resident

of _____ State _____ Hereby

give my willful consent to Mr/ Dr _____ of Max Bupa Health

Insurance Company Limited to verify and collect necessary documents/ statements including but not limited to certified copies of medical records from your esteemed hospital for the purpose of settlement of my Insurance claim.

My other relevant details are provided below;

Detail of Insured:-

DOA:-

DOD:-

MRD/ Indoor/ IP No:-

Policy No:-

I request you to provide all the information/documents as required by Max Bupa Health Insurance Company Ltd.

Name

Signature/ Thumb Impression

Witness Name & Signature