zuno
easy. breezy. surely.

Request for Cashless Hospitalization for Health Insurance Policy Part - C (Revised)

NEED CASHLESS HOSPITALISATION? PLEASE HELP US WITH SOME DETAILS.

(Do fill up this form in BLOCK LETTERS)

DETAILS OF THE THIRD PARTY ADMINISTRATOR/ INSURER/ HOSPITAL

a. Name of TPA/Insurance company: _____

b. Toll free phone number: | | | | | | | | | | |

c. Toll free fax: | | | | | | | | | | |

Name of Hospital: _____

i) Address: _____

_____

ii) Rohini ID: | | | | | | | | | | | | | | | iii) E-mail ID: _____

DON'T WORRY, THINGS WILL BE JUST FINE! CAN YOU TELL US SOMETHING ABOUT THE PATIENT? (To be filled by Insured/Patient)

A. Name of the Patient: _____

B. Gender: ☐ Male ☐ Female ☐ Third Gender C. Age: | | Years | | Months D. Date of Birth: D D M M Y Y Y Y

E. Contact No.: | | | | | | | | | | F. Contact No. of Attending Relative: | | | | | | | | | |

G. Insured's ID Card No.: | | | | | | | | | | |

H. Policy No./Name of Company: | | | | | | | | | | | | | | | | _____

I. Employee ID: | | | | | | | | | | |

J. Currently do you have any other mediclaim /health insurance? ☐ Yes ☐ No

i) Company Name: _____

ii) Give Details: _____

K. Do you have a Family Doctor/Physician?: ☐ Yes ☐ No

L. Name of the Family Doctor/Physician: _____

M. Contact No., if any: | | | | | | | | | | |

N. Current Address of Insured Patient: _____

O. Occupation of Insured Patient: _____

(PLEASE COMPLETE DECLARATION OF THIS FORM)

TO BE FILLED BY THE TREATING DOCTOR/HOSPITAL

A. Name of the Treating Doctor: _____ B. Contact No.: | | | | | | | | | | |

C. Nature of Illness/Disease with Presenting Complaint: _____

D. Relevant Critical Findings: _____

E. Duration of the Present Ailment: | | | Days

i) Date of First Consultation: D D M M Y Y Y Y

ii) Past History of Present Ailment, if any: _____

F. Provisional Diagnosis: _____

i) ICD 10 Code: _____

G. Proposed Line of Treatment:

i) Medical Management: ☐ ii) Surgical Management: ☐ iii) Intensive Care: ☐ iv) Investigation: ☐ v) Non-allopathic Treatment: ☐

H. If Investigation and/or Medical Management, provide details: _____

i) Route of Drug Administration: _____

I. If Surgical, Name of Surgery: _____

i) ICD I0 PCS Code: _____

J. If Other Treatment, Provide Details: _____

K. How Did Injury Occur?: _____

L. In Case of Accident

i) 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 (if yes, attach report): ☐ Yes ☐ No

M. In case of Maternity: ☐ G ☐ P ☐ L ☐ A i) Expected Date of Delivery: D D M M Y Y Y Y

A FEW DETAILS ABOUT THE ACTUAL ADMISSION, PLEASE (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. Emergency/Planned Hospitalization Event?: Emergency ☐ Planned ☐

D. Mandatory Past History of any Chronic Illness: If yes (Since month/year)

i) Diabetes: Yes ☐ No ☐ MM YYYY

ii) Heart Disease: Yes ☐ No ☐ MM YYYY

iii) Hypertension: Yes ☐ No ☐ MM YYYY

iv) Hyperlipidemias: Yes ☐ No ☐ MM YYYY

v) Osteoarthritis: Yes ☐ No ☐ MM YYYY

vi) Asthma/COPD/Bronchitis: Yes ☐ No ☐ MM YYYY

vii) Cancer: Yes ☐ No ☐ MM YYYY

viii) Alcohol/Drug Abuse: Yes ☐ No ☐ MM YYYY

ix) Any HIV/STD Related Ailment: Yes ☐ No ☐ MM YYYY

x) Any other ailment, give details: _____ MM YYYY

E. Expected number of Days/stay in hospital: ☐☐☐ Days

F. Days in ICU: ☐☐☐ Days

G. Room Type: _____

H. Per Day Room Rent + Nursing and Service Charges + Patient's Diet: _____

I. Expected Cost of Investigation + Diagnostics: _____

J. ICU Charges: _____

K. OT Charges: _____

L. Professional Surgeon Fees + Anesthetist Fees + Consultation Charges: _____

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. Estimated Total Cost of Hospitalisation: _____

THIS DECLARATION IS IMPORTANT, SO PLEASE READ IT CAREFULLY.

We confirm having read, understood and agreed to the declarations made in 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 and Sign

DECLARATION BY THE INSURED 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 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/TPA and 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 shall forfeit my claim and agree to indemnify the 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 foregoing 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 No.: | | | | | | | | | | |

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 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 Health Services Agreement.

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 Health Services Agreement or applicable laws.

Date: D D M M Y Y Y Y

Time: H H M M

Hospital Seal: _____

Doctor's Signature: _____