FUTURE GENERALI

TOLL
FREE
PHONE:
1800
103
8889

TOLL
FREE
FAX:
1800
103
9998

E
MAIL:
fgh@futuregenerali.in

PRE-AUTHORIZATION/CLAIMFORMFORCASHLESSFACILITY
Patient
Name:
____
____
Health
Card
No.____
Gender:

Male
Female
Age:
____
years

FUTURE GENERALI

Employee ID / Company Name ____

Patient Mobile No. ________________________________ Expected Admission Date: ______________________ Expected Length of Stay: _______ days

Name of Treating Doctor: ____

Mobile No: ______________________________________

Name of Family Physician: ____

Mobile No: _______________________________________

Name of Hospital: ____ _________

City:

____

____

Details
of
presenting
complaints:

____

____

Duration
of
Ailment:

______
years

______
months

____
days
Provisional
Diagnosis:

____

Relevant
Clinical
Findings:

____

____

Investigations
Report
(if
any):

____

____

Proposed
line
of
treatment

during
hospitalization:
____
____

PAST
HISTORY
OF
THE
FOLLOWING
WITH
DURATION:

Disease
/
Ailment
Past
History
Duration/
other
details
Hypertension
/
Cardiovascular
Diseases
Yes
No
Diabetes
Yes
No
Asthma
Yes
No
Any
Surgery
/

Hospitalization
Yes
No
Any
Other
Disease
/
Disability
Yes
No
Obstetric
History
Yes
No
Status
:
G
P
A
L
LMP:
Intentional
Self
Injury
Yes
No
Accidental
injury
under
the
influence
Intoxicating
Drugs
of
Alcohol
or
Yes
No

Expense
Head
Amount
(Rs.)
Expense
Head
Amount
(Rs.)
Room
Rent
Investigations
Doctor
/
Consultant
visit
charges
Medicines
/
Consumables
Surgeon
charges
Equipment
/
Monitor
etc
Operation
Theatre
Charges
Miscellaneous
(specify)
Package
Charges
Service
Tax

Estimate of Expenses: Total Amount Rs. ______________________________

Class of accommodation: ____________________

I have completed this form and will be responsible for correctness of the medical information certified by me. I agree that Future Generali shall not

be liable to make payment in case of any discrepancy between the preauthorization form and discharge summary.

Signature of Doctor / Hospital Representative: ________________________________

Stamp / Seal of Hospital ___________

BENEFICIARY CONSENT / AUTHORISATION

I
have
‘No
Objection’
to
Future
Generali
obtaining
details
of
my
treatment
/
collecting
documents
and
also
hereby
authorize
Future
Generali
to
pay
the
hospital
bill
from
the
sum
insured
of
my
insurance
policy.
I
also

undertake
to
pay
all
non
medical
/
non
authorized
expenses
in
the
hospital
bill
directly
to
the
hospital
at
the
time
of
discharge.
In
case
Future
Generali
issues
"Denial
of
cashless
facility"
to
the
provider,
I
have
'No

objection'
in
paying
the
hospital
bill
for
the
treatment
given.
All
information
provided
above
is
true
and
I
agree
that
if
I
have
provided
any
false
or
untrue
information,
my
right
to
claim
the
expenses
shall
be
absolutely

forfeited.

NAME
OF
INSURED____
____
SIGNATURE
OF
INSURED:
____

CMP001
-
Preauthorization
Form

♀