FORM 1: CASHLESS REQUEST FORM

IFFCO TOKIO GENERAL INSURANCE COMPANY LIMITED

TO BE FILLED BY THE INSURED / PATIENT

Name of Patient :	Age :	Sex :	M	F	
Contact Number :	Email :				
Name of Proposer:	Relation to Proposer:				
Address :					
Policy Type : Indv / Group (GROUP NAME)					
Card ID No.	Policy No._____ Emp.ID_____				
Any Past Policy (Y/N)	If Y, attach copies				
Are you presently covered under any other similar type & scheme, cancer / medical / health insurance etc. Give Details					

TO BE FILLED BY THE TREATING DOCTOR / HOSPITAL

Doctor (Name & Mobile No)	Qualification:	Reg.No. :	
Presenting complaints with duration:			
Relevant Clinical Findings :			
Earlier history of the present ailment if any :			
Date of First Consultation (Fax Prescription)			
Rx / Tests done so far (FAX documents) :			
Provisional Diagnosis :		ICD - 10 CM Code:	
Proposed Line of Treatment :	□ Investigation □ Intensive Care □ Medical Management □ Surgical		
(a) If 'Investigation &/or Medical management' provide detailed line of treatment with route of drug administration :-			
(b) If Surgical, name of the Surgery & its details			
(c) For other treatments, furnish details :		ICD 10 PCS Code :	
Likely DOA	Likely length of stay	Room Type	Room No. :
In Case of ACCIDENTS : Is it RTA □ Y □ N MLC □ Y □ N Date of injury :			**In case of MATERNITY** G____P____L____A_____ __. LMP_____
How did injury occur			
FIR Attached : □ Y □ N Alcohol / Drug Intoxication □ Y □ N If 'Y' send the Analyser Report			

HOSPITAL DETAILS

Hospital name :	**Hosp ID***:	E-Mail :
Hospital Address:		Pin Code :
Key Contact Person:		Mobile

ESTIMATED EXPENSES DETAILS		Past History of chronic illness (Y/N)							If Y, Duration
Per Day Room Rent+Nursing		(a)	Diabetes	:	Y	/	N		
Consultation Charges		(b)	Hypertension	:	Y	/	N		
Investigation + diagnostics		(c)	Heart Disease	:	Y	/	N		
Medicines + Consumables		(d)	Br. Asthma/COPD	:	Y	/	N		
Surgeon fees		(e)	Osteo Arthritis	:	Y	/	N		
OT expenses		(f)	Cancer	:	Y	/	N		
Implants (if any)		(g)	Any Other Ailment	:	Y	/	N		
Any Others (pl. specify)		(h)	Any h/o Alcohol	:	Y	/	N		
All incl. Package (if applicable)		(i)	Any HIV or STD	:	Y	/	N		
TOTAL		(j)	Any Other Ailment	:	Y	/	N		

***We confirm having read understood and agreed to the Declaration on the reverse of this form**

HOSPITAL DECLARARTION

1. We have no objection to any authorized ITGI official verifying documents pertaining to hospitalization.
2. All valid original documents **duly countersigned by the insured / patient (listed below)** will be sent to ITGI within 7 days of the patient's discharge.
3. All non –medical expenses and expenses not relevant to hospitalization or illnesses, which are not payable by ITGI will be collected from the patient.
4. **WE AGREE THAT ITGI WILL NOT BE LIABLE TO MAKE THE PAYMENT IN THE EVENT OF ANY DISCREPANCY BETWEEN THE FACTS IN THIS FORM AND DISCHARGE SUMMARY**
5. The patient declaration (below) has been signed by the patient or by his representative in our presence.
6. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications.
7. We will abide by the terms and conditions agreed in the MOU.

Hospital Seal Doctor's Signature

DECLARATION BY THE PATIENT / REPRESENTATIVE

1. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the ITGI after discharge. I agree to sign on the Final Bill & the Discharge Summary before my discharge.
2. Payment to hospital is governed by the terms and conditions of the policy. In case ITGI is not liable to settle the hospital bill, I take complete responsibility to settle the bill.
3. All non-medical expenses and expenses not relevant to current hospitalization and the amounts over & above the limit authorized by ITGI will be paid by me. In case any clarification is needed on admissibility of a particular item, I shall contact ITGI Toll Free Number 1800-354-4599
4. I hereby declare to abide by the rules and regulations 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 ITGI
5. I agree and understand that ITGI is in no way warranting the service of the hospital & that ITGI is in no way guaranteeing that the services provided by the hospital will be of a particular quality or standard.
6. 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, my right to claim reimbursement of the said expenses shall be absolutely forfeited. I further declare that, in respect of the above treatment, no benefits are admissible under any other Medical Scheme or Insurance.

Patient's/ Insured's Name_____ Patient's/ Insured's Signature ____

Phone No: _____

DOCUMENTS TO BE PROVIDED IN ORIGINAL BY THE HOSPITAL IN SUPPORT OF CLAIM (DURING CLAIM SUBMISSION)

1. Detailed Discharge Summary and all Bills from the hospital
2. Cash Memos from the Hospitals / Chemists supported by proper prescription.
3. Receipts and Pathological Test Reports from Pathologists, supported by note from the attending Medical Practitioner / Surgeon recommending such pathological Tests.
4. Surgeon's Certificate stating nature of operation performed / OT NOTES and Surgeon's Bill and Receipt.
5. Certificates from attending Medical Practitioner / Surgeon that the patient is fully cured.