MDINDIA HEALTHCARE SERVICES (TPA) PVT. LTD.

REQUEST FOR PRE-AUTHORIZATION

[A-2008]

FOR CASHLESS ASSISTANCE - TOLL FREE NO: 1800 233 4505 FAX NO: 020 – 2530 0030 MOBILE NO: 093 2644 2922

UAN Number (Voice) 18602334448 UAN Number (Fax) 18602334449

PART I: TO BE FILLED BY PATIENT / RELATIVE / ATTENDENT: **DATE: / / 200**

Name of Patient:	Age: Yrs	Sex: M / F	Name of Proposer:
Insurance Company: NIA/ NIC/ OIC/ UIIC/ RELIANCE/ OTHER	Policy Since:		MDI ID No : **MDI5- 000**
Policy No: [Kindly enclose current & previous year policy copy]	Emp. No :		Corporate Name :
Previous Claim / Hospitalization: Yes / No. If Yes, then Date:___/____/_______ & Diagnosis:			

PART II: TO BE FILLED BY TREATING DOCTOR:

Presenting Complaints :					Duration :
Clinical Findings	BP: / mm of Hg	Pulse: /min	CVS:	CNS:	RS:

PROVISIONAL ΔSIS:		
Treatment : Conservative: Oral:	I.V :	
Surgery:	Grade: Minor/Intermediate/Major/Supra Major.	Anaesthesia: GA/ LA/ SA/ EA.

INVESTIGATION FINDINGS CONFIRMING THE ΔSIS: [Kindly enclose reports]

PAST HISTORY	YES/NO	DURATION
Hypertension	Y / N	
Diabetes	Y / N	
Cardiac Ailments	Y / N	
Asthma/ COPD	Y / N	
Osteoarthritis	Y / N	
Cancer	Y / N	
HIV I & II	Y / N	
Others	Y / N	

PERSONAL HISTORY WITH DURATION:		
1] Alcoholism/ Smoking/ Tobacco Chewing/ Gutkha/ Drugs.		YES / NO
2] History of past illness relevant to present illness.		YES / NO
3] Present ailment is a complication of pre-existing disease/ injury/ surgery ?		YES / NO
4] Is the disease/ injury self inflicted ?		YES / NO
MANDATORY : A] In case of RTA – 1] MLC/ FIR [Kindly enclose the copy]		YES / NO
2] Is the injury caused directly or indirectly due to use of alcohol / drugs ?		YES / NO
3] Cause of Injury sustained:	4] Date & Time:	
B] In case of Maternity – 1] LMP:	2] EDD:	3] G___P___A___L___

PART III: TO BE FILLED BY HOSPITAL:

Name of Hospital:			Room+ Nursing Charges =Rs / day
Location:		Provider Code:	ICU+ Nursing Charges =Rs / day
City:	Fax No:	Date of Admission:	Consultation Charges =Rs / day
Phone No:		Duration of Stay:	Surgeon+ Anaest.Charges =Rs
Name of TPA Co-ordinator:		Class of Accommodation:	Surgery+ O.T. Charges =Rs
Mobile No:	Hospital E-mail ID:		Investigation Charges =Rs
Name of Treating Doctor:			Medicine/ Implant Charges =Rs
Mobile No:	E-mail ID:		Total Charges =Rs

HOSPITAL DECLARATION: MDIndia will not be held liable for payment in the event of any discrepancy between the facts presented at the time of admission & in final documents submission.

Signature of Treating Doctor: ________________Registration No: _____________________________Rubber Stamp of Hospital: ________________________

INSURED [PATIENT] CONSENT: I have "No Objection" to MDIndia obtaining the details of my treatment / collecting documents & hereby authorize MDIndia to Settle the hospital bill and reimburse itself / receive the amount from my claim receivable from the insurance company. I / We agree to pay the cost of Hospitalization if authorization given by TPA becomes null and void due disclosure of wrong and incorrect information regarding the nature, duration & past history of all ailments. This consent is also final discharge for hospitalization part of the claim where it has affected the payment. I reserve the right to submit Pre / post hospitalization claims separately and when required and as per the policy terms and conditions.

Patients Signature: ________________________E-mail ID: __________________________________Mobile No: ____________________________________