

**REQUEST FOR ELIGIBILITY OF TREATMENT**

**PATIENT'S DETAILS**

Full name \_\_\_\_\_  
 Gender \_\_\_\_\_ Age/Date of birth \_\_\_\_\_  
 Corporate Name \_\_\_\_\_ Employee ID \_\_\_\_\_  
 Max Bupa Card number (8 digits) OR Policy Number (14 digits) 

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 Mandatory document attached (please tick in relevant box)  
 Valid Photo Id proof  Pan Card  Passport  Driving license  Election Card  Others (please specify) \_\_\_\_\_

**PROVIDER'S DETAILS**

Hospital name and address \_\_\_\_\_  
 Hospital code \_\_\_\_\_ Telephone number \_\_\_\_\_ Fax number \_\_\_\_\_  
 Hospital E-mail \_\_\_\_\_  
 Name of treating doctor \_\_\_\_\_ Contact Number \_\_\_\_\_

**MEDICAL INFORMATION**

Presenting Complaints with duration \_\_\_\_\_  
 \_\_\_\_\_  
 Vital signs: BP \_\_\_\_\_ Pulse \_\_\_\_\_ Temperature \_\_\_\_\_ Respiratory Rate \_\_\_\_\_  
 Important examination/investigation findings \_\_\_\_\_  
 \_\_\_\_\_  
 When was this condition first diagnosed? (please attach first consultation papers) \_\_\_\_\_  
 \_\_\_\_\_  
 Provisional Diagnosis \_\_\_\_\_  
 Proposed line of treatment \_\_\_\_\_ Mode of administration (oral/parenteral/rectal) \_\_\_\_\_  
 Proposed surgery/procedure (if any) \_\_\_\_\_  
 Is this emergency or planned hospitalization? \_\_\_\_\_  
 Is this a Day care procedure or requires inpatient stay for more than 24 hours? \_\_\_\_\_  
 Details of patient's regular medication (if any) \_\_\_\_\_

**OBSTETRIC HISTORY**

G \_\_\_\_\_ P \_\_\_\_\_ L \_\_\_\_\_ A \_\_\_\_\_ If pregnant, LMP \_\_\_\_\_ EDD \_\_\_\_\_

**TO BE FILLED IN CASE OF ACCIDENTS/SUSPICIOUS OCCURENCES**

Signs of being under the influence of alcohol at the time of hospitalization (Yes/No) \_\_\_\_\_  
 MLC filed (Yes/No) (If yes, please attach copy) \_\_\_\_\_ MLC Number 

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 FIR copy available (Yes/No)(if yes, please attach copy) \_\_\_\_\_ FIR Number 

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 Circumstances of incident \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**HOSPITALIZATION DETAILS**

Proposed date of admission \_\_\_\_\_ Room category \_\_\_\_\_ Room Type  Sharing  Single  
Proposed length of stay \_\_\_\_\_ Expected length of stay in days in a) ICU \_\_\_\_\_ b) Non ICU \_\_\_\_\_

**ESTIMATED COSTS**

Total Room Rent \_\_\_\_\_ Total ICU rent \_\_\_\_\_ Doctor Visiting charges \_\_\_\_\_  
Pharmacy charges \_\_\_\_\_ Surgeon charges \_\_\_\_\_ OT charges \_\_\_\_\_  
Anesthetist charges \_\_\_\_\_ other charges (Please provide details) \_\_\_\_\_  
Any separate cost of implants (if applicable please specify) \_\_\_\_\_  
Total cost of hospitalization/ all inclusive package charges (if any applicable) \_\_\_\_\_

**PAST HISTORY OF ANY ILLNESS**

Name of illness	(Diagnosis if applicable) with duration	Name of illness	(Diagnosis if applicable) with duration
Diabetes Mellitus	(yes/no) _____	Hypertension	(yes/no) _____
Respiratory disease	(yes/no) _____	Heart Disease	(yes/no) _____
Osteoarthritis	(yes/no) _____	Cancer	(yes/no) _____
HIV	(yes/no) _____	STD	(yes/no) _____
Epilepsy	(yes/no) _____	CVA	(yes/no) _____
Any other condition _____			

Personal Habits	please specify habit& quantity of intake	Past History	Duration
Bidi/Cigarette/paan/ Gutka/Alcohol/Narcotics	_____	_____	_____

Treating Doctor Signature \_\_\_\_\_ Registration number & Qualification of treating doctor \_\_\_\_\_  
Date and Place \_\_\_\_\_ Seal of hospital \_\_\_\_\_

**Declaration & Authorization**

I hereby declare that the above information given is true and correct.  
I further authorize any hospital, physician, insurance company or organizations that has any records or knowledge of me or my health to furnish such information to Max Bupa Health Insurance Company Limited ("Max Bupa") and all information with respect to any illnesses or injuries, medical history, consultation, prescriptions or treatment and copies of all hospital or medical records. A photostat copy of this authorization shall be considered as effective and valid as the original.  
I understand that if I and / or the Member(s) fail to provide any information requested in this Pre-authorization form, it may result in the inability of Max Bupa to accept or process this Pre-authorization.  
I understand that all Members' personal information collected or held by Max Bupa will be used for processing the claims and analysis related to insurance / reinsurance business or any association or federation of insurance company within or outside India.

Member/Relative Signature \_\_\_\_\_ Member/Relative Name \_\_\_\_\_  
Relationship to member \_\_\_\_\_ Date & Place \_\_\_\_\_ Contact Number \_\_\_\_\_

**INSTRUCTIONS**

Please ensure this information is provided at least 72 hours prior to admission & within 48 hours of admission incase of emergencies. Failure to complete this information in full could delay our ability to provide a decision.  
Any approvals granted on receipt of this form would be valid for a period of ten days from the date of approval. All treatment must commence within this period. Any delay beyond ten days would result in all approvals becoming void and requisitions would have to be submitted afresh for approvals.  
Please return this document duly filled to the following fax number 180030703333.



**Max Bupa Health Insurance Company Limited**

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