Park Mediclaim TPA Pvt. Ltd.

702, Vikrant Tower, Rajendra Place, New Delhi – 110008Tel. No. 25747454, 25747455, 43191000-01-02-05-06 Fax. 41539390-43191003-04
Email: park@parkmediclaim.com

PRE-AUTHORIZATION REQUEST FORM

(To Be Filled in By Treating Consultant)

Park ID No.:____________________________ Corporate Name & Emp Code : ____

Patient Name: ____Age: __________Yrs. Sex: Male / Female

Patient 's tel No. (Off.) _________________________________Mobile: ____________________________ Res: _________________________________

Name of Hospital: ____Treating Doctor: ____________________________________

Presenting Complaints with Durations: ____

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Past History:

Disease	Duration		Disease	Duration	
DM			Arthritis		
HT			COPD / TB		
IHD / CAD			Any other Chronic Ailment		
			Similar Ailment		

Maternity Cases: Gravida ________________ Para _______________ LMP ____________EDD ________________No. of Live Children: _________________

In C/O Accidents, **influence of Alcohol / Intoxicant**: Yes / No Whether **MLC** Done: Yes / No

Date of Admission: __________________________________Expected duration of stay: _______________________Room No. _________________________

Class of Accommodation _______________________Admitting Diagnosis: ____

Plan of Treatment: ____

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Estimated Expenses: Rs.___________________________

Detail of Estimated Expenses: **Amount in Rs**.

Room, Board & Nursing Expenses - _________________________

Surgeon, Anesthetist, Medical Practitioner, Consultants & Specialist fees - _________________________

Investigations - _________________________

Anesthesia, Blood, Oxygen, OT Charges, Surgical appliances, Medicines, Drugs, Diagnostic Material & X – Ray, Dialysis, Chemotherapy, Radiotherapy, Cost of Pacemaker, Artificial Limbs and Cost of Stent and Implant - _________________________

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

Signature & Stamp of Consultant **Signature & Stamp of the Hospital**

(To Be Filled in By Insured / Claimant)

I have 'no objection' in Park Mediclaim obtaining details of my treatment / collecting documents and / or verifying hospital records.
I reserve the right to submit pre / post hospitalization or other claim separately as and when required and as per policy terms and conditions, which I have read and understood.
In case, the letter of authorization is not utilized at the above hospital, I agree to inform and surrender the letter of authorization to the Park Mediclaim. I am aware that park Mediclaim will update my sum insured only after receipt of the letter (in case of non utilization of authorization letter).
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, suppress or conceal any material fact, then, my right to claim reimbursement of the said expenses would stand forfeited. I further declare that in respect of the above treatment, no benefits are admissible under any other medical scheme or insurance.

Previous Policy details – Policy No. ____Insurance Company ______________________________________

Previous Claim details - Ailment: __________________________________Dated: _______________________ Amount:_____________________________

Concurrent Policy details: ____ Contact Info: ____

Name: ____Signature (Insured / Claimant) ____