Pre-Authorization Request Form

To be filled by the Insurer. Please fill in CAPITAL only.

Details of the Insured

Policy No. :

Patient Name :

Age (in years) :

Gender : M F

Company Name (If applicable) :

Employee Name (if applicable) :

Employee ID :

Relation with Proposer/Employee :

Address :

Contact No. : - Mobile :

E-mail :

Consent by the Insured

I have no objection to Religare Health Insurance Company Limited obtaining details of my treatment or collecting documents from the concerned hospital. I, hereby, also authorize RHICL to pay or reimburse the medical expenses as per the terms and conditions of the policy. This authorization shall become null and void in the event of

- Incorrect and/or misleading information regarding the duration of ailments and/or information regarding health status
- Any discrepancy in the information provided at the time of submission of final documents

I/We agree to pay the cost of hospitalization in case of the above stated scenarios
I acknowledge and agree that the information provided by me is true and to the best of my knowledge.

Date : / / (DD/MM/YYYY)

Signature of Patient/Relative
(Name of Patient/Relative)

To be filled by the Hospital. Please fill in CAPITAL only.

Details of Treatment

Hospital Name & Address :

Contact No. : -

Fax No. :

Treating Doctor's Name :

Speciality :

Doctor's Contact No. : -

Registration No. :

Presenting Complaints : _____

History of past illness(es) relevant to present illness : _____

Clinical findings : _____

Provisional diagnosis : _____

Investigation findings : _____

Treatment plan : _____

Is the present illness related to/a complication of any any pre-existing illness or previous medical treatment? ☐ Yes ☐ No

Particulars	Yes/No	Since When
Diabetes		
Hypertension		
Heart Diseases		
COPD/B.Asthma		
Cancer		
Arthritis		
STD/HIV		
Alcohol/Drug abuse/Intoxication		
Any other Pre-existing disease - Please specify?		

Estimated Expense on Treatment

Particulars	Details	Amount
Admission - Planned/Emergency		
Expected date of Admission		
Approximate duration of stay - ICU		
Approximate duration of stay - Room		
Total duration of stay		
Class of Accommodation		
Room Rent + Nursing charges		
Investigation charges		
Surgeon charges		
Doctor charges		
Consumables/Medicines		
Anesthesia + OT charges		
Implants if any		
Package rate (if any)		
Approximate total expenses		

In case of Maternity, No. of live children ☐

Obstetrical History ☐ Yes ☐ No _____

LMP : ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)

EDD : ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)

In case of an Accident, was there any evidence of Alcohol/Drug/Intoxication ☐ Yes ☐ No

Medico Legal Case ☐ Yes ☐ No

RHICL will not be held liable for payment in the event of any discrepancy between the facts presented at the time of admission and in the final documentation submitted.

_____ _____

Signature & stamp of treating doctor Stamp of Hospital/Signature