Health India TPA Services. Pvt. Ltd.

60, 6th floor, Shree Krishna Centre Mithakhali Six Road, Navrangpura, Ahmedabad : 380009

hirsby.ahm@healthindiatpa.com Website: www.healthindiatpa.com Tel: +91-079-30612409

RASHTRIYA SWASTHYA BIMA YOJANA

Manual Process CASHLESS Pre-Authorisation Request Form

DATE: _____ **WEEK DAY:** _____ **MONTH:** _____ **YEAR:** _____ **TIME:** _____:_____ AM / PM

SERVICE PROVIDER DETAILS

Hospital Name: _____ **Hospital Code:** _____

Hospital Address: _____ **Block:** _____ **Dist:** _____

POLICY DETAILS

Policy No: _____ **Name Of The Insurance Co:** _____

BENEFICIARY DETAILS

Unique Relationship Number (URN): _____

Name of the BPL Family Head (as appearing on the Smart Card): _____

Age: _____ **Years | Gender: Male / Female | Contact Number:** _____

Name of the Patient: _____ **Age:** _____ **Years | Gender: Male / Female**

Relation to the Family Head: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Parent** ☐ **Others -- Specify:** _____

(Your Claim May be Denied if these Information are not Furnished)

Name - Treating Doctor: _____ **Qualification:** _____ **Regis#:** _____ **Tel:** _____

Presenting Complaints with Exact Duration: - _____

Relevant Clinical Findings:- _____

H/O Any Past Illness relevant to the present Illness: - _____

Positive findings of Investigations done:- _____

Provisional/Differential Diagnosis: _____

Proposed line of Treatment: - _____

PROVISIONAL CODE: _____ **PROCEDURE CODE:** _____ **SERIAL CODE:** _____

PROCEDURE NAME: _____ **HOSP DAYS:** _____ **COST:** _____

Whether First Consultation _____ **or Regular Patient** _____ **Since** _____

In case of R.T.A was patient under the influence of Alcohol/Any other Drugs Yes/No MLC No: _____

(Please Fax a copy of the M L C Report)

Date of Admission: _____

Approx Expenses (I N R): _____

Room Rent Per-day: _____

Investigation Charges: _____

Package Rate: _____

Approx Length of Hospitalization: _____

Class of Accommodation: _____

Doctor/Surgeon Fees: _____

Surgical & Consumables: _____

Any other: _____

Signature of Doctor: _____ **Stamp of Hospital:** _____

I have 'No Objection' to Health India obtaining details of my treatment / collecting documents and also hereby authorize Health India to pay the hospital bill & reimburse itself / receive the amount from my claim receivable from my insurance company. If my claim is rejected, I hereby undertake to pay Health India the amount paid by them to the hospital. This consent is also final discharge for Hospitalization part of the claim where it has effected the payment. I reserve the right to submit pre / post hospitalization or other claims separately as and when required and as per the policy terms and conditions.

BPL Head / Dependant / Attendant Signature / Thumb Impression: _____ Name: _____