TTK HEALTHCARE SERVICES PRIVATE LIMITED
PRE-AUTHORIZATION REQUEST FORM

Form No. 7
Version 5 / Dec 06

PART-I (TO BE FILLED IN BY THE INSURED)

Policy No:		**TTK ID Card No:**	
Pt. Name		Age / Sex	Mobile No:
Occupation		Designation	
Emp. ID		Corporate Name	

Address & Tel. No. of Insured:

Signature of Insured:

PART – II TO be filled in by the Doctor / Hospital in utmost Good Faith

Chief Complaints			
Duration of ailment		Any past illness Relevant to present ailment	
Clinical findings			
Provisional Diagnosis			
Plan of Treatment	Medical / Surgical	* Treatment relating to (Please fill details below)	a. Maternity b. Trauma c. Alternative Medicine
Name and address of the Hospital		Hospital Tel No. / Hospital Fax No.	
Name of TPA Coordinator		Empanelment No.	

Likely Date & Ti me of Admission		**Past history of any chronic illness If Yes, Duration Mandatory** SINCE ? YEARS	
Is this an Emergency / a Planned Hospitalization Event ?		a) Diabetes :	Yes / No
Expected no. of days stay in Hosp		b) Hypertension :	Yes / No
Class of accommodation		c) Heart Disease :	Yes / No
Per Day Room Rent + Nursing & Service Charges + Patient's Diet		d) Br. Asthma :	Yes / No
Expected cost for Investigation + Medicines + Consumables & Other Hospital expenses if any & OT Charges		e) COPD :	Yes / No
Doctor's = Surgeon + Asst Surgeon + Anesthetist Fees + Visit Charges		f) Osteo Arthritis :	Yes / No
All inclusive Package Charges if any applicable		g) Cancer :	Yes / No
Any separate Cost of Implants (if applicable please specify)		h) Any h / o Alcohol abuse / intoxication?	Yes / No
SUM TOTAL EXPECTED COST OF HOSPITALIZATION Rs:		i) Any HIV or STD / Related ailments?	Yes / No
		j) Any other Ailment :	Yes / No If Yes, give details

*** MANDATORY IN MATERNITY**

Menstrual History

Obstetric History

G_____ P_____ A_____ L_____

LMP: EDD:

NORMAL / LSCS Expected

*** MANDATORY IN R.T.A.**

H/O ALCOHOL ABUSE: YES / NO

MLC / FIR COPY : YES / NO

CIRCUMSTANCES :

*** MANDATORY FOR ALL CASES**

Name of the Treating Doctor

Signature

Mobile No:

Hospital Stamp

Date

Consent by Patient/Insured/Beneficiary: I/We have no objection to TTK officials visiting the Hospital / Nursing Home to check the details of treatment. TTK is authorized to collect documents pertaining to my treatment from the Hospital / Nursing Home. I/We have provided the necessary information accurately to the best of my knowledge. I/We agree to pay the cost of the hospitalization if authorization given by TPA becomes null and void due to wrong and incorrect information regarding the duration of ailments.

Patient's Signature

Toll Free Voice : 1800-425-7878 / 8885 **Toll Free Fax : 1800-425-2626** [Please see over leaf for instructions]