Vipul MedCorp Private Limited
515, Udyog Vihar, Phase V
Gurgoan, Haryana - 122016

Pre-Authorisation Request Form

Part-I (To be filled by the Insured)

Policy No:- ______ V.M.C I.D. No: - ______ Corporate Name: - ______
Name of the Employee: - ______ Age: - ______ yrs Sex: - M / F
Phone No. (Office):- ______ Phone No. (If any):- ______
Name of the Patient: - ______ Age: - ______ yrs Sex: - M / F
Relation to the Employee: - ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other- Please Specify: - ______

Your Claim may be rejected if these informations are not given

Part-II (To be filled in by the Hospital) All Columns are Compulsory

Name of the Treating Doctor:- ______ Phone No. ______
Name of the Hospital/Nursing Home:- ______ Tel No.:- ______
Add.:- ______
Presenting Complaints with Exact Duration: - ______
Relevant Clinical Findings:- ______
H/O Any Past Illness relevant to the present Illness:- ______
Whether present illness is a complication of any Pre-existing disease/ Operation/ Past- diseases:- ______
Positive findings of Investigations done:- ______
Provisional/Differential Diagnosis: - ______
Proposed line of Treatment: - ______
Whether First Consultation ______ or regular patient ______ Since ______
Past H/O HT N: Yes/No/Not Known: if Yes Since ______ Diabetes : Yes/No/Not Known: if Yes Since ______
IHD: Yes/No/Not Known: if Yes Since ______ Heart Disease: Yes/No/Not Known: if Yes Since ______
COPD/TB: Yes/No/Not Known: if Yes Since ______ Asthma: Yes/No/Not Known: if Yes Since ______
Osteoarthritis: Yes/No/Not Known: if Yes Since ______ Cancer: Yes/No/Not Known: if Yes Since ______
Glucoma: Yes/No/Not Known: if Yes Since ______ Cataract: Yes/No/Not Known: if Yes Since ______
Pre-existing disease if any:- ______ Duration:- ______
In case of **R.T.A** was patient under the influence of Alcohol/Any other Drugs Yes. /No M L C No.:- ______
(Please Fax a copy of the M L C report)
In case of **Maternity Claim**:- No of live children:- ______ Gravida:- ______ Para:- ______ L:- ______
L.M.P:- ______ E.D.D:- ______

(For the above do attach the Doctor First Prescription)

Date of Admission:- ______ Approx Length of Hospitalization:- ______
Approx Expenses (I N R):- ______ Class of Accommodation:- ______
Room Rent Per-day: - ______ Surgery charges:- ______
Investigation Charges: - ______ Any other:- ______
Package Rate:- ______ Stamp of Hospital:- ______
Signature of Doctor:- ______

Part-III (To be filled by the Insured) Insured Consent / Authorisation

I have 'No Objection' to Vipul MedCorp obtaining details of my treatment / collecting documents and also hereby authorize Vipul MedCorp 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 Vipul MedCorp 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.

Do you have any previous policy details? – (If any) Yes/No: - Policy No:- ______
Insurance Company: ______ Date: ______ Amount ______
Signature/s.: ______ Name: ______