

CHOLAMANDALAM MS GENERAL INSURANCE COMPANY LIMITED

Claims Processing Centre: Hari Nivas Towers, Second Floor,
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PLEASE FAX / SCAN PAGE 1 ONLY

REQUEST FOR CASHLESS HOSPITALISATION FOR MEDICAL INSURANCE POLICY

DETAILS OF THE THIRD PARTY ADMINISTRATOR

(To be filled in block letters)

- a) Name of TPA / Insurance company:
b) Toll free phone number:
c) Toll free FAX:

TO BE FILLED BY THE INSURED / PATIENT

- a) Name of the Patient:
b) Gender: Male Female c) Age: Years Months d) Contact number:
e) Insured card ID number: f) Policy number / Corporate:
g) Employee ID: h) Currently do you have any other Mediclaim / Health insurance: Yes No
i. Company Name ii. Give details:
iii. Policy No. iv. Sum Insured
j) Contact number:

(PLEASE COMPLETE DECLARATION ON THE REVERSE SIDE OF THIS FORM)

TO BE FILLED BY THE TREATING DOCTOR / HOSPITAL

- a) Name of the treating doctor: b) Contact number:
c) Nature of ILLNESS / Disease with presenting complaints d)Relevant clinical findings:
e) Duration of the present ailment: Days I) Date of first consultation: D D M M Y Y II) Past history of present ailment if any:
f) Provisional diagnosis: I) ICD 10 Code:
g) Proposed line of treatment : Medical Management Surgical Management Intensive care Investigation Non allopathic treatment
h) If Investigation & / or Medical Management provide details i) Route of drug administration:
j) If Surgical, name of surgery : I) ICD 10 PCS Code:
k) If other treatments provide details: k) How did injury occur:
l) In case of accident: II) Is it RTA: Yes No III) Date of injury: D D M M Y Y iv) Reported to Police: Yes No FIR No
V) Injury / Disease caused due to substance abuse / alcohol consumption: Yes No VI) Test conducted to establish this: Yes No (If Yes, attach reports)
l) In case of Maternity: G P L A LMP D D M M Y Y

Details of the patient admitted

- a) Date of admission: D D M M Y Y b) Time: H H : M M
c) Is this an emergency / a planned hospitalization event?: Emergency Planned
d) Expected no. of days stay in hospital: Days e) Room Type:
f) Per Day Room Rent + Nursing & Service Charges + Patient's Diet: Rs.
g) Expected cost for investigation + diagnostics. : Rs.
h) ICU Charges: Rs.
i) OT Charges: Rs.
j) Professional fees Surgeon + Anesthetist Fees + consultation Charges: Rs.
k) Medicines + Consumables + Cost of Implants (if applicable please specify) . Other hospital expenses if any: Rs.
l) All inclusive package charges if any applicable Rs.
m) Sum Total expected cost of hospitalization Rs.

Mandatory: Past History of any chronic illness

If yes, since (month / year)

- Diabetes M M Y Y
Heart Disease M M Y Y
Hypertension M M Y Y
Hyperlipidemias M M Y Y
Osteoarthritis M M Y Y
Asthma / COPD / Bronchitis M M Y Y
Cancer M M Y Y
Alcohol or drug abuse M M Y Y
Any HIV or STD / Related ailments M M Y Y

Any other Ailment give details:

(PLEASE READ VERY CAREFULLY)

DECLARATION

We confirm having read understood and agreed to the Declarations on the reverse of this form

- a) Name of the treating doctor: S U R N A M E F I R S T N A M E M I D D L E N A M E
b) Qualification: c) Registration No. with State Code:

Signature of treating doctor

Hospital Seal (Must include Hospital ID)

Patient / Insured Name & Signature:

Note : Please enclose a cancelled cheque / copy of the same, NEFT cannot be facilitated without the cancelled cheque / copy

(IMPORTANT: PLEASE TURN OVER)

PAGE 2: NOT TO BE FAXED/SCANNED

DECLARATION BY THE PATIENT / REPRESENTATIVE

- 1. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Insurer/T.P.A after the discharge. I agree to sign on the Final Bill & the Discharge Summary, before my discharge.
- 2. Payment to hospital is governed by the terms and conditions of the policy. In case the Insurer / TPA is not liable to settle the hospital bill, I undertake to settle the bill as per the terms and conditions of the policy.
- 3. All non-medical expenses and expenses not relevant to current hospitalization and the amounts over & above the limit authorized by the Insurer/T.P.A not governed by the terms and conditions of the policy will be paid by me. In case any clarification is needed on admissibility of a particular item I shall contact T.P.A at the Toll Free Number on the reverse of this form.
- 4. I hereby declare to abide by the terms and conditions of the policy and if at any time the facts disclosed by me are found to be false or incorrect I forfeit my claim and agree to indemnify the Insurer / T.P.A
- 5. I agree and understand that T.P.A is in no way warranting the service of the hospital & that the Insurer / TPA is in no way guaranteeing that the services provided by the hospital will be of a particular quality or standard.
- 6. I hereby warrant the truth of the forgoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppression or concealment, my right to claim reimbursement of the said expenses shall be absolutely forfeited. I further declare that, in respect of the above treatment, no benefits are admissible under any other Medical Scheme or Insurance
- 7. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer / TPA.

a) Patient's / Insured's Name: _____

b) Contact number: _____ d) Patient's / Insured's Signature: _____

HOSPITAL DECLARATION

- 1. We have no objection to any authorized TPA / Insurance Company official verifying documents pertaining to hospitalization.
- 2. All valid original documents duly countersigned by the insured / patient as per the checklist below will be sent to TPA / Insurance Company within 7 days of the patient's discharge.
- 3. All non medical expenses , OR expenses not relevant to hospitalization or illness, OR expenses disallowed in the Authorization Letter of the TPA / Insurance Co, OR arising out of incorrect information in the pre-authorisation form will be collected from the patient.
- 4. WE AGREE THAT TPA / INSURANCE COMPANY WILL NOT BE LIABLE TO MAKE THE PAYMENT IN THE EVENT OF ANY DISCREPANCY BETWEEN THE FACTS IN THIS FORM AND DISCHARGE SUMMARY or other documents.
- 5. The patient declaration has been signed by the patient or by his representative in our presence.
- 6. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications.
- 7. We will abide by the terms and conditions agreed in the MOU.

Hospital Seal

Doctor's Signature

DOCUMENTS TO BE PROVIDED BY THE HOSPITAL IN SUPPORT OF THE CLAIM

- 1. Detailed Discharge Summary and all Bills from the hospital
- 2. Cash Memos from the Hospitals / Chemists supported by proper prescription.
- 3. Receipts and Pathological Test Reports from Pathologists, supported by note from the attending Medical Practitioner / Surgeon recommending such pathological Tests.
- 4. Surgeon's Certificate stating nature of operation performed and Surgeon's Bill and Receipt.
- 5. Certificates from attending Medical Practitioner / Surgeon that the patient is fully cured.