HDFC ERGO General Insurance Company Limited

PLEASE FAX/SCAN PAGE 1 ONLY

REQUEST FOR CASHLESS HOSPITALISATION FOR MEDICAL INSURANCE POLICY

DETAILS OF THE THIRD PARTY ADMINISTRATOR (All fields are mandatory and fill in CAPITALS only)

a) Name of the TPA/Insurance Company:

b) Toll free phone no:

c) Toll free FAX

TO BE FILLED BY INSURED/PATIENT

a) Name of the Patient: (First Name) (Middle Name) (Last Name)

b) Gender: ☐ Male ☐ Female c) Age: Years Y Y Months M M d) Date of birth: D D M M Y Y Y Y

e) Contact Number: f) Contact number of attending relative:

g) Insured Member ID card No: h) Policy No./Corporate Name:

I) Employee ID j) Currently do you have any Mediclaim/Health Insurance: ☐ Yes ☐ No

k) Company Name:

l) Give details:

m) Do you have a family physician: ☐ Yes ☐ No n) Name of the family physician:

o) Contact No, if any (PLEASE COMPLETE DECLARATION ON THE REVERSE SIDE OF THE FORM)

TO BE FILLED BY 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 present ailment: Days f) Date of first consultation: D D M M Y Y Y Y g) Past history of present ailment, if any

h) Provisional Diagnosis I) ICD Code:

j) Proposed line of treatment ☐ Medical Management ☐ Surgical Management ☐ Intensive Care Unit ☐ Investigation ☐ Non allopathic treatment

k) Investigational &/or Medical Management provide details m) Route of drug administration

n) If surgical name of surgery o) ICD 10 PCS code

p) If other treatment provide details q) How did injury occur

r) In case of Accident: I. Is RTA: ☐ Yes ☐ No ii. Date of injury: D D M M Y Y Y Y iii. Reported to police: ☐ Yes ☐ No iv. 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 report)

Details of patient admitted

a) Date of admission: D D M M Y Y Y Y b) Time: H H : M M

c) Is this a emergency/a planned hospitalisation 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	D D	M M
☐ Heart Disease	D D	M M
☐ Hypertension	D D	M M
☐ Hyperlipidemias	D D	M M
☐ Osteoarthritis	D D	M M
☐ Asthma/ COPD/ Bronchitis	D D	M M
☐ Cancer	D D	M M
☐ Alcohol or drug abuse	D D	M M
☐ Any HIV or STD / Related ailments	D D	M M

Any other Ailment give details:

DECLARATION

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

a) Name of the treating doctor : (First Name) (Middle Name) (Last Name)

b) Qualification : c) Registration No. with state code:

I/We hereby understand, declare, consent and authorise the Company that personal health details, medical history and financial information, as provided to the Company may be utilised for processing the claim made under the Policy. ..... I/We hereby also understand, declare and consent that the Company shall have right to retain the same for providing services related to insurance.

Hospital Seal (Must include Hospital ID)

Patient I Insured Name & Signature

DECLARATION BY THE PATIENT / REPRESENTATIVE

1. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Insurer/TPA after the discharge.
2. Payment to hospital is subject to fulfilment of 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/TPA will be paid by me.
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/ TPA to the extent of payment done by them
5. I agree and understand that TPA 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 understand and declare that the information, declaration & statements provided by me is true is all aspects and in case the same is found to be manipulated, misrepresented or incorrect, my right to claim reimbursement under the policy shall absolutely be forfeited.
7. I agree to make payment to the Hospital against all expenses incurred on treatment which are not approved for payment by the Insurer.

Patient's/ Insured's Name:_____

Contact No.:_____ Patient's/ Insured's Signature:_____

HOSPITAL DECLARATION

1. We have no objection to any authorized TPA/ Insurance Company official/ Authorised representative verifying documents pertaining to hospitalization.
2. All valid original documents duly countersigned by the insured/ patient as per the checklist mentioned in the claim form 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 expenses arising out of ailment not disclosed/ wrongly disclosed 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 (Must include Hospital ID)

Patient I Insured Name & Signature

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

1. Original copy of detailed Discharge Summary and all Bills from the hospital
2. Original copy of cash Memos from the Hospitals / Chemists supported by prescription.
3. Original copy of receipts, Investigation Reports and Radiological Films, supported by note from the attending Medical Practitioner/ Surgeon recommending such investigations.
4. Original copy of surgeon's Certificate stating nature of operation performed and Surgeon's Bill and Receipt.
5. Pre-authorization is approved subject to successful submission of KNOW YOUR CUSTOMER (KYC) documents. As per Anti-Money Laundering / Counter Financing of Terrorism (AML / CFT) - Guidelines for General Insurers issued vide Ref: IRDA/SDD/GDL/CIR/020/02/2013 dated February 8, 2013, in case claim is of Rs. 1 Lakh and above the insured is required to submit KYC documents for processing the payment.
6. Please provide any one of the following documents to fulfill KYC norms:
   a. Driving License / AADHAR Card / Voter Card / Passport / any other Government authorised identity proof of the insured carrying name and photograph.