

PLEASE FAX/SCAN PAGE 1 ONLY REQUEST FOR CASHLESS HOSPITALISATION FOR MEDICAL INSURANCE POLICY

	Y ADMINISTRATOR (To be filled in block letters)
a) Name of TPA	: E-Meditek Insurance TPA Limited
b) Toll free phone number d) FAX No	: 1800 102 3242 c) Hot Line : 0124 - 4980555 : 0124 - 4466677
d) I AX No	TO BE FILLED BY THE INSURED / PATIENT
a) Name of the Patient	
b) Gender	Male Female c) Age: Years Y Months M M d) Date of Birth D D M M Y Y Y Y
e) Contact number	f) ID number
g) Contact Number of attending re	elative
h) Policy number/Name of corpor	ate i) Employee ID
j) Currently do you have any other	r Mediclaim/Health insurance Yes No Company Name
Give details	
k) Do you have a family physiciar	Yes No I) Name of the family physician
m) Contact number, If any	(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 ailmen	t DAYS i. Date of first consultation D D M M Y Y ii. Past history
f) Provisional diagnosis	of present ailment if any
	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	ii) Route of drug administration Oral Parenteral
i) If Surgical, name of surgery	i. ICD 10 PCS Code
ii. Type of Anaesthesia	Local GA Spinal
j) If other treatment Provide details	k) How did
I) In case of accident	injury occur i. Is it RTA Yes No ii. Date of Injury D M M Y Y iii. Reported to Police iv. FIR No.
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	ubstance abuse / alcohol comsumption Yes No vi. Test conducted to establish this Yes No (If Yes attach reports)
m) In case of Maternity	G P L A Date of Delivery D D M M Y Y
Details of the patient admitted	Mandatory: Past History of any Mandatory: Past History of any If yes, since Chronic illness C
a) Date of admission	S) I I I I I I I I I I I I I I I I I I I
c) Is this an emergency / a planned hospitalization event?	
d) Expected no. of days stay in hospital Days e) Room Type Heart Disease	
f) Per Day Room Rent + Nursing	& Service Charges Rs. Hypertension M M Y Y
	Hyperlipidemias M M Y Y
g) Expected cost for investigation	Hyperlipidemias M M Y Y
g) Expected cost for investigation h) ICU Charges	Hyperlipidemias M M Y Y
	Hyperlipidemias
h) ICU Charges	Hyperlipidemias
h) ICU Charges i) OT Charges j) Professional fees Surgeon + Ar + consultation Charges k) Medicines + Consumables + C	Hyperlipidemias
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h) ICU Charges i) OT Charges j) Professional fees Surgeon + Ar + consultation Charges k) Medicines + Consumables + C please specity), Other hospital l) All inclusive package charges	Hyperlipidemias M M Y Y Holiagnostics Rs. Osteoarthritis M M M Y Y Rs. Osteoarthritis M M M Y Y Asthma/COPD/Bronchitis M M Y Y Cancer M 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
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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/E-Meditek Insurance TPA Limited 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 / E-Meditek Insurance TPA Limited 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 amount over & above the limit authorized by the Insurer/ E-Meditek Insurance TPA Limited not governed by the terms and conditions of the policy will be paid by me.
- 4. I hereby declare to abide by the terms and conditions of the policy and if at any facts disclosed by me are found to be false or incorrect I forfeit my claim and agree to indemnify the insurer / E-Meditek Insurance TPA Limited
- 5. I agree and understand that E-Meditek Insurance TPA Limited is in no way warranting the service of the hospital & that the Insurer/ E-Meditek Insurance TPA Limited is 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 with respect to the
- 7. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the insurer/ E-Meditek Insurance TPA Limited.

a) Patient's / Insured's Name		
b) Contact number	c) Patient's / Insured's Signature	
HOSPITAL DECLARATION		
1. We have no objection to E-Meditek Insurance TPA Limited/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 E-Meditek Insurance TPA Limited / 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 E-Meditek (TPA) Services Limited/ Insurance Co. OR arising out of incorrect information in the pre-authorisation form will be collected from the patient.		
4. WE AGREE THAT E-Meditek Insurance TPA Limited / INSURANCE COMPANY WILL NOT BE LIABLE TO MAKE THE PAYMENT IN THE EVENT OF ANY DISCREPANCY BETWEEN THE FACTS IN THIS FORM		
5. The patient declaration has been signed by the patient or by his represent in our presence.		
6. We agree provide clarification 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.