

Pre-Authorisation Form - 'Secure' Request for Cashless Hospitalisation for Medical Insurance Policy

- I. To be filled in CAPITAL LETTERS only.
- 2. If there is insufficient space, please provide further details on a separate sheet.
- 3. Please Fax/Scan Page I & 2 only.

Details of the Third Party Administrator														
a) Name of TPA/Insurance Company :														
b) Toll Free Phone No.: c) Toll Free FAX:														
d) Name of Hospital:														
i) Address :														
ii) Rohini ID :														
iii) Email ID :														
To be filled by the Insured/Patient														
a) Name of the Patient :														
(First Name) (Middle Name) (Last Name)														
b) Gender : M F Other c) Age: (YY) (MM) d) Date of Birth: / /														
e) Contact Number :														
f) Contact Number of Attending Relative:														
g) Insured Card ID Number :														
h) Policy Number/Name of Corporate :														
i) Employee ID:														
j) Currently do you have any other Mediclaim/Health Insurance : Yes No														
i) Company Name :														
il) Give Details :														
k) Do you have a family physician : Yes No														
I) Name of the family physician :														
m) Contact Number, if any :														
n) Current Address of the Insured Patient :														
o) Occupation of Insured Person :														
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 : // // (DD/MM/YYYY)														
ii) Past history of present ailment if any :														
f) Provisional diagnosis:														
i) ICD I0 Code:														

Non allopathic treatment h) If Investigation &/or Medical Management provide details: i) Route of drug administration: i) If Surgical, name of surgery: i) ICD 10 PCS Code: j) If other treatments provide details: k) How did injury occur: l) In case of accident: i) Is it RTA: Yes No ii) Date of injury: / / / DD/MM/YYYY) iii) Reported to Police: Yes No iv) FIR No: v) Injury/Disease caused due to substance abuse/alcohol consumption: Yes No)/MM/YYYY)
i) Route of drug administration: i) If Surgical, name of surgery: i) ICD I0 PCS Code: j) If other treatments provide details: k) How did injury occur: l) In case of accident: i) Is it RTA: Yes No ii) Date of injury: y)/MM/YYYY)
i) If Surgical, name of surgery: ii) ICD I0 PCS Code: j) If other treatments provide details: k) How did injury occur: l) In case of accident: i) Is it RTA: Yes No ii) Date of injury: // // // // // // // // // // // // //)/MM/YYYY)
i) ICD I0 PCS Code: j) If other treatments provide details: k) How did injury occur: l) In case of accident: i) Is it RTA: Yes No ii) Date of injury: // // // (DD/MM/YYYY) iii) Reported to Police: Yes No iv) FIR No.: v) Injury/Disease caused due to substance abuse/alcohol consumption: Yes No)/MM/YYYY)
j) If other treatments provide details: k) How did injury occur: l) In case of accident: i) Is it RTA: Yes No ii) Date of injury: // // // (DD/MM/YYYY) iii) Reported to Police: Yes No iv) FIR No.: v) Injury/Disease caused due to substance abuse/alcohol consumption: Yes No	//MM/????
k) How did injury occur :	//MM/????
I) In case of accident: i) Is it RTA: Yes No ii) Date of injury: // // (DD/MM/YYYY) iii) Reported to Police: Yes No iv) FIR No.: v) Injury/Disease caused due to substance abuse/alcohol consumption: Yes No	//MM/????
iii) Reported to Police : Yes No iv) FIR No.: v) Injury/Disease caused due to substance abuse/alcohol consumption : Yes No)/MM/YYYY)
v) Injury/Disease caused due to substance abuse/alcohol consumption : Yes No)/MM/YYYY)
)/MM/YYYY)
)/MM/YYYY)
vi) Test conducted to establish this :)/MM/YYYY)
m) In case of Maternity: G P L A Date of Delivery: // / / / (DD	
Details of the patient admitted	
a) Date of Admission : / / (DD/MM/YYYY) b) Time of Admission : : (HH:MM)	
c) Is this an emergency/a planned hospitalization event?:	
d) Expected no. of days stay in hospital : days e) Days in ICU : days f) 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). : Rs.	
I) Other hospital Expenses: if any : Rs.	
m) All inclusive package charges if any applicable : Rs.	
n) Sum Total expected cost of hospitalization : Rs.	
Mandatory: Past History of any chronic illness If yes, since (month/year)	
Diabetes (MM/YY)	
Heart Disease (MM/YY)	
Hypertension (MM/YY)	
Hyperlipidemias (MM/YY)	
Osteoarthritis (MM/YY)	
Asthma/COPD/Bronchitis (MM/YY)	
Cancer (MM/YY)	
Alcohol or drug abuse (MM/YY)	
Any HIV or STD / Related ailments (MM/YY) Any other Ailment give details:	

We confirm having read understood and agreed to the Declarations on the next page of this form. Name of the treating doctor:	D	eclaration																																				
Declaration by the Patient/Representative A larger to allow the hoositato submit all original documents pertaining to hospitalization to the insurer/TPA after the discharge. I agree to sign on the Final Bill 8 the Discharge Summary, before my discharge. By Patient/Insured Name & Signature Not to be Faxed or Scanned. A larger to allow the hoositato submit all original documents pertaining to hospitalization to the insurer/TPA after the discharge. I agree to sign on the Final Bill 8 the Discharge Summary, before my discharge. By Patient Summary, before my discharge. A larger to allow the hoositato submit all original documents pertaining to hospitalization and the amounts over & above the limit authorized by the insurer/TPA no governed by the terms and conditions of the policy. A line-medical expenses and expenses and expenses not relevant to current hospitalization and the amounts over & above the limit authorized by the insurer/TPA no governed by the terms and conditions of the policy and if a rany time the facts disclosed by me are found to be false or incorrect I forfeit my claim and agree to and empty the insurer/TPA is in no way guaranticeing that the services provided by the hospital by the insurer/TPA. I larger and understand that TPA is in no way warrating the service of the hospital & that the Insurer/TPA is in no way guaranticeing that the services provided by the hospital was not all the properties of the company of the hospital services of the hospital	W	e confirm having read understo	od aı	nd ag	greed	dto:	the [Dec	larat	tior	1S OI	n th	ne ne	extp	age	oft	his fo	orm.													(Pl	ease	e rea	ıd ve	ery ca	arefu	ılly)	
Patient/Insured Name & Signature Declaration by the Patient/Representative Not to be Faxed or Scanner a. Lagres to allow the hospital so submit all original documents pertaining to hospitalization to the Insurer/TPA after the discharge, lagres to sign on the final Bill of the Discharge Summary, before my discharge. b. 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, Lundertake to settle the bilds per the terms and conditions of the policy and if an any time the facts disclosed by me are found to be false or incorrect if orfeit my claim and agree to indernify the Insurer/TPA. d. Thereby declare to abide by the terms and conditions of the policy and if any time the facts disclosed by me are found to be false or incorrect if orfeit my claim and agree to indernify the Insurer/TPA is in no way guaranteeing that the services provided by the hospital will be of a particular quality or standard. I. Breeze warms that that not held free frogong particulars in every respect and lagree that if I have made or shall make any false or untrue statement suppression or concealment with respect to the claim, my right to claim reimbursement of the said expenses shall be absolutely forfetted. J. Breeze in warms the truth of the frogong particulars in every respect and lagree that if I have made or shall make any false or untrue statement suppression or concealment with respect to the claim, my right to claim reimbursement of the said expenses shall be absolutely forfetted. J. Breeze in demnify the hospital against all expenses incurred on my beland it, which are not removable by the Insurer TPA. I. Well authorize Insurance Company/TPA to contact me/us through mobile/email for any update on this claim. a) Pottent's finsured's Signature: Date: Time: Hospital Declaration b) Contact Number: c) Email ID (optional): d) Potent's finsured's Signature in the sense object of the mobile stream of the pottent of the shall response to the	a)	Name of the treating doctor:																														T						
Hospital Sed (Must include Hospital ID) Patient/Representative Not to be Faxed or Scanner a. Lagree to allow the hospital to submit all original documents pertaining to hospitalization to the insurer/TPA after the discharge. Lagree to sign on the Final Bill is the Discharge Summary before my discharge. b. Payment to hospital is governed by the terms and conditions of the policy. c. All non-medical expenses and conditions of the policy will be paid by me. d. Honerby declare to abuse by the terms and conditions of the policy will be paid by me. c. All non-medical expenses and expenses not relevant to current hospitalization and the amounts over 8 above the limit authorized by the Insurer/TPA no governed by the terms and conditions of the policy will be paid by me. c. All non-medical expenses and expenses not relevant to current hospitalization and the amounts over 8 above the limit authorized by the Insurer/TPA in terms and conditions of the policy will be paid by me. Liberably expense to abuse by the terms and conditions of the policy and if a rany time the facts disclosed by me are found to be false or incorrect! for first my claim and agree to indemnify the insurer/TPA is no no way guaranteeing that the services provided by the hospital will be of a particular quality or standard. Liberably warrant the ruth of the forgoing particulars in every respect and lagree that if I have made or shall make any false or untrue statement suppression or concestment with respect to the claim, my right to claim reimbursement of the said expenses shall be absolutely for friend. Liberably warrant the ruth of the forgoing particulars injuried to claim reimbursement of the said expenses shall be absolutely for friend. Jagree to indemnify the hospital alignstral expenses incurred on my behalf which are not reimbursed by the Insurer TPA. We wait to be a summarized to the contact me/us stronger to a summarized to the scale of the patient of the said expenses shall be absolutely for insured. We agree that TPA insurance	b)	Qualification:																													T							
Declaration by the Patient/Representative a. lagree to allow the hospital to submit all original documents pertaining to hospitalization to the Insurer/TPA after the discharge. I agree to sign on the Final Bill & the Discharge Summary, before my discharge. b. 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 apertime terms and conditions of the policy will be paid by me. c. All non-medical expenses and expenses not relevant to current hospitalization and the amounts over & above the limit authorized by the Insurer/TPA no governed by the terms and conditions of the policy will be paid by me. d. 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 If forfeit my claim and agree to indemnify the hospital por standard. I hereby declare to a bide 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 If forfeit my claim and agree to indemnify the hospital for a particular quality or standard. I hereby active a particular quality or standard. I hereby active a particular quality or standard. I hereby amount 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 claim, my right to claim reimbursement of the said expenses shall be absolutely forfeited. g. lagree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer/TPA. b. We attend to survival to a survival to claim reimbursement of the said expenses shall be absolutely forfeited. g. lagree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the lensurer of TPA. b. We are no objection to any surhorized TPA/Insurance Company official venifying documents pert	c)	Registration No. with State Co	de:																												İ	Ī						
Declaration by the Patient/Representative a. lagree to allow the hospital to submit all original documents pertaining to hospitalization to the Insurer/TPA after the discharge. I agree to sign on the Final Bill & the Discharge Summary, before my discharge. b. 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 apertime terms and conditions of the policy will be paid by me. c. All non-medical expenses and expenses not relevant to current hospitalization and the amounts over & above the limit authorized by the Insurer/TPA no governed by the terms and conditions of the policy will be paid by me. d. 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 If forfeit my claim and agree to indemnify the hospital por standard. I hereby declare to a bide 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 If forfeit my claim and agree to indemnify the hospital for a particular quality or standard. I hereby active a particular quality or standard. I hereby active a particular quality or standard. I hereby amount 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 claim, my right to claim reimbursement of the said expenses shall be absolutely forfeited. g. lagree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer/TPA. b. We attend to survival to a survival to claim reimbursement of the said expenses shall be absolutely forfeited. g. lagree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the lensurer of TPA. b. We are no objection to any surhorized TPA/Insurance Company official venifying documents pert																																						
Declaration by the Patient/Representative a. lagree to allow the hospital to submit all original documents pertaining to hospitalization to the Insurer/TPA after the discharge. I agree to sign on the Final Bill & the Discharge Summary, before my discharge. b. 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 apertime terms and conditions of the policy will be paid by me. c. All non-medical expenses and expenses not relevant to current hospitalization and the amounts over & above the limit authorized by the Insurer/TPA no governed by the terms and conditions of the policy will be paid by me. d. 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 If forfeit my claim and agree to indemnify the hospital por standard. I hereby declare to a bide 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 If forfeit my claim and agree to indemnify the hospital for a particular quality or standard. I hereby active a particular quality or standard. I hereby active a particular quality or standard. I hereby amount 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 claim, my right to claim reimbursement of the said expenses shall be absolutely forfeited. g. lagree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer/TPA. b. We attend to survival to a survival to claim reimbursement of the said expenses shall be absolutely forfeited. g. lagree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the lensurer of TPA. b. We are no objection to any surhorized TPA/Insurance Company official venifying documents pert		Hospital Seal (Must include Hospital ID)													Patient/Insured Name & Signature														_									
a. Lagree to allow the hospital to submit all original documents pertaining to hospitalization to the Insurer/TPA after the discharge. Lagree to sign on the Final Bill & the Discharge Summary, before my discharge. A 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. All non-medical expenses and expenses not relevant to current hospitalization and the amounts over & above the limit authorized by the lasurer/TPA nor governed by the terms and conditions of the policy will be paid by me. All non-medical expenses and expenses not relevant to current hospitalization and the amounts over & above the limit authorized by the lasurer/TPA nor governed 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 clain and agree to indemnify the hospital activation quality or standard. 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 clain and agree to indemnify the hospital act quality or standard. I hereby declare to a subject to the diam, my right to dain reimbursement of the said expenses shall be absolutely forfeited. I large to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the insurer TPA. It was authorized Insurance Company/TPA to contact me/us through mobile/email for any update on this claim. a) Patient's/insured's Name: b) Contact Number: C) Email ID (optional): c) Email ID (optional): d) Patient's/insured's Signature: Date: Time: Hospital Declaration We have no objection to any authorized TPA/Insurance Company official venifying documents pertaining to hospitalization. b) All valid original documents duly countersigned by the insured/patient as per the checklist below will be sent to TPA/Insurance Co		1 Tospital Seal (1 Tust include 1 to	Japin	LaiiL)																					ıaı	.ICI I	L/ II	isui	cu	i Nai	110	ال کی	igi id	atui	C		
the Discharge Summary before my discharge. D. 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. All non-medical expenses and expenses not relevant to current hospitalization and the amounts over & above the limit authorized by the Insurer/TPA no governed by the terms and conditions of the policy will be paid by me. In Innon-medical expenses and expenses not relevant to current hospitalization and the amounts over & above the limit authorized by the Insurer/TPA no governed 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 forfielt my claim and agree to indemnify the Insurer/TPA. In Igne 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. In Interest warrant the truth of the forgoing particulars in every respect and lagree that if I have made or shall make any false or untrue statement suppression or concealment with respect to the claim, my right to claim reimbursement of the said expenses shall be absolutely forfeited. In Interest the properties of the forgoing particulars in every respect and lagree that if I have made or shall make any false or untrue statement suppression or concealment with respect to the claim, my right to claim reimbursement of the said expenses shall be absolutely forfeited. In Interest the properties of the false of the interest of the said expenses shall be absolutely forfeited. In Interest the interest of the false or untrue statement suppression or concealment with respect to the claim, my right to claim reimbursement of the said expenses shall be absolutely forfeited. In Interest the interest the false of the interest the false of the interest the interest the false of the int	D	eclaration by the Patier	nt/F	Rep	res	ent	ativ	⁄e																			Ν	ot	to	b	e F	ax	ed	lo	r S	ca	nne	C
billas per the terms and conditions of the policy. All non-medical expenses and expenses not relevant to current hospitalization and the amounts over & above the limit authorized by the Insurer/TPA not governed by the terms and conditions of the policy will be paid by me. In the policy and if at any time the facts disclosed by me are found to be false or incorrect! forfeit my claim and agree to indemnify the Insurer/TPA. In page 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. 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 claim, my right to claim reimbursement of the said expenses shall be absolutely forfeited. I lagree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer/TPA. In I/We authorize Insurance Company/TPA to contact me/us through mobile/email for any update on this claim. a) Patient's/Insured's Name: b) Contact Number: c) Email ID (optional): d) Patient's/Insured's Signature: Date: Date: Time: Hospital Declaration We have no objection to any authorized TPA/Insurance Company official verifying documents pertaining to hospitalization. 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. 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. The patient declaration has been signed by the patient or by his representative in our presence. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in	a.						l do	cum	nents	s pe	erta	ainir	ng to	hos	spita	lizat	ion 1	to th	e Ir	nsur	er	TP/	A af	ter	th	e di	sch	arg	e.I	agr	ee t	o si	gn d	on t	the	Fina	al Bill	8
c. All non-medical expenses and expenses not relevant to current hospitalization and the amounts over & above the limit authorized by the Insurer/TPA no governed by the terms and conditions of the policy will be paid by me. d. Ihereby 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 clair and agree to indemnify the Insurer/TPA. 1. Tagree 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. Ihereby 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 claim, my right to claim reimbursement of the said expenses shall be absolutely forfeited. g. Tagree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer/TPA. h. I/We authorize Insurance Company/TPA to contact me/us through mobile/email for any update on this claim. a) Patient's/Insured's Signature: b) Contact Number: c) Email ID (optional): d) Patient's/Insured's Signature: Date: Time: Hospital Declaration a. We have no objection to any authorized TPA/Insurance Company official verifying documents pertaining to hospitalization. b. 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. c. 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. d) The patient declaration has been signed by the patient or by his representative in our presence. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibi	b.							ond	lition	ns c	of th	ne p	olicy	. In o	case	the	Insu	ırer/	TPA	∆ is	no	t lia	ble	to	set	tle t	he	hos	spit	al b	ill, I	unc	dert	tak	e to	set	tle th	ıe
d. Thereby 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. 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. 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 claim, my right to claim reimbursement of the said expenses shall be absolutely forfeited. g lagree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer/TPA. I. I/We authorize Insurance Company/TPA to contact me/us through mobile/email for any update on this claim. a) Patient's/Insured's Name: b) Contact Number: c) Email ID (optional): d) Patient's/Insured's Signature: Date: Time: Hospital Declaration a. We have no objection to any authorized TPA/Insurance Company official verifying documents pertaining to hospitalization. b. 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. c. 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. d) The patient declaration has been signed by the patient or by his representative in our presence. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications. We confirm that no additional amount would be collected from the insured in excess of Agreed Package Rates except costs towards non-admissible amounts (including additional charges due to	c.	All non-medical expenses and	d ex	pens	ses n	ot r	eleva							aliza	tion	anc	d the	am	our	nts (OVE	er 8	k ab	OV	e th	ne li	mit	au	thc	riz	ed b	y t	he	Ins	urei	·/TF	PA no)†
e. lagree 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. f. 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 claim, my right to claim reimbursement of the said expenses shall be absolutely forfeited. g. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer/ TPA. h. I/We authorize Insurance Company/TPA to contact me/us through mobile/email for any update on this claim. a) Patient's/Insured's Name: b) Contact Number: c) Email ID (optional): d) Patient's/Insured's Signature: Date: Time: Hospital Declaration a. We have no objection to any authorized TPA/Insurance Company official verifying documents pertaining to hospitalization. b. 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. c. 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. d) The patient declaration has been signed by the patient or by his representative in our presence. e. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications. f. We will abide by the terms and conditions agreed in the MOU. g. We confirm that no additional amount would be collected from the insured in excess of Agreed Package Rates except costs towards non-admissible amount (including additional charges due to opting higher room rent than eligibility/choosing separate line of treatment which is not envisaged/considered in package). h. We	d.	I hereby declare to abide by th	e tei	rms a	and c		,				,			at an	y tin	ne tł	ne fa	icts c	disc	lose	ed l	oy n	ne a	ıre	fou	nd	to b	oe f	alse	or	inco	orre	ect	l fo	rfei	t m ₎	/ clair	Υ
f. I hereby warrant the truth of the forgoing particulars in every respect and lagree that if I have made or shall make any false or untrue statement suppression or concealment with respect to the claim, my right to claim reimbursement of the said expenses shall be absolutely forfeited. g. I lagree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer/ TPA. h. I/We authorize Insurance Company/TPA to contact me/us through mobile/email for any update on this claim. a) Patient's/Insured's Name: b) Contact Number: c) Email I/D (optional): d) Patient's/Insured's Signature: Date: Time: Hospital Declaration a. We have no objection to any authorized TPA/Insurance Company official verifying documents pertaining to hospitalization. b. 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. c. 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. d. The patient declaration has been signed by the patient or by his representative in our presence. e. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications. f. We will abide by the terms and conditions agreed in the MOU. g. We confirm that no additional amount would be collected from the insured in excess of Agreed Package Rates except costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility/choosing separate line of treatment which is not envisaged/considered in package). h. We confirm that no recoveries would be made from the deposit amount collected from the insured except for costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility/choo	e.	lagree and understand that TF	PA is	in no	o way				the	sei	rvic	e o	fthe	hos	pita	l&t	hat t	he Ir	nsui	rer/	TP	'A is	in r	10 \	νaγ	⁄ gu	araı	nte	eing	gth	at th	ne s	serv	vice	es pr	ovio	ded b))
g. lagree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurent/TPA. h. I/We authorize Insurance Company/TPA to contact me/us through mobile/email for any update on this claim. a) Patient's/Insured's Name: b) Contact Number: c) Email ID (optional): d) Patient's/Insured's Signature: Date: Time: Hospital Declaration a. We have no objection to any authorized TPA/Insurance Company official verifying documents pertaining to hospitalization. b. 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. c. 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 summarry or other documents. d. The patient declaration has been signed by the patient or by his representative in our presence. e. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications. f. We will abide by the terms and conditions agreed in the MOU. g. We confirm that no additional amount would be collected from the insured in excess of Agreed Package Rates except costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility/choosing separate line of treatment which is not envisaged/considered in package). h. We confirm that no recoveries would be made from the deposit amount collected from the insured except for costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility/choosing separate line of treatment which is not envisaged/considered in package). i. In the event of unauthorized recovery of any additional amount from the Insured in excess of Agreed Package Rates, the authorized TPA / Insurance Company reserves the right to recover the same from us (the Ne	f.	I hereby warrant the truth of t	he f	orgo	, ping p	arti	cula	rs in																				or	unt	rue	: sta	ten.	nen	nt su	nbb	ress	sion c	٦٢
a) Patient's/Insured's Name: b) Contact Number: c) Email ID (optional): d) Patient's/Insured's Signature: Date: Time: Hospital Declaration a. We have no objection to any authorized TPA/Insurance Company official verifying documents pertaining to hospitalization. b. 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. c. 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. d. The patient declaration has been signed by the patient or by his representative in our presence. e. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications. f. We will abide by the terms and conditions agreed in the MOU. g We confirm that no additional amount would be collected from the insured in excess of Agreed Package Rates except costs towards non-admissible amount (including additional charges due to opting higher room rent than eligibility/choosing separate line of treatment which is not envisaged/considered in package). h. We confirm that no recoveries would be made from the deposit amount collected from the insured except for costs towards non-admissible amount (including additional charges due to opting higher room rent than eligibility/choosing separate line of treatment which is not envisaged/considered in package). i. In the event of unauthorized recovery of any additional amount from the Insured in excess of Agreed Package Rates, the authorized TPA / Insurance Company reserves the right to recover the same from us (the Network Provider) and/or take necessary action, as provided under the MoU or applicable laws.	g.	· ·			,	_																		,														
b) Contact Number: d) Patient's/Insured's Signature: Date: Time: Hospital Declaration a. We have no objection to any authorized TPA/Insurance Company official verifying documents pertaining to hospitalization. b. 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. c. 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. d. The patient declaration has been signed by the patient or by his representative in our presence. e. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications. f. We will abide by the terms and conditions agreed in the MOU. g. We confirm that no additional amount would be collected from the insured in excess of Agreed Package Rates except costs towards non-admissible amount (including additional charges due to opting higher room rent than eligibility/choosing separate line of treatment which is not envisaged/considered in package). h. We confirm that no recoveries would be made from the deposit amount collected from the insured except for costs towards non-admissible amount (including additional charges due to opting higher room rent than eligibility/choosing separate line of treatment which is not envisaged/considered in package). i. In the event of unauthorized recovery of any additional amount from the Insured in excess of Agreed Package Rates, the authorized TPA/Insurance Company reserves the right to recover the same from us (the Network Provider) and/or take necessary action, as provided under the MoU or applicable laws. Hospital Seal Doctor's Signature	h.																																					
d) Patient's/Insured's Signature: Date: Time: Hospital Declaration a. We have no objection to any authorized TPA/Insurance Company official verifying documents pertaining to hospitalization. b. 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. c. 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. d. The patient declaration has been signed by the patient or by his representative in our presence. e. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications. f. We will abide by the terms and conditions agreed in the MOU. g. We confirm that no additional amount would be collected from the insured in excess of Agreed Package Rates except costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility/choosing separate line of treatment which is not envisaged/considered in package). h. We confirm that no recoveries would be made from the deposit amount collected from the insured except for costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility/choosing separate line of treatment which is not envisaged/considered in package). In the event of unauthorized recovery of any additional amount from the Insured in excess of Agreed Package Rates, the authorized TPA / Insurance Company reserves the right to recover the same from us (the Network Provider) and/or take necessary action, as provided under the MoU or applicable laws. Hospital Seal Doctor's Signature		a) Patient's/Insured's Name:																																				_
Hospital Declaration a. We have no objection to any authorized TPA/Insurance Company official verifying documents pertaining to hospitalization. b. 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. c. 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. d. The patient declaration has been signed by the patient or by his representative in our presence. e. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications. f. We will abide by the terms and conditions agreed in the MOU. g. We confirm that no additional amount would be collected from the insured in excess of Agreed Package Rates except costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility/choosing separate line of treatment which is not envisaged/considered in package). h. We confirm that no recoveries would be made from the deposit amount collected from the insured except for costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility/choosing separate line of treatment which is not envisaged/considered in package). i. In the event of unauthorized recovery of any additional amount from the Insured in excess of Agreed Package Rates, the authorized TPA/Insurance Company reserves the right to recover the same from us (the Network Provider) and/or take necessary action, as provided under the MoU or applicable laws. Doctor's Signature		b) Contact Number:					-													c))	Ema	ail IE) (pt	iona	al) :											_
 a. We have no objection to any authorized TPA/Insurance Company official verifying documents pertaining to hospitalization. b. 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. c. 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. d. The patient declaration has been signed by the patient or by his representative in our presence. e. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications. f. We will abide by the terms and conditions agreed in the MOU. g. We confirm that no additional amount would be collected from the insured in excess of Agreed Package Rates except costs towards non-admissible amount: (including additional charges due to opting higher room rent than eligibility/choosing separate line of treatment which is not envisaged/considered in package). h. We confirm that no recoveries would be made from the deposit amount collected from the insured except for costs towards non-admissible amount: (including additional charges due to opting higher room rent than eligibility/choosing separate line of treatment which is not envisaged/considered in package). i. In the event of unauthorized recovery of any additional amount from the Insured in excess of Agreed Package Rates, the authorized TPA / Insurance Company reserves the right to recover the same from us (the Network Provider) and,/or take necessary action, as provided under the MoU or applicable laws. 		d) Patient's/Insured's Signatur	`e:_											Da	ate:									Т	ime	e:_												
 b. 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. c. 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. d. The patient declaration has been signed by the patient or by his representative in our presence. e. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications. f. We will abide by the terms and conditions agreed in the MOU. g. We confirm that no additional amount would be collected from the insured in excess of Agreed Package Rates except costs towards non-admissible amount: (including additional charges due to opting higher room rent than eligibility/choosing separate line of treatment which is not envisaged/considered in package). h. We confirm that no recoveries would be made from the deposit amount collected from the insured except for costs towards non-admissible amount: (including additional charges due to opting higher room rent than eligibility/choosing separate line of treatment which is not envisaged/considered in package). i. In the event of unauthorized recovery of any additional amount from the Insured in excess of Agreed Package Rates, the authorized TPA / Insurance Company reserves the right to recover the same from us (the Network Provider) and,/or take necessary action, as provided under the MoU or applicable laws. 	Н	ospital Declaration																																				
patient's discharge. c. 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. d. The patient declaration has been signed by the patient or by his representative in our presence. e. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications. f. We will abide by the terms and conditions agreed in the MOU. g. We confirm that no additional amount would be collected from the insured in excess of Agreed Package Rates except costs towards non-admissible amount: (including additional charges due to opting higher room rent than eligibility/choosing separate line of treatment which is not envisaged/considered in package). h. We confirm that no recoveries would be made from the deposit amount collected from the insured except for costs towards non-admissible amount: (including additional charges due to opting higher room rent than eligibility/choosing separate line of treatment which is not envisaged/considered in package). In the event of unauthorized recovery of any additional amount from the Insured in excess of Agreed Package Rates, the authorized TPA / Insurance Company reserves the right to recover the same from us (the Network Provider) and,/or take necessary action, as provided under the MoU or applicable laws. Doctor's Signature		,									,				, ,	_						_																
c. 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. d. The patient declaration has been signed by the patient or by his representative in our presence. e. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications. f. We will abide by the terms and conditions agreed in the MOU. g. We confirm that no additional amount would be collected from the insured in excess of Agreed Package Rates except costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility/choosing separate line of treatment which is not envisaged/considered in package). h. We confirm that no recoveries would be made from the deposit amount collected from the insured except for costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility/choosing separate line of treatment which is not envisaged/considered in package). i. In the event of unauthorized recovery of any additional amount from the Insured in excess of Agreed Package Rates, the authorized TPA / Insurance Company reserves the right to recover the same from us (the Network Provider) and,/or take necessary action, as provided under the MoU or applicable laws. Hospital Seal Doctor's Signature	b.	_	uly c	count	tersi	gnec	d by	the	insu	rec	d/pa	atie	nt as	s per	^ the	e che	eckli	st be	elov	V W	ill b	oe s	ent	to	TP.	a/Ir	nsui	ran	ce (Coi	npa	ıny	witl	hin	7 d	ays	of th	E
e. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications. f. We will abide by the terms and conditions agreed in the MOU. g. We confirm that no additional amount would be collected from the insured in excess of Agreed Package Rates except costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility/choosing separate line of treatment which is not envisaged/considered in package). h. We confirm that no recoveries would be made from the deposit amount collected from the insured except for costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility/choosing separate line of treatment which is not envisaged/considered in package). i. In the event of unauthorized recovery of any additional amount from the Insured in excess of Agreed Package Rates, the authorized TPA / Insurance Company reserves the right to recover the same from us (the Network Provider) and,/or take necessary action, as provided under the MoU or applicable laws. Hospital Seal Doctor's Signature	c.			mpa	ıny w	/ill n	ot b	e lia	ıble 1	to 1	mak	ke t	he p	aym	nent	in tl	he e	vent	of	any	⁄ di	scre	ера	ncy	be	etw	een	th	e fa	ıcts	in t	his	for	m a	and	disc	charg	įe
f. We will abide by the terms and conditions agreed in the MOU. g. We confirm that no additional amount would be collected from the insured in excess of Agreed Package Rates except costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility/choosing separate line of treatment which is not envisaged/considered in package). h. We confirm that no recoveries would be made from the deposit amount collected from the insured except for costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility/choosing separate line of treatment which is not envisaged/considered in package). i. In the event of unauthorized recovery of any additional amount from the Insured in excess of Agreed Package Rates, the authorized TPA / Insurance Company reserves the right to recover the same from us (the Network Provider) and,/or take necessary action, as provided under the MoU or applicable laws. Hospital Seal Doctor's Signature	d.	The patient declaration has be	en s	igne	d by t	the p	oatie	nt c	or by	his	rep	ore	sent	ative	e in c	ourp	ores	ence	<u>.</u>																			
g. We confirm that no additional amount would be collected from the insured in excess of Agreed Package Rates except costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility/choosing separate line of treatment which is not envisaged/considered in package). h. We confirm that no recoveries would be made from the deposit amount collected from the insured except for costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility/choosing separate line of treatment which is not envisaged/considered in package). i. In the event of unauthorized recovery of any additional amount from the Insured in excess of Agreed Package Rates, the authorized TPA / Insurance Company reserves the right to recover the same from us (the Network Provider) and,/or take necessary action, as provided under the MoU or applicable laws. Hospital Seal Doctor's Signature	e.								_		ding	this	shos	pita	lizat	ion	and	wet	ake	the	SC	le r	esp	on:	sibi	lity	for	any	/de	lay	n of	fer	ing	cla	rific	atio	ns.	
(including additional charges due to opting higher room rent than eligibility/choosing separate line of treatment which is not envisaged/considered in package). h. We confirm that no recoveries would be made from the deposit amount collected from the insured except for costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility/choosing separate line of treatment which is not envisaged/considered in package). In the event of unauthorized recovery of any additional amount from the Insured in excess of Agreed Package Rates, the authorized TPA / Insurance Company reserves the right to recover the same from us (the Network Provider) and,/or take necessary action, as provided under the MoU or applicable laws. Hospital Seal Doctor's Signature		,				_					nm t	the	incu	red	in ev	VCAS	s of	Agr	aed	l Par	-l-s	ισe	Rat	<u>۵</u> د د	200	ent	COS	ete ·	tow	/arc	de ni	on-	adr	nice	sible	am	ooun.	t٠
(including additional charges due to opting higher room rent than eligibility/choosing separate line of treatment which is not envisaged/considered in package). i. In the event of unauthorized recovery of any additional amount from the Insured in excess of Agreed Package Rates, the authorized TPA / Insurance Company reserves the right to recover the same from us (the Network Provider) and,/or take necessary action, as provided under the MoU or applicable laws. Hospital Seal Doctor's Signature		(including additional charges d	ue to	o opt	ting h	nighe	er ro	om	rent	t th	an e	eligi	bility	//ch	oosi	ng s	epar	ate l	ine	oft	re	atm	ent	wł	nich	is r	not	en	/isaş	gec	l/coi	nsic	dere	ed i	n pa	ıcka	ige).	
reserves the right to recover the same from us (the Network Provider) and,/or take necessary action, as provided under the MoU or applicable laws. Hospital Seal Doctor's Signature	h.																																					ţ:
	i.																																			Cor	mpar	1)
		-																																				
		Hospital Seal																										[Dod	toı	r's S	igna	 atur	re				_
Date : I ime :	_	·	Τ.																													_						
	Da	te:	I im	ie : _					_																													