



Cashless Request Form

Please tick the box against the appropriate TPA as mentioned in ID card

 <p>Paramount Health services TPA Pvt Ltd Elite Auto House, 54-A, 2nd Floor, M. VasANJI Road, Mumbai – 400093. Tel: 022-5662 0808, Fax: 022-28259743</p>	 <p>Emeditek (TPA) Services Ltd 577, Udyog Vihar, Phase-5, Gurgaon Tel: 0124-4466666, Fax: 0124-4466677</p>
--	--

PART A: TO BE FILLED BY TREATING CONSULTANT

Name: Shri/Smt/Kum: _____ Age: ____ Yrs Sex: _____

Patients Tel.No(Off): _____ Mob: _____ Resi: _____ Fax: _____

Member ID. No: _____ Corporate Name / Emp Code: _____

Policy No: _____ Policy Period: _____

Name of Treating Doctor: _____ Doctors Tel.No: _____

Name of Hospital / Nursing Home: _____

Name of Family Physician: _____ Tel. No: _____

Presenting complaint: _____

History of Presenting complaint: _____

Duration of Presenting complaint: _____

Relevant Clinical finding: _____

Relevant past history & treatment: _____

Investigation reports (attach separate sheet): _____

Provisional/Differential diagnosis: _____

Proposed treatment plan (attach separate sheet): _____

Particulars	Yes/ No	Since When
Hypertension		
IHD		
Osteoarthritis		
COPD/ Bronchial Asthama		
Any other Chronic Disorder		

Particulars	Yes/ No	Since When
Diabetes		
Heart Diseases (Date of First episode)		
Cancer		
Alcohol/Drug abuse		
Maternity cases: Gravida _____ Para _____ Living _____ LMP _____		

In case of Accidents, influence of alcohol / any other drugs: **Yes / No** Whether MLC done: **Yes / No**

Particulars	Details
Date of admission	
Approximate expenses	
Room Rent	
Investigation Charges	
Name of Implant	
Cost of Implant	

Particulars	Details
Approximate duration of stay	
Class of accommodation	
Doctor / Surgeon Fees	
OT Charges/ Anesthesia/ Medicines	
Package Rate	
Total Amount	

PART B – TO BE FILLED BY THE HOSPITAL AUTHORITIES

TPA will not be held liable for the payment in the event of any discrepancy between the facts of presented at the time of admission & in final documents submission

Signature & Stamp of Treating Doctor: _____

Rubber Stamp of Hospital & Signature: _____

PART C- TO BE FILLED UP BY THE INSURED

I have 'No Objection' to TPA obtaining details of my treatment / collecting documents and also hereby authorize TPA to pay the hospital bill & reimburse itself / receive the amount from my claim receivable from my insurance company. If my claim is rejected, I/we (the patient) will pay for the hospital & related expenses should this authorization become null & void due to wrong and/ or misleading and/or incorrect information regarding the duration of ailments and/or other historical information regarding my (patients) health status/. I acknowledge and agree that information provided by me are true and up to the best of my knowledge.

Previous policy details – Policy No: _____ Insurance Company: _____

Previous claim details ailment: _____ Date: _____ Amount: _____

Concurrent policy details: _____ Contact info: _____

Name: _____ Signature (Insured / Claimant): _____