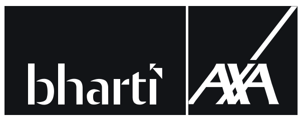

redefining /
general insurance

Bharti AXA General Insurance Company Limited

1800-103-2292 (Toll Free)
claims@bharti-axagi.co.in
SMS <CLAIM> to 5667700
www.bharti-axagi.co.in

REQUEST FOR CASHLESS HOSPITALISATION FOR MEDICAL INSURANCE POLICY

Important Note

PLEASE FAX / SCAN PAGE 1 to 3 ONLY

Issuance of this form not to be taken as an admission of liability

Please fill this form in **Block Letters** and **Tick the Boxes** ✓ where appropriate and do not leave any column unanswered.

If any detail or information is not readily available, please do not delay despatch of this report and such particulars may be sent later.

1 Details of the Third Party Administrator

Name of TPA / Insurance company

Toll free phone number

Toll free FAX

2 To be filled by the insured / patient

Name of the patient

Gender ☐ Male ☐ Female Age Years Y Y Months M Date of birth D D M M Y Y Y Y

Contact No. Contact No. of the attending relative

Insured card ID number

Policy number / Name of corporate Employee ID

Currently do you have any other Mediclaim / Health insurance ☐ Yes ☐ No

Company Name

Give details

Do you have a family physician ☐ Yes ☐ No Name of the family physician

Contact number, if any

3 To be filled by the treating doctor / hospital

Name of the treating doctor Contact No.

Nature of ILLNESS / Disease with presenting complaints

Relevant clinical findings

Duration of the present ailment ☐☐☐ Days Date of first consultation D D M M Y Y Y Y

Past history of present ailment if any

Provisional diagnosis ICD 10 Code

Proposed line of treatment: ☐ Medical Management ☐ Surgical Management ☐ Intensive care ☐ Investigation ☐ Non allopathic treatment

If Investigation & / or Medical Management provide details

Route of drug administration

If Surgical, name of surgery ______ ICD 10 Code

If other treatments provide details ______

How did injury occur ______

In case of accident: Is it RTA ☐ Yes ☐ No Date of injury D D M M Y Y Y Y

Reported to Police ☐ Yes ☐ No FIR No

Injury / Disease caused due to substance abuse / alcohol consumption ☐ Yes ☐ No Test conducted to establish this ☐ Yes ☐ No
(If Yes attach reports)

In case of Maternity ☐ G ☐ P ☐ L ☐ A Date of delivery D D M M Y Y Y Y

4 Details of the patient admitted

Date of admission D D M M Y Y Y Y Time H H : M M

Is this an emergency / a planned hospitalization event? ☐ Emergency ☐ Planned

Expected no. of days stay in hospital: Days Room Type ______

Per Day Room Rent + Nursing & Service Charges + Patient's Diet Rs.

Expected cost for investigation + diagnostics Rs.

ICU Charges Rs.

OT Charges Rs.

Professional fees Surgeon + Anesthetist Fees + consultation Charges Rs.

Medicines + Consumables + Cost of Implants (if applicable please) Rs.

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

5 Declaration

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

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

Qualification

Registration No. with State Code

Hospital Seal
(Must include Hospital ID)

Patient / Insured Name & Signature

6 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.
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 with respect to the claim, my right to claim reimbursement of the said expenses shall be absolutely forfeited.
7. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer / TPA.

Data Privacy Notice:

I/We hereby provide consent to the Company for collecting/retaining any information relating to Me/Us including Sensitive Personal Information (“hereinafter cumulatively referred to as “INFORMATION”), that is either available with the Company or disclosed by Me/Us while obtaining the policy of Insurance from the company or otherwise. I/We further understand that the Company may use the INFORMATION for servicing the Insurance policy obtained by Me/Us and for same may share the INFORMATION with any reinsurer, insurance association, medical authorities, other Insurers, statutory authorities, court, governmental body, regulator etc., or with services provider(s) engaged by the Company for servicing the Insurance policy, underwriting the risk, settlement of claim etc. without obtaining our specific consent for such sharing and we hereby provide our consent to Company for same.

I/We understand that whenever I/We would like to update/correct the INFORMATION, we will intimate the Company for the same, so as to enable the Company to amend/correct the INFORMATION accordingly. Further in the event I/We would like to withdraw My/Our consent provided herein, I/We would intimate the Company of the same in writing and also understand that, in the event of such withdrawal by Me/Us, the Company reserves the right to not provide Me/Us the Services for which it has sought the INFORMATION.

Patient's / Insured's Name ____________________

Contact number ____________________ Patient's / Insured's Signature ____________________

7 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

8 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.

CLAIM FORM/PRE-AUTH/THINQ/08-15. Insurance is the subject matter of solicitation.

redefining /
general insurance