

REQUEST FOR CASHLESS HOSPITALISATION FOR HEALTH INSURANCE POLICY

PART C (Revised)

TO BE FILLED IN BLOCK LETTERS

Name of the hospital: Hospital location: Hospital email ID: ROHINI ID:														
DETAILS OF THIRD PARTY ADMINISTRATOR a) Name of TPA company. Modi Assist Incurance TPA Put Ltd. b) Phone no: 090 22069666 c) Toll Free Fay no: 1900 425 0550														
a) Name of TPA company: Medi Assist Insurance TPA Pvt Ltd b) Phone no.: 080 22068666 c)Toll Free Fax no.: 1800 425 9559														
a) Name of the patient: b) Gender: Male Female Third gender c) Contact no.: d) Alternate contact no.: e) Age: Years Y Y Months M M f) Date of birth: D M M Y Y Y Y Y g) Insurer ID card no.: i) Employee ID: j) Currently do you have any other medical claim/health Insurance: Yes No j,1) Insurer name: j,2) Give details:														
k) Do you have a family physician, if yes: Name:														
TO BE FILLED BY THE TREATING DOCTOR/HOSPITAL														
a) Name of the treating doctor: b) Contact no.: b) Contact no.:														
c) Name of Illness/disease with presenting complaints: d) Relevant clinical findings:														
e) Duration of the present ailment: days e.1) Date of first consultation: DDMMYYYYY														
e.2) Past history of present ailment if any:														
f) Provisional diagnosis: f.1) ICD 10 code:														
g) Proposed line of treatment: Medical management Surgical management Intensive care Investigation Non-Allopathic treatment														
h) If investigation and/or medical management, provide details: h.1) Route of drug administration: IV														
i) If Surgical, name of surgery: i.1) 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: D D M M 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, If yes attach reports: Yes No														
m) In case of maternity: G P L A n) Expected date of delivery: D D M M Y Y Y														
DETAILS OF THE PATIENT ADMITED														
a) Date of admission: DDMMYYYYY b) Time of admission: HHMMM c) This is an emergency/ a planned hospitalization event														
d) Expected no. of days stay in hospital: Days e) Days in ICU: Days f) Room type:														



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g) Per Day Room F	Rent + Nursing &	Service	charge	s + P	atient	's Diet:		Rs.								p. <i>l</i>	Manc	atory	past	histor	y of a	any c	hro	nic ill	nes	s. If y	es (s	ince	month	/year)	
h) Expected cost for investigation + diagnostics:											T						1.	Diabe	tes										M	М	Υ	Υ
i) ICU Charges:											Ti						2.	Heart	Dise	ase									M	М	Υ	Υ
j) OT Charges:		Rs.	ī								3.	Нуреі	tens	ion									M	Μ	Υ	Υ						
k) Professional fee	es:	Rs.	4. Hyperlipidemias													M	Μ	Υ	Υ													
L) Medicines + Co		Rs.	ī		Ti						5.	Osteo	arth	itis									M	М	Υ	Υ						
m) Other hospital		Rs.	٦Ė								6.	Asthn	na/ C	OPD /	Bron	chitis	5						M	Μ	Υ	Υ						
n) All inclusive package charges if any applicable :									٦'n		Πİ						7.	Cance	r										M	М	Υ	Υ
o) Sum Total expected cost of hospitalization								Rs. 8. Alcohol or drug abuse											M	М	Υ	Υ										
								_									9.	Any H	IV oı	STD /	relat	ed ai	lme	nts					M	М	Υ	Υ
																	10.	Any o	ther	ailmer	nt giv	e de	ails	:								
DECLARATION (PLEASE READ VERY CAREFULLY)																																
We confirm havin	g read understoo	d and a	greed to	o the	e decla	ration c	f this f				(,	, ISE IIE	10 11		C/ 111L	. 01																
a) Name of the tre	eating doctor:			7					7																					$\neg \vdash$		
b) Qualification:	[$\exists \vdash$		ī	ī		ilii		ī						ш		ـــــــــــــــــــــــــــــــــــــ	istrat	ion l	⊸∟ lo. wit	h Sta	te co	ഥ de:		F	ï	F			╁		i
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a. I agree to allo	-				docum	ents pe	tainin	g to h	ospit	alizatio	n to	the Insi	urer/T	PΑ	after	the	disc	narge	. I aç	ree to	sign	on t	ne F	inal	Bill	& the	e Dis	char	ge Su	nmaı	y, be	fore
my discharge. b. Payment to he		ed by the	e terms	and	l cond	itions of	the po	licy.	In cas	e the I	nsur	er / TPA	A is n	ot lia	able t	o se	ettle 1	he ho	spita	ıl bill, l	und	ertak	e to	sett	le th	ne bil	las	per tl	ne teri	ns an	d cor	ıdi-
tions of the po	olicy.	•					·	•																								
the policy will	be paid by me.	•					·													•				•			•					13 01
 d. I hereby decla insurer / TPA 	are to abide by the	e terms	and co	naiti	ions o	tne poi	cy and	ıraı	any i	ime the	е тас	ts disci	osea	by r	ne ar	етс	una	to be	raise	or inc	corre	CT I TO	пе	t my	cıaı	m an	a a	gree 1	o inae	mnity	tne	
e. I agree and ur ular quality or		PA is in	no way	war	rantino	the se	vice o	f the	hospi	tal & th	at th	e Insur	er / T	PA i	is in r	no w	ay g	uarar	teei	ng tha	the	servi	ces	prov	ride	d by t	he I	nospi	al wil	be o	a pa	rtic-
f. I hereby warra	ant the truth of the											ve mad	e or s	shall	mak	e ar	ny fa	se or	untr	ue sta	teme	nt, sı	ıppı	essi	on c	r cor	ncea	ılmen	t with	respe	ct to	the
g. I agree to inde	emnify the hospita	al again	st all ex	pen	ises in	curred o	n my	beha	lf, wh	ich are	not i					sure	r/ TF	A.														
h. "I/We authoriz	e insurance con	ірапу/ і	PA IO C	onta	ici me	us tillot	ign me	blie/	eman	ior any	upc	iate on	uns	Jam	1																	
a) Patient's / Insur	red's name:														П																	
b) Contact number	er:			Ī					c) I	mail I): (Op	otional)						ΠÏ			Ī		Γ		Γ	Ï	Ï			ī	Ī	Ī
d) Patient's / Insur	red's signature:												Da	ite:	D	D	М	М	Υ	YY	Υ]	1	ime:	Н	Н	М	М				
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HOSPITAL DECLA	ARATION																															
a. We have no ol	bjection to any au																							_								
 b. All valid origina c. We agree that 																														cume	nts.	
d. The patient dee. We agree to p													he sc	ole r	eeno	neih	ility f	or an	اماء ،	av in d	offerir	na cla	rifi	atio	ne		-					
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f. We will abide I			would h	e cc															vard	s non-	admı	ssible	e ar	nour	its (nclud	ding	addi	ional	charg	es du	ie to
g. We confirm that	at no additional a	mount		ig se	eparat	e iii ie oi	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).														ıg											
9. We confirm that opting higher rh. We confirm that	at no additional a room rent than el at no recoveries	mount i igibility would b	choosin e made	fror	m the	deposit						conside	ered i	n na		le)			ı uu.	nissibl	e am	ount	s (ir	clud	ing	addit	iona	I cha	rges (lue to		-
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