RELIANCE HEALTH INSURANCE

# PRE-AUTHORISATION FORM

UIN: UIIHLIP18012V011718

## TO BE FILLED BY THE INSURED

a) Insured's Name:

b) Contact No.

c) Email:

d) Policy No.: e) UHID No.:

f) If Group Policy, Company Name: g) Employee Id:

h) PAN:

## PATIENT DETAILS

a) Name:

b) UHID: c) Age: d) Date of Birth:

e) Gender: ☐ Male ☐ Female

f) Email: g) Mobile No.:

h) Relation with insured: ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Son ☐ Daughter ☐ Others

i) Address:

j) City: k) Pin Code:

l) Attendant Name:

m) Attendant's Mobile No.:

n) Currently covered by any other Mediclaim / Health Insurance: ☐ Yes ☐ No

o) Date of commencement of first Insurance without break: (DD/MM/YYYY)

p) If yes, Company name: Policy No.: Sum Insured (₹):

## HOSPITAL DETAILS

a) Name:

b) Address:

c) City:

d) Pin Code:

e) Contact Details

**Hospital Employee**

Name:

Contact No.: Fax No.: Email:

**Treating Doctor Details**

Name: Dr.

Qualification: Reg No.: Mobile No.:

f) Attendant's Email:

g) Date of Admission: (DD/MM/YYYY)

h) Time: HH : MM

i) Is this an emergency/a planned hospitalisation event?: ☐ Emergency ☐ Planned

j) Expected no. of days stay in hospital: days

k) Room Type: ☐ Single AC ☐ Single Non AC ☐ Twin Sharing AC ☐ Twin Sharing Non AC ☐ Multi Bed ☐ Others

l) Package Rate: ☐ Yes ☐ No

m) Is yes, Package Charges

Implant Charges

n) If package not applicable,

| | |
|---|---|
| Per day Room Rent + Nursing and Service Charges + Patient's Diet: | ₹ |
| Expected cost for Investigation and Diagnostics: | ₹ |
| ICU Charges: | ₹ |
| OT Charges: | ₹ |
| Professional Fees Surgeon + Anaesthetist Fees + Consultation Charges: | ₹ |
| Medicines + Consumables + Cost of Implants: | ₹ |
| (if applicable please specify, other hospital expenses) | |
| Sum total expected cost of hospitalisation: | ₹ |

**TO BE FILLED BY TREATING DOCTOR**

a) Name:

b) Contact No.:

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:

iii. ICD 10 code:

f) Provisional Diagnosis:

g) Proposed line of Treatment: ☐ Medical Management ☐ Surgical Management ☐ Intensive Care ☐ Investigation ☐ Non-allopathic Treatment

h) If investigation and/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

vi. Test conducted to establish this: ☐ Yes ☐ No (If Yes, attach reports)

m) In case of Maternity: ☐ G ☐ P ☐ L ☐ A i. Date of Delivery: DD/MM/YYYY

Patient Signature:

Date & Place:

Treating Doctor Signature:

Stamp of Hospital:

## DECLARATION BY THE PATIENT/ REPRESENTATIVE

1. I agree to allow the hospital to submit all original documents pertaining to hospitalisation to the Insurer 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 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 hospitalisation and the amounts over and above the limit authorised by the Insurer 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.
5. 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.
6. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer.

Patient/Insured Name:

Contact No.:

Patient/Insured Signature: