MEDICARE T.P.A Services(I) Pvt. Ltd.
6B, Paul Mansions, Bishop
Lefroy Road, Kolkata 700 020

PLEASE FAX/SCAN PAGE 1 ONLY

Pre-Authorization Form

REQUEST FOR CASHLESS HOSPITALISATION FOR MEDICAL INSURANCE POLICY

Name of the Hospital :

Hospital Location :

Hospital Fax No. :

DETAILS OF THE THIRD PARTY ADMINISTRATOR (To be filled in block letters)

a) Name of the TPA / Insurance Company : **Medicare TPA Services (I) Private Limited** b) Contact Ph No : **033-4007994** c) FAX No : **033-22893385**

To Be filled in By Insured / Patient

a) Name of the patient :

b) Gender : Male ☐ / Female ☐ c) Age : Years (Y Y) Months (M M) d) Date of birth (DD/MM/YYYY) : (D D M M Y Y Y Y)

e) Contact No : f) Insured Member ID card no.:

g) Policy No/Corporate Name: g) Employee ID

h) Currently do you have any Medicliam/Health Inrasurance: Yes ☐ /No Company Name:

Give details :

i) Do you have a family physician : Yes ☐ /No ☐ j) Name of the family physician :

k) Contact No., if any :

PLEASE COMPLETE DECLARATION ON THE REVERSE SIDE OF THIS FORM

To Be filled by the Treating Doctor / Hospital

a) Name of treating doctor: b) Contact No:

c) Name of ILLNESS / Disease with presenting complaints

d) Relevant clinical findings:

e) Duration of present ailment: Days i) Date of first consultation: (D D M M Y Y)

ii) Past history of present aliment, if any :

f) Provisional Diagnosis:

iii) ICD 10 Code :

g) Proposed line of treatment : ☐ Medical Management ☐ Surgical management ☐ Intensive Care ☐ Investigation ☐ Non allopathic treatment

h) Investigational &/or Medical Management provide details :

i) Route of drug administration:

j) If Surgical name of surgery:

k) ICD 10 Code :

l) If other treatment provide details :

m) How did injury occur:

n) In case of Accident : i) Is it RTA : Yes ☐ /No ☐ ii) Date of injury : (D D M M 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: Yes ☐ /No ☐ If yes, attach report

o) In case of maternity: G P L A Date of delivery : (D D M M Y Y Y Y)

Details of patient admitted

a) Date of admission (D D M M Y Y) b) Time : (H H M M)

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

d) Expected no of days stay in hospital : Days e) 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). Other hospital expenses if any : Rs.

l) All inclusive package charges if any applicable : Rs.

m) 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 :

DECLRATION

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

Name of the treating doctor :

Qualification : Registration no with state code :

Hospital Seal (Must include Hospital ID)

Patient / Insured Name & Signature :

IMPORTANT: Please Turn Over