ICICI Lombard GENERAL INSURANCE

ICICI Lombard Health Care

CASHLESS AUTHORIZATION REQUEST NOTE

Toll Free Number: 1800 2666 • Fax Number: 1800 209 8880 / 040 6698 9160 / 61 • Email us: cashlessrequest@icicilombard.com

TO BE FILLED BY THE INSURED / PATIENT

1) Name of Patient:

2) Gender: ☐ Male ☐ Female 3) Age: ☐☐ Years 4) Date of Birth: D D M M Y Y Y Y 5) Mobile No.:

5) Insured Card ID No: 6)Email ID: _____

7) Policy No.

8) a) Corporate Policy No.: _____ b) Corporate Policy Name: _____

c) Employee ID: _____ 9) Currently do you have any other Mediclaim / Health insurance ☐ Yes ☐ No If Yes, Company Name _____

_____ Give details _____

10) a) Name of the family physician: _____ b) Contact Number:

11) ID/Age Proof Attached: ☐ Aadhar Card ☐ Passport ☐ Driving License ☐ 10 th Class Certificate ☐ Others _____

TO BE FILLED BY THE TREATING DOCTOR / HOSPITAL

1) a) Name of the treating doctor _____ b) Mobile No.:

2) a) Name of Hospital: _____ b) Contact No.:

c) NT Code: _____ d) Email ID: _____ e) Fax No. _____

3) Nature of Illness / Disease with presenting complaints: _____

4) Relevant clinical findings: _____

5) a) Past history of present ailment, if any: _____

_____ b) Duration of present ailment: ☐☐☐ Days c) Date of first consultation: D D M M Y Y Y Y

6) a) Provisional diagnosis: _____

_____ b) ICD 10 Code:

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

8) a) If Investigation & / or Medical management, provide details: _____

_____ b) Route of drug administration: _____

9) a) If Surgical, name of surgery: _____

_____ b) ICD 10 PCS Code:

10) If other treatments provide details: _____

11) In case of accident: a) Is it RTA: Y N b) Date of injury: D D M M Y Y Y Y c) Reported to Police: Y N FIR No. _____

12) a) Injury / Disease caused due to substance abuse / alcohol consumption: Y N b) Test conducted to establish this : Y N, attach report.

13) a) In case of Maternity: ☐ G ☐ P ☐ L ☐ A b) Date of Delivery: D D M M Y Y Y Y

Details of the patient admitted

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

c) Is this an emergency / 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: ₹

g) Expected cost for investigation + diagnostics: ₹

h) ICU Charges: ₹

i) OT Charges: ₹

j) Professional fees Surgeon + Anesthetist Fees + consultation Charge: ₹

k) Medicines + Consumables + Cost of Implants (if applicable Please specify). Other hospital expenses if any: ₹

I) All inclusive package charges if any applicable: ₹

Sum total expected cost of hospitalization: ₹

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
☐ Other ailments: _____	

PLEASE READ VERY CAREFULLY • THIS FORM IS TO BE FILLED IN BLOCK LETTERS

DECLARATION

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

a) Name of the treating doctor: SURNAME FIRSTNAME MIDDLENAME

b) Qualification: c) Registration No. with state code:

Signature of treating doctor | Hospital Seal (Must include Hospital NT ID) | Patient / Insured Name & Signature:

(PLEASE COMPLETE DECLARATION ON THE REVERSE SIDE OF THIS FORM)

NOT TO BE FAXED/SCANNED

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.

a) Patient's / Insured's Name: _____

b) Address: _____

c) Contact Number: ☐☐☐☐☐☐☐☐☐☐ d) Patient's / Insured's Signature:

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

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.