

PRE – AUTHORIZATION FORM

REQUEST FOR CASHLESS HOSPITALIZATION FOR HEALTH INSURANCE POLICY / TO BE FILLED IN BLOCK LETTERS



GOOD HEALTH
INSURANCE
TPA LIMITED

Please fill all pages : This is Page 1 of 4

Tel : 1 8 6 0 4 2 5 3 2 3 2
Fax : 1 8 6 0 4 2 5 4 2 4 2
Email : preauth@ghpltpa.com
Web : www.goodhealthtpa.com

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DETAILS OF THIRD PARTY ADMINISTRATOR AND HOSPITAL

NAME OF THE TPA	G	O	O	D	H	E	A	L	T	H	I	N	S	U	R	A	N	C	E	T	P	A	L	T	D	.									
TOLL FREE PHONE NO.	1	8	0	0	4	2	5	3	2	3	2	TOLL FREE FAX NO.													1	8	6	0	4	2	5	4	2	4	2
HOSPITAL NAME																																			
HOSPITAL LOCATION				A	R	E	A																												
HOSPITAL ROHINI ID												HOSPITAL TPA ID																							
HOSPITAL FAX NO.												HOSPITAL PHONE NO.																							
HOSPITAL EMAIL ID																																			

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TO BE FILLED IN BY INSURED/PATIENT : DETAILS OF INSURED/PATIENT (Please also sign the declaration on last page of this form)

PATIENT NAME																															
GENDER	MALE	FEMALE	THIRD GENDER	AGE		YEARS / MONTHS		DATE OF BIRTH		D	D	/	M	M	/	Y	Y	Y	Y												
CONTACT NO.									CONTACT NO. OF ATTENDING RELATIVE																						
OCCUPATION									TPA CARD ID																						
POLICY NO./CORPORATE NAME																															
EMPLOYEE ID																															
ADDRESS OF THE INSURED PATIENT																															

DO YOU HAVE ANY OTHER MEDICLAIM ☒ YES / ☐ NO

POLICY NO.

INSURANCE CO. NAME

DO YOU HAVE A FAMILY PHYSICIAN ☒ YES / ☐ NO

PHYSICIAN NAME

CONTACT NO.

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TO BE FILLED IN BY TREATING DOCTOR / HOSPITAL (Please also sign the declaration on last page of this form)

TREATING DOCTOR NAME

CONTACT NO.

NATURE OF
ILLNESS / DISEASE
WITH PRESENTING
COMPLAINT

RELEVANT CRITICAL
FINDINGS

PAST HISTORY OF
PRESENT AILMENT

DURATION OF PRESENT AILMENT DAYS

DATE OF 1ST CONSULTATION / /

PROVISIONAL
DIAGNOSIS

PROPOSED LINE
OF TREATMENT
(PLS TICK)

- ☐ MEDICAL MANAGEMENT
☐ SURGICAL MANAGEMENT
☐ INTENSIVE CARE
☐ INVESTIGATION
☐ NON-ALLOPATHIC TREATMENT

ICD 10 CODE

PLEASE PROVIDE DETAILS OF (IF ANY)

INVESTIGATIONS

MEDICAL MANAGEMENT

ROUTE OF DRUG
MANAGEMENT

NAME OF SURGERY

ICD 10 PCS CODE

OTHER TREATMENT

HOW DID INJURY OCCUR

IN CASE OF
ACCIDENT : IS IT RTA

YES / NO

REPORT TO POLICE

YES / NO

DATE OF INJURY

/ /

FIR NO.

INJURY/DISEASE CAUSED
DUE TO SUBSTANCE
ABUSE/ALCOHOL
CONSUMPTION

YES / NO

TEST CONDUCTED TO
ESTABLISH THIS (IF YES,
ATTACH REPORT)

YES / NO

IN CASE OF MATERNITY

G

P

L

A

EXPECTED DATE OF DELIVERY

/ /

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DETAILS OF PATIENT ADMITTED

DATE OF ADMISSION / /

TIME OF ADMISSION /

EXPECTED NO. OF DAYS
/ STAY IN HOSPITAL DAYS

ROOM TYPE

IS THIS AN EMERGENCY /
PLANNED HOSPITALIZATION
EVENT

EMERGENCY

PLANNED

DAYS IN ICU DAYS

COST IN INR / RS.

MANDATORY PAST HISTORY OF ANY CHRONIC ILLNES

IF YES, SINCE

PER DAY ROOM RENT +
NURSING & SERVICE CHARGES
+ PATIENTS DIET

EXPECTED COST OF
INVESTIGATION + DIAGNOSTIC

ICU CHARGES

OT CHARGES

PROFESSIONAL FEES SURGEON
+ ANESTHETIC FEES +
CONSULTATION CHARGES

MEDICINES + CONSUMABLES +
COST OF IMPLANTS (PLS
SPECIFY)

OTHER HOSPITAL EXPENSES, IF
ANY

ALL-INCLUSIVE PACKAGE
CHARGES IF APPLICABLE

SUM-TOTAL EXPECTED COST
OF HOSPITALIZATION

DIABETIES..... /

HEART DISEASE..... /

HYPERTENSION..... /

HYPERLIPIDEMIAS..... /

OSTEOARTHRITIS..... /

ASTHAMA/COPD/BRONCHITIS /

CANCER..... /

ALCOHOL/DRUG ABUSE..... /

ANY HIV OR STD RELATED
AILMENT..... /

ANY OTHER AILMENT, GIVE
DETAILS..... /

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DECLARATION

WE CONFIRM HAVING READ, UNDERSTOOD AND AGREED TO THE DECLARATION OF THIS FORM

NAME OF THE TREATING DOCTOR

QUALIFICATION

REGISTRATION NO. WITH STATE CODE

HOSPITAL SEAL
INCLUDING
HOSPITAL ID

PATIENT /
INSURED NAME
AND SIGN

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DECLARATION BY THE PATIENT / REPRESENTATIVE :

- I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Insurer/TPA after the discharge. I agree to sign on the Final Bill & the Discharge Summary, before my discharge.
- Payment to the 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.
- All non-medical expenses and expenses not relevant to current hospitalization and the amount over & above the limit authorized by the Insurer / TPA not governed by the terms and conditions of the policy will be paid by me.
- 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 Insurer / TPA.
- I agree and understand that TPA 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.
- 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.
- I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer / TPA.
- "I/We authorize Insurance Company / TPA to contact me / us through mobile / email for any update on this claim."

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

b) Contact Number: _____

c) e-mail Id (Optional): _____

d) Patient's / Insured's Signature: _____

Date: DD / MM / YYYY

Time: HH / MM

HOSPITAL DECLARATION :

- We have no objection to any authorized TPA / Insurance Company official verifying documents pertaining to hospitalization.
- All valid original documents duly countersigned by the insured / patient as per the checklist below will be sent to the TPA / Insurance Company within 7 days of the patient's discharge.
- 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.
- The patient declaration has been signed by the patient or by his representative in our presence.
- We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications.
- We will abide by the terms and conditions agreed in the MOU.
- We confirm that no additional amount shall be collected for the insured in excess of the Agreed Package Rates except 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).
- 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).
- In the event of unauthorized recovery of any additional amount from the Insured in excess of Agreed Package Rates, the authorized TPA / Insurance Company reserves the right to recover the same from us (the Network Provider) and / or take necessary action, as provided under the MOU or applicable laws.

HOSPITAL SEAL
INCLUDING
HOSPITAL ID

DOCTOR'S
NAME AND
SIGN