Medi Assist

MEDI ASSIST INDIA PRIVATE LTD

TOLL FREE FAX: 1800 425 9559

REQUEST FOR CASHLESS HOSPITALISATION / CLAIM FORM FOR MEDICAL INSURANCE POLICY

To be filled in block letters in black ink only / Please fill all the Columns Completely

To Be Filled By the Insured /Patient

1. Name of Patient : **Contact Number :**	2. Age _____	3. Sex : ☐ M / ☐ F
4. TPA ID No:	5. Policy No / Corporate	6. Employee ID:
7. Any other Cancer/Medical/Health Insurance etc - Give Details		

To Be Filled By the Treating Doctor/Hospit al

8 (a) Name of treating Doctor:& Mobile No.			
8 (b) Doctor's Qualification		8 (c) Dr. Reg. No:	
9. Nature of ILLNESS / Disease with presenting complaints			
10. Duration of the present ailment			
11. Earlier history of the present ailment if any			
12. Relevant clinical findings			
13.Provisional Diagnosis			
14.Proposed line of treatment: ☐ Investigation ☐ Intensive Care ☐ Medical Management ☐ Surgical Management			
14 (a) If 'Investigation' &/or 'Medical Management', please provide detailed line of treatment with route of drug administration			
14 (b) If 'Surgical' name the Surgery to be conducted and its details			
14 (c) If **Chemotherapy** – which cycle?		14 (d) If **Radiotherapy** – how many fractions?	
14 (e) For any other treatment, please furnish details			
15. ICD 10 PCS Code			
16. **In case of 'Injury':** 16 (a) How did injury occur?			
16 (b) Was it intentional self injury? Attempted Suicide?	☐**Y** / ☐**N**	16 (c) Is it **R**oad **T**raffic **A**ccident?	☐**Y** / ☐**N**
16 (d) Was it under influence of Alcohol	☐**Y** / ☐**N**	16 (e) Breath Analyser Report attached	☐**Y** / ☐**N**
16 (f) Was it under influence of Drugs	☐**Y** / ☐**N**	16 (g) Date of Injury	
16 (h) FIR / MLC Attached	☐**Y** / ☐**N**	16 (i) If no MLC done – reason thereof	
17. In case of **Maternity**: (a) G _____ P _____ L _____ A _____		17 (b) LMP	
18 (a) Probable Date & Time of Admission		18 (b) Is this **Planned** or **Emergency** Hospitalisation?	**Planned/Emergency**
18 (c) Expected No. of days of Hospital stay		18 (d) Class of Accommodation	

18 (e) Details of Hospitalisation Expenses	**Amount**
i) Room Rent (Per day)	
ii) Nursing Charges (Per day)	
iii) Patient's Diet Charges	
iv) Investigation/ Diagnostic Charges	
v) Surgeon/ Assistant/ Anaesthetist/ Consultant Charges	
vi) Medicine & Consumables Excluding Implants/ Stents	
vii) Implants/ Stents & High Value Consumables	
viii) OT Charges	
ix) Other Charges (Please Specify):	
If Package charges: (1) Primary Surgery: _____	
(2) Second Surgery: _____	
Total Estimated Expenses	

19. History of Smoking if any		
20. Past History of any Chronic Ailment - **MANDATORY**		
Ailment	**Yes/ No**	**Duration - dd/ mm/ yy**
a) Diabetes		
b) Hypertension		
c) Heart Disease		
d) Br. Asthma/ COPD		
e) Osteo Arthritis		
f) Cancer		
g) Any other		
h) Any history of Alcohol abuse		**Yes/ No**
i) Any HIV/ STD related ailment		**Yes/ No**
j) Whether the Defect is Congenital Internal/ External?		Internal/External
k) Any other relevant information:		

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

Treating Doctor's Name & Signature	**Hospital Seal**	**Hospital ID Number**	**Name & Signature of the Patient/ Insured**

HOSPITAL DECLARARTION

1. We have no objection to any authorized TPA 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 within 7 days of the patient's discharge.
3. All non –medical expenses and expenses not relevant to hospitalization or illness those are not payable by TPA will be collected from the patient.
4. **WE AGREE THAT TPA WILL NOT BE LIABLE TO MAKE THE PAYMENT IN THE EVENT OF ANY DISCREPANCY BETWEEN THE FACTS IN THIS FORM AND DISCHARGE SUMMARY**
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 an d 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 _____

DECLARATION BY THE PATIENT / REPRESENTATIVE

1. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the T.P.A a fter 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 Medi Assist is not liable to settle the hospital bill, I take complete responsibility to settle the bill.
3. All non-medical expenses and expenses not relevant to current hospitalization and the amounts over & above the limit authorized by T.P.A will be paid by me. In case any clarification is needed on admissibility of a particular item I shall contact **T.P.A Toll Free Telephone Number 1800 425 9449**
4. I hereby declare to abide by the rules and regulations 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 T.P.A
5. I agree and understand that T.P.A is in no way warranting the service of the hospital & that Medi Assist 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, my right to claim reimbursement of the said expenses shall be absolutely forfeited. I further declare that, in respect of the above treatment, no benefits are admissible under any other Medical Scheme or Insurance.

Patient's/ Insured's Name_____ Patient's/ Insured's Signature _____

Phone No: _____

DOCUMENTS TO BE PROVIDED BY THE HOSPITAL IN SUPPORT OF THE CLAIM

1. Detailed Discharge Summary and all Bills from the hospital duly countersigned by the Insured/ patient
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.
6. Supporting Bills and Stickers for Implants & Stents