



REQUEST FOR CASHLESS HOSPITALISATION FOR HEALTH INSURANCE POLICY PART C (Revised)

TO BE FILLED IN BLOCK LETTERS

Name of the hospital:

Hospital location: Hospital ID:

Hospital email ID: ROHINI ID:

DETAILS OF THIRD PARTY ADMINISTRATOR

a) Name of TPA company: **Medi Assist Insurance TPA Pvt Ltd** b) Phone no.: **080 22068666** c) Toll Free Fax no.: **1800 425 9559**

TO BE FILLED BY INSURED/PATIENT

a) Name of the patient:

b) Gender: Male Female Third gender c) Contact no.: d) Alternate contact no.:

e) Age: Years Months f) Date of birth: g) Insurer ID card no.:

h) Policy number/Name of corporate: i) Employee ID:

j) Currently do you have any other medical claim/health Insurance: Yes No j.1) Insurer name:

j.2) Give details:

k) Do you have a family physician, if yes: Name: k.1) Contact no.:

l) Occupation of insured patient:

m) Address of insured patient:

TO BE FILLED BY THE TREATING DOCTOR/HOSPITAL

a) Name of the treating doctor: b) Contact no.:

c) Name of illness/disease with presenting complaints: d) Relevant clinical findings:

e) Duration of the present ailment: days e.1) Date of first consultation:

e.2) Past history of present ailment if any:

f) Provisional diagnosis: f.1) ICD 10 code:

g) Proposed line of treatment: Medical management Surgical management Intensive care Investigation Non-Allopathic treatment

h) If investigation and/or medical management, provide details: h.1) Route of drug administration: IV Oral Other

i) If Surgical, name of surgery: i.1) 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: 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, If yes attach reports: Yes No

m) In case of maternity: G P L A n) Expected date of delivery:

DETAILS OF THE PATIENT ADMITTED

a) Date of admission: b) Time of admission: c) This is an emergency/ a planned hospitalization event

d) Expected no. of days stay in hospital: Days e) Days in ICU: Days f) Room type:

