Rothshield Healthcare (TPA) Services Limited

Corporate Office : 402, Raheja Chambers, Nariman Point, Mumbai - 400 021. India
Tel. : +91 22 22022147 / 22048144 Fax : +91 22 22854415 Tollfree No. : 1800 228 144
E-mail : info@rothshield.co.in Website : www.rothshield.co.in TPA Licence No. 030

PRE-AUTHORIZATION REQUEST FORM

(To be filled in block letters)

Patient's Details (To be filled in by the Insured)

Name of the Patient: _____ Sex: _____ Age: _____

Policy No: _____ RS.ID.No. _____

Telephone No.- Mobile _____ Resi. _____

Address: _____

Previous Policy and/or Concurrent Polic No: _____

_____

Corporate Name: _____ Emp code: _____

To be filled in by the Doctor

Name of the Hospital: _____

Name: Dr. _____ Tel. No.: _____ Fax No.: _____

Address : _____

Presenting Complaints : _____

Duration of complaints : _____

Clinical Findings : _____

Relevant past history and Treatment : _____

Investigations : _____

Provisional Diagnosis : _____

Plan of Treatment : _____

Past History Details

Disease	Yes/ No	Since	Disease	Yes/ No	Since
Hypertension:			Cancer		
Diabetes:			T. B./Asthma/COPD		
Cardiac Disease:			Osteoarthritis		
Any Chronic Disease			Alcohol /Drug Abuse		

Whether MLC Done:

Maternity: Gravida: Para: Abortion: Living: LMP:

Estimate of Hospital Expenses

Particulars	Details	Particulars	Details
Date of Admission		OT Charges / Anesthesia	
Duration of Stay		Medicine / Consumables	
Class of Accommodation		Investigation charges	
Approximate Expenses		Surgical / Professional fees	
Room Rent Per Day		Approx. (Total charges)	

Hospital Declaration: All Original Documents will be submitted to ROTHSHIELD HEALTHCARE TPA after discharge of patient from hospital within period of one week We have no objection to any authorized official verifying the documents / Records. **Declaration by Patient:** I / We solemnly agree to pay the cost of Hospitalization if authorization given by TPA stands null & void due to disclosure of any wrong / incomplete information. If any claim is rejected under policy terms & Conditions, or excess payment is made over insured amount available in the policy, I hereby undertake to pay RHSL and/or Insurance Company the amount paid by them to the Hospital against preauthorization requested by me. I/We also reserve the right to submit pre/post Hospitalization claim separately as per policy terms & conditions.

Patient Signature / Thumb Impression

Stamp of Treating Doctor: **Hospital Stamp & Signature**