ApolloMunich HEALTH INSURANCE

Let's Uncomplicate

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

(TO BE FILLED IN BLOCK LITTERS)

DETAILS OF THE THIRD PARTY ADMINISTRATOR/ INSURER/ HOSPITAL:

a. Name of TPA/Insurance company:

b. Toll free phone number:

c. Toll free fax:

d. Name of Hospital:

i. Address

ii. Rohini ID

iii. e-mail id

TO BE FILLED BY INSURED/PATIENT

A. Name of the Patient:

B. Gender: ☐ Male ☐ Female ☐ Third Gender

C. Age: Y Y M M

D. Date of Birth: D D M M Y Y Y Y

E. Contact Number:

F. Contact number of attending Relative:

G. Insured Card ID number:

H. Policy number/Name of Corporate:

I. Employee ID:

J. Currently do you have any other mediclaim /health insurance: ☐ Yes ☐ No

i. Company Name:

ii. Give Details :

K. Do you have a family Physician: ☐ Yes ☐ No

L. Name of the Family Physician:

M. Contact number, if any:

N. Current Address of Insured Patient:

O. Occupation of Insured Patient:

(PLEASE COMPLETE DECLARATION OF THIS FORM)

TO BE FILLED BY TREATING DOCTOR/HOSPITAL

A. Name of the treating Doctor:

B. Contact number:

C. Nature of Illness/Disease with presenting complaint:

D. Relevant Critical Findings:

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E. Duration of the present ailment ☐☐☐ Days

i. Date of First consultation: D D M M Y Y Y Y

ii. Past history of present ailment, if any

F. Provisional diagnosis:

i. 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

i. Route of Drug Administration

I. If surgical, name of surgery

i. ICD 10 PCS code

J. If other treatment, provide details

K. How did injury occur

L. In case of accident

i. Is it RTA: ☐ Yes ☐ No ii. Date of Injury: ☐ Yes ☐ No

iii. Report to Police ☐ Yes ☐ No iv. FIR NO ☐ Yes ☐ No

v. Injury /Disease caused due to substance abuse/alcohol consumption ☐ Yes ☐ No

vi. Test conducted to establish this (if yes, attach report) ☐ Yes ☐ No

M. In case of Maternity

☐ G ☐ P ☐ L ☐ A i. Expected date of Delivery D D M M Y Y Y Y

DETAILS OF PATIENT ADMITTED

A. Date of admission D D M M Y Y Y Y

B. Time of admission H H : M M

C. Is this an emergency/planned hospitalization event:

☐ Emergency ☐ Planned

D. Mandatory Past History of any chronic illness

If yes (Since month/year)

☐	Diabetes	M M Y Y Y Y
☐	Heart disease	M M Y Y Y Y
☐	Hypertension	M M Y Y Y Y
☐	Hyperlipidemias	M M Y Y Y Y
☐	Osteoarthritis	M M Y Y Y Y
☐	Asthma/COPD/Bronchitis	M M Y Y Y Y
☐	Cancer	M M Y Y Y Y
☐	Alcohol/Drug abuse	M M Y Y Y Y
☐	Any HIV/ or STD Related ailment	M M Y Y Y Y

Any other ailment, give details

E. Expected number of Days/stay in hospital

F. Days in ICU

G. Room Type

H. Per day room rent+nursing and service charges+ patients diet

I. Expected cost of investigation + diagnostic

J. ICU charges

K. OT charges

L. Professional fees Surgeon+ Anesthetist Fees + consultation Charges:

M. Medicines+ Consumables + Cost of lmplants (if applicable please specify)

N. Other hospital expenses if any

O. All-inclusive package charges if any applicable

P. Sum Total expected cost of hospitalization

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DECLARATION (Please read very carefully)

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

a. Name of the treating doctor

b. Qualification:

c. Registration number with State code

Hospital Seal
(Must include Hospital ID)

Patient/Insured Name and Sign

DECLARATION BY THE PATIENT/ REPRESENTATIVE

a. 1 agree to allow the hospital to submit all original documents pertaining to hospitalization to the lnsurer/T.P.A after the discharge. I agree to sign on the Final Bill & the Discharge Summary, before my discharge.
b. 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.
c. All non-medical expenses and expenses not relevant to current hospitalization and the amounts over & above the limit authorized by the lnsurer/T.P.A not governed by the terms and conditions of the policy will be paid by me.
d. 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
e. 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.
f. 1 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.
g. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer /TPA.
h. "I/We authorize Insurance Company/TPA to contact me/us through mobile/email for any update on this claim".

a. Patient's/ lnsured's Name:

b) Contact number:

c) E-mail Id (optional)

d) Patient's/ lnsured's Signature:

Date: D D M M Y Y Y Y Time: H H : M M

HOSPITAL DECLARATION

a. We have no objection to any authorized TPA / Insurance Company official verifying documents pertaining to hospitalization.
b. 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.
c. 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.
d. The patient declaration has been signed by the patient or by his representative in our presence.
e. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications.
f. We will abide by the terms and conditions agreed in the MOU.
g. We confirm that no additional amount would be collected from the insured in excess of 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).
h. 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).
i. 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

Doctor's Signature

Date: D D M M Y Y Y Y Time: H H : M M

Annexure

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You Need to Know

- **Prefer E-Preauthorization** for quick updates – https://epreauth.apollomunichinsurance.com
- **Incomplete preauth forms** will delay the entire the cashless process of cases/claims.
- Enclose all medical documents with supporting report.
- In case of cashless verification/required additional information, status will be updated with in 48hrs.

Vitals at the time of admission

BP : mm of Hg	Temp : F		Coherent & conscious
			Disoriented
Pulse rate :	SPO2%		Unconsciousness
Respiratory Rate :	RBS mg/dl		Non ambulatory
Dehydration	Hypotonic	Isotonic	Hypertonic
Relevant clinical findings:			
Justification / Indication for admission by treating Doctor:			
Route of administration (Oral / IM / IV): Medicine details :			
Diagnosis			
Whether present ailment is a complication of pre-existing disease / surgery: ☐ Yes ☐ No If Yes, please specify:			
Investigation findings :			

Insurance desk:

SPOC Name: (Mr./Ms./Mrs.)																																		
Contact No											Email-ID:																								

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KYC declaration (If claimed / estimation amount is more than or equal to 1 lakh)*	
CKYC number	
Contact Mail ID	Mobile:
Proposer Name (As per Policy)	
Mother's name of Proposer	
Father's name of Proposer	
Latest Business /Occupation of Proposer	

Copy of Address Proof, self-attested: (any one form of below list)

a. Passport
b. Voter Id
c. Driving licence
d. NREGA job card
e. Utility bill which is not more than two months old of any service provider (electricity, telephone, post-paid mobile phone) in the name of proposer.
f. Property or Municipal Tax Receipt Bank account or Post Office savings bank account statement (first page and 2nd page with transactions not older than 3 months) in the name of Proposer.

Copy of Identity Proof, self-attested: (any one form of below list)

a. Passport
b. Voter Id
c. Pancard
d. Driving licence
e. NREGA job card
f. Others (Any Notified by the Central government)

Recent (Not older than 3 months) passport size Photograph of Proposer

Photograph

Proposer (policy holder) Signature:

Date:

Place:

Apollo Munich Health Insurance Co. Ltd. • Central Processing Center, 2nd & 3rd Floor, iLABS Centre, Plot No. 404-405, Udyog Vihar, Phase-III, Gurgaon-122016, Haryana • **Corp. Off.** 1st Floor, SCF-19, Sector-14, Gurgaon-122001, Haryana • **Reg. Off.** Apollo Hospitals Complex, 8-2-293/82/J III/DH/900 Jubilee Hills, Hyderabad, Telangana - 500033 • For more details on risk factors, terms and conditions, please read sales brochure carefully before concluding a sale • **IRDAI Reg. No.** - 131 • **CIN:** U66030TG2006PLC051760