Bajaj Allianz General Insurance Company Limited.
Regd. & Head Office: Bajaj Allianz House, Airport Road, Yerawada, Pune 411 006
CIN: U66010PN2000PLC015329

Caringly yours

BAJAJ Allianz

Health Administration Team: *A - Wing 2nd Floor, Bajaj Finserv Building, Behind Weikfield IT Park, Off Nagar Road, Viman Nagar | Pune - 411 014
Phone No.: 020-30305858/ 1800-103-2529 Fax: 020-30512224/ 6/ 7 | **Email**: preauth@bajajallianz.co.in

CASHLESS FORM

PLEASE FAX/SCAN PAGE 1 AND 2 ONLY
REQUEST FOR CASHLESS HOSPITALISATION FOR MEDICAL INSURANCE POLICY

DETAILS OF THE PROVIDER

Hospital Name/nursing Home Name: P.D.HINDUJA NATIONAL HOSPITAL & M.R.C, MUMBAI.

City Name: VEER SAVARKAR MARG, MAHIM, MUMBAI-400016 Pin Code:

State Name: Hospital ID:

Landmark: Rohini ID:

Hospital Contact No: Fax No: TPA desk No: Email ID: A@B.COM

TO BE FILLED BY THE INSURED/PATIENT

a) Name of the Patient: .

b) Current Address of the Insured patient:

c) Gender: ☐ Male ☐ Female d) Age: 0 0 Years ☐☐ Months e) Date of birth:

f) Name of the Attendant: g) Contact number, if any:

h) Contact number:

i) Insured card ID number:

j) Policy number / Name of corporate:

k) Employee ID:

l) Currently do you have any other Mediclaim /Health insurance? ☐ Yes ☐ No

Company Name:

Give details:

m) Do you have a family physician? ☐ Yes ☐ No

n) Name of the family Physician:

o) Contact number, if any: p) Insured E-mail ID:

TO BE FILLED BY THE TREATING DOCTOR / HOSPITAL

a) Name of the treating doctor:

b) Contact number:

c) Nature of Illness / Diseases with presenting complaint:

d) Relevant Critical Findings:

Pulse	BP	CNS	PA	RS	CVS	

e) Duration of the preset ailment:

i. Date of First Consultation:

ii. Past history of present ailment, if any:

f) Provisional diagnosis:

i. ICD 10 code:

g) Propose 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:

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: Yes No

m) In case of Maternity:

G

P

L

A

i) Date of delivery/LMP:

Details of the patient admitted

a) Date of admission: ☐☐☐☐☐☐☐☐☐☐ b) Time: ☐☐☐☐☐☐☐☐☐☐

c) Is this an emergency/a planned hospitalization event? ☐ Emergency ☑ Planned

d) Expected no. of day stay in hospital: ☐ Days

e) Expected no. of day stay in ICU: ☐

f) Room Type: ☐

g) Per Day Room Rent + Nursing & Service Charges + Patient's Diet: 0

h) Expected cost for investigation + Diagnostics: 0

i) ICU Charges: 0

j) OT Charges: 0

k) Processional fees Surgeon + Anesthetist Fees +consultation Charges: 0

l) Medicines + Consumables + Cost of Implants: 0

m) All-inclusive package charges if any applicable: 0

n) Sum Total expected cos of hospitalization:

Mandatory: Past History of any chronic illness

☐ 1) Diabetes
☐ 2) Heart Disease
☐ 3) Hypertension
☐ 4) Hyperlipidemias
☐ 5) Osteoarthritis
☐ 6) Asthma/COPD/Bronchitis
☐ 7) Cancer
☐ 8) Alcohol or drug abuse
☐ 9) Any HIV or STD/Related
10) Any other Ailment gives details:

DECLARATION

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

a) Name of the treating doctor:
b) Qualification:
c) Registration No. with Stat Code:

Hospital Seal

Patient Insured Name & Signature

DECLARATION BY THE PATIENT / REPRESENTATIVE

- I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Insurer/T.P.A after the discharge. I agree to sign on the Final Bill & the Discharge Summary, before my discharge.
- 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.
- All non-medical expenses and expenses not relevant to current hospitalization and the amounts over & above the limit authorized by the Insurer/T.P.A 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 identify the Insurer / T.P.A
- 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.
- 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) Patient's / Insured's Signature:

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 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 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 responsibility the sole for any delay in offering clarifications
- We will abide by the terms and conditions agreed in the MOU.
- 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).
- 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

Doctor's Signature