FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

Phone: 1800 209 1016 / 1800 103 8889
Fax: 1800 209 1017 / 1800 103 9998
Email: fgh.cashless@futuregenerali.in

FUTURE GENERALI Health

Hospital Id No: **FGH-PAF-03**

PRE-AUTHORIZATION / CLAIM FORM FOR CASHLESS FACILITY

----------TO BE FILLED BY THE INSURED/PATIENT----------

Patient Name: _____ Health Card No _____

Gender: ☐ Male ☐ Female Age: ☐☐ (Yrs) DOB: _____ Policy No: _____

Patient/Attendant Mobile No. _____ Employee ID _____ Company _____

Currently do you have any other Mediclaim / Health ☐ Yes ☐ No (if yes, provide other insurance details)

Insurance Co. Name _____ Policy No: _____

Sum Insured _____ since how long you have this cover _____

Do you have Family Physician? ☐ Yes ☑ No Name of Family Physician: _____ Mobile _____

----------TO BE FILLED BY THE TREATING DOCTOR /HOSPITAL----------

Name of the Hospital: P. D. HINDUJA NATIONAL HOSPITAL & M. R City: MUMBAI

Type of hospitalization: ☐ Emergency ☑ Planned Expected Admission Date: _____ Time of Admission _____

Expected Length of Stay: _____ (days) Name of Treating Doctor: _____ Mobile No: _____

Nature of Illness / Disease with Presenting Complaints: _____

Relevant Clinical Findings: _____

Duration of present Ailment: _____ Date of First Consultation: _____

Past History of Present Ailment if any _____

Provisional Diagnosis: _____ ICD Code: _____

Proposed Line of Treatment during Hospitalization: ☐ Medical ☐ Surgical ☐ Intensive ☐ Investigation ☐ Non Allopathic treatment

If Investigation & /or Medical Management, provide details: _____

Route of Drug Administration: _____ If Surgical. Name of Surgery: _____

Type of Anesthesia: ☐ Local ☐ General ☐ Regional ☐ Dissociative ICD PCS Code: _____

If other treatments provide details: _____

In case of Accident / Injury: ☐ RTA ☐ Intentional Self Injury Date of Accident / Injury: _____

How did injury occur: _____

Injury / Diseases caused due to Substance Abuse / Alcohol ☐ Yes ☐ No

Test conducted to establish this: ☐ Yes ☐ No Reported to Police: ☐ Yes ☐ No FIR / MLC No: _____

In case of Maternity: G ___ P ___ L ___ A ___ LMP Date: _____ FIR / MLC No: _____

Mode of Delivery: ☐ VD ☐ LSCS

PAST HISTORY OF ANY CHRONIC ILLNESS WITH

Disease / Ailment					Duration (Specify Days / Month / Year)
Hypertension	Yes		No		
Hyperlipidemia	Yes		No		
Cancer	Yes		No		
Osteoarthritis	Yes		No		
Diabetes	Yes		No		
Cardiovascular Diseases	Yes		No		
Asthma / COPD / Bronchitis	Yes		No		
Any Surgery / Hospitalization	Yes		No		
Any Other Disease / Disability	Yes		No		
Congenital	Yes		No		Internal / External
Any HIV or STD/Related Ailments	Yes		No		
Alcohol or Drug Abuse	Yes		No		

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Expense Head	Amount (Rs.)	Expense Head	Amount (Rs.)
Room Rent per day + Nursing/Service charges + Diet	0	Investigations + Diagnostics	0
ICU charges per day	0	Medicines / Consumables	0
Doctor / Consultant visit charges	0	Equipment / Monitor etc	
Surgeon charges + Anesthetist	0	Miscellaneous (specify)	
Operation Theatre Charges	0	Implant Charges (If any)	0
Package Charges			

Estimate of Expenses: Total Amount Rs. _____ Class of Accommodation: _____

----------DECLARATION----------

I have completed this form and will be responsible for correctness of the medical information certified by me. I agree that Future Generali shall not be liable to make payment in case of any discrepancy between the preauthorization form and discharge summary.

Name of the treating Doctor: _____ Qualification: _____

MCI Registration No with State Code: _____

Signature of Doctor: _____ Stamp / Seal of Hospital _____

BENEFICIARY CONSENT / AUTHORISATION I have 'No Objection' to Future Generali obtaining details of my treatment / collecting documents and also hereby authorize Future Generali to pay the hospital bill from the sum insured of my insurance policy. I also undertake to pay all non medical / non authorized expenses in the hospital bill directly to the hospital at the time of discharge. In case Future Generali issues "Denial of cashless facility" to the provider, I have 'No objection' in paying the hospital bill for the treatment given. All information provided above is true and I agree that if I have provided any false or untrue information, my right to claim the expenses shall be absolutely forfeited.

NAME OF INSURED: _____ SIGNATURE OF INSURED: _____

INSURED Email ID: _____ INSURED Mobile No: _____

Declaration by the patient/representative

I agree to allow the hospital to submit all original documents pertaining to hospitalization to the insurer after the discharge. I agree to sign on the final bill and the discharge summary before my discharge. Payment to hospital is governed by the terms and conditions of the policy. In case the insurer 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 and above the limit authorized by the insurer not governed by the terms and conditions of the policy will be paid by me. In case any clarification is needed on admissibility of a particular item I shall contact insurer at the toll free no on the reverse of the form. I hereby declare to abide by the terms and conditions of the policy and it 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. I agree and understand that insurer is in no way warranting the services of the hospital and the insurer 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 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. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the insurer.

Patient's /Insured's Name _____ Contact No: _____ Signature _____

Hospital Declaration

We have no objection to any authorized insurance company official verifying documents pertaining to hospitalization. All valid original documents duly counter singed by the insured/patient as per the check list below will be sent to insurance company within 7 days of the patient's discharge. All non medical expenses or expenses not relevant to hospitalization/illness, or expenses disallowed in the authorization letter of the insurance company, or arising out of incorrect information in the preauthorization form will be collected from the patient.

WE AGREE THAT 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 has been signed by the patient or by his / her representative in our presence. We agree to provide clarification for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications. We will abide by the terms and conditions agreed in the MOU.

Hospital Seal: Doctor's Signature:

Documents to be provided by the hospital in support of the claim

1. Authorization Letter
2. Original Detailed Discharge Summary
3. Original Hospital Main Bill and Detailed Break Up
4. All Original Pharmacy Bills and Investigation Bill if any
5. All Investigation Reports & Prescriptions Including OT Notes