

**Please fill this form completely.**

**To Be Filled By the Insured /Patient**

1. Name of Patient : \_\_\_\_\_
2. Contact No. : \_\_\_\_\_ 3. Age (yrs) : \_\_\_\_\_ 4) Sex : Male  / Female
5. Insured Card ID No : \_\_\_\_\_ 6. Policy No / Corporate : \_\_\_\_\_ 7) Emp ID : \_\_\_\_\_
8. Are you presently covered under any other similar type & scheme, cancer/medical/health insurance etc. (Give Details) : \_\_\_\_\_
9. Name of the Family physician and Mobile no : \_\_\_\_\_

**To Be Filled By the Treating Doctor/Hospital**

10. Name of Hospital : \_\_\_\_\_ City : \_\_\_\_\_  
Phone : \_\_\_\_\_ Fax : \_\_\_\_\_  
Name of treating doctor & Mobile No. : \_\_\_\_\_
11. Nature of illness / Disease with presenting complaints : \_\_\_\_\_
12. Relevant clinical findings : \_\_\_\_\_
13. Duration of the present ailment : \_\_\_\_\_
14. Date of first consultation and earlier history of the present ailment if any : \_\_\_\_\_
15. a) Provisional Diagnosis : \_\_\_\_\_ b) ICD 10 Code : \_\_\_\_\_
16. Proposed line of treatment: Investigation  Intensive Care  Medical Management  Surgical Management  Non-allopathic treatment
17. If 'Investigation &/or Medical Management' provide detailed line of treatment with route of drug administration : \_\_\_\_\_
18. a) If Surgical, name of the Surgery along with PCS code & its details : \_\_\_\_\_  
b) ICD 10 PCS Code : \_\_\_\_\_
19. For other treatments, please furnish details : \_\_\_\_\_
20. a) How did injury occur? : \_\_\_\_\_  
b) In case of ACCIDENTS :  
Is it RTA : Yes  / No  Date of injury(DD/MM/YY) : / /   
FIR / MLC Attached : Yes  / No  Alcohol / Drug Intoxication : Yes  / No  If Yes send the Analyser Report
- c) In case of MATERNITY : Gravida  Para  Living Children  Abortions  LMP (DD/ MM/ YY) : / /
21. a) Probable Date & Time of Admission (DD/ MM/ YY) : / /  & (HH : MM) :   
b) Is this an Emergency / a Planned Hospitalization Event? : Emergency  Planned   
c) Expected no. of days stay in Hospital : \_\_\_\_\_ d) Room Type : \_\_\_\_\_  
e) Per Day Room Rent + Nursing & Service Charges + Patient's Diet : \_\_\_\_\_  
f) Expected cost for Investigation + diagnostics : \_\_\_\_\_  
g) ICU charges : \_\_\_\_\_ h) OT charges : \_\_\_\_\_  
i) Professional fees Surgeon + Anesthetist Fees + Consultation charges : \_\_\_\_\_  
j) Medicines + Consumables + Cost of Implants (if applicable please specify) . Other Hospital expenses if any : \_\_\_\_\_  
k) All inclusive Package Charges if any applicable : \_\_\_\_\_  
l) **Sum total expected cost of Hospitalization : Rs.** \_\_\_\_\_
22. Past history of any chronic illness :  
i. Diabetes Yes  / No  If Yes, Duration ( Months /Years) : \_\_\_\_\_  
ii. Heart Disease Yes  / No  If Yes, Duration ( Months /Years) : \_\_\_\_\_  
iii. Hypertension Yes  / No  If Yes, Duration ( Months /Years) : \_\_\_\_\_  
iv. Hyperlipidemia Yes  / No  If Yes, Duration ( Months /Years) : \_\_\_\_\_  
v. Osteoarthritis Yes  / No  If Yes, Duration ( Months /Years) : \_\_\_\_\_  
vi. Asthma/ COPD/Bronchitis: Yes  / No  If Yes, Duration ( Months /Years) : \_\_\_\_\_  
vii. Cancer Yes  / No  If Yes, Duration ( Months /Years) : \_\_\_\_\_
23. i. Any h/o Alcohol abuse / intoxication? Yes  / No  If Yes, Duration ( Months /Years) : \_\_\_\_\_  
II. Any HIV or STD / Related ailments? Yes  / No  If Yes, Duration ( Months /Years) : \_\_\_\_\_  
III. Any other Ailment? Yes  / No  If Yes, Please give details : \_\_\_\_\_
24. Any other relevant information : \_\_\_\_\_

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

Treating Doctor's Name & Signature :

Patients/insured's Name & Signature :

Qualification and Registration Number :

Hospital Seal :

**HOSPITAL DECLARATION**

1. We have no objection to any authorized TPA / Insurance Company official/ Authorised representative verifying documents pertaining to hospitalization.
2. All valid original documents duly countersigned by the insured / patient as per the checklist mentioned in claim form and will be sent to TPA / Insurance Company within 7 days of the patient's discharge.
3. All non – medical expenses or expenses not relevant to hospitalization or illness, or expenses disallowed in the Authorisation Letter of the TPA / Insurance Co, or arising out of incorrect information in the pre-authorisation form will be collected from the patient.
4. 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.
5. The patient declaration has been signed by the patient or by his representative in our presence.
6. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications.
7. We will abide by the terms and conditions agreed in the MOU.

Hospital Seal :

Doctor's Signature :

**DECLARATION BY THE PATIENT/ REPRESENTATIVE**

1. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Insurer/TPA after the discharge. I agree to sign on the Final Bill & the Discharge Summary, before my discharge.
2. 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.
3. All non-medical expenses and expenses not relevant to current hospitalization and the amounts over & above the limit authorized by the Insurer/TPA 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 TPA at the Toll Free Number mentioned below.
4. 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 / TPA.
5. I agree and understand that TPA 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.
6. 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, 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.
7. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer / TPA.

Patient's/ Insured's Name :

Patients/insured's Signature :

Phone Number :

**TPA Details**

Family Health Plan Ltd.

- Address : Claims Department, Family Health Plan Ltd, Srinilaya – Cyber Spazio, Suite No. 101, 102, 109 & 110, Ground Floor, Road No. 2, Banjara Hills, Hyderabad, 500 034.
- Toll Free : 1800 - 425 - 4033
- Fax : +91-40-23541400
- Website : www.fhpl.net