Optima Restore
Pre-Authorization Form

ApolloMunich HEALTH INSURANCE

10th Floor, Building No. 10, Tower B, DLF City Phase II, DLF Cyber City, Gurgaon-122002

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, Duration (Months /Years) : _____
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 :

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HOSPITAL DECLARARTION

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 wiill 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

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