

MDINDIA HEALTHCARE SERVICES (P) LTD.

Cashless Toll Free No – 1800 233 4505

REQUEST FOR AUTHORIZATION LETTER

DATE: ___ / ___ / ___

PART I: TO BE FILLED BY PATIENT

FAX : 020 - 25300030

NAME OF PATIENT : Corporate Name: _____ Emp. ID _____	MDI ID NO.
AGE: _____ SEX: M <input type="checkbox"/> F <input type="checkbox"/> PHONE NO. _____ FAX NO. _____	INSURANCE COMPANY: POLICY NUMBER:
Any claim : YES / NO Amount: Settled / Rejected Date: _____	POLICY: FRESH / RENEWAL ___ / ___ / ___ (If Renewal then date and year in which first policy was taken)

PART II: TO BE FILLED BY TREATING DOCTOR

NAME OF TREATING DOCTOR: PHONE NO. _____ MOBILE NO. _____	PRESENTING COMPLAINT WITH DURATION:																																													
<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%;">P / H:</td> <td style="width:10%;">YES</td> <td style="width:10%;">NO</td> <td style="width:10%;">SINCE</td> <td style="width:10%;"></td> </tr> <tr> <td>HYPERTENSION:</td> <td>Y</td> <td>N</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>DIABETES:</td> <td>Y</td> <td>N</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>CARDIAC AILMENTS:</td> <td>Y</td> <td>N</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>ASTHMA / COPD:</td> <td>Y</td> <td>N</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>OSTEO ARTHRITIS:</td> <td>Y</td> <td>N</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>CANCER:</td> <td>Y</td> <td>N</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>HIV:</td> <td>Y</td> <td>N</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>OTHERS:</td> <td>Y</td> <td>N</td> <td>_____</td> <td>_____</td> </tr> </table>	P / H:	YES	NO	SINCE		HYPERTENSION:	Y	N	_____	_____	DIABETES:	Y	N	_____	_____	CARDIAC AILMENTS:	Y	N	_____	_____	ASTHMA / COPD:	Y	N	_____	_____	OSTEO ARTHRITIS:	Y	N	_____	_____	CANCER:	Y	N	_____	_____	HIV:	Y	N	_____	_____	OTHERS:	Y	N	_____	_____	RELEVANT CLINICAL FINDINGS: CVS - _____ BP - _____ RS - _____ P/A - _____ CNS - _____ GYNAEC - _____ OTHERS - _____
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HIV:	Y	N	_____	_____																																										
OTHERS:	Y	N	_____	_____																																										
Is the disease self inflicted? YES / NO Are the diseases / injury caused directly / indirectly due to use of alcohol / drugs? YES / NO IN CASE OF RTA: FIR / MLC YES / NO	History of any past illness relevant to present disease: YES / NO Details: Whether present ailment is a complication of any pre-existing disease / operation? YES / NO																																													
DIAGNOSIS: DETAILS OF TREATMENT RECEIVED: PROPOSED LINE OF TREATMENT:	DETAILS OF INVESTIGATIONS TO CONFIRM THE DIAGNOSIS: <table border="1" style="width:100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th style="width:5%;">NO</th> <th style="width:65%;">INVESTIGATION</th> <th style="width:30%;">RESULT</th> </tr> </thead> <tbody> <tr><td>1.</td><td>BSL</td><td>_____</td></tr> <tr><td>2.</td><td>Complete Blood Count</td><td>_____</td></tr> <tr><td>3.</td><td>Urine analysis</td><td>_____</td></tr> <tr><td>4.</td><td>Urea / Electrolytes</td><td>_____</td></tr> <tr><td>5.</td><td>ECG / ECHO</td><td>_____</td></tr> <tr><td>6.</td><td>X-Ray / Ultrasonography</td><td>_____</td></tr> <tr><td>7.</td><td>Other Relevant Investigations</td><td>_____</td></tr> </tbody> </table>	NO	INVESTIGATION	RESULT	1.	BSL	_____	2.	Complete Blood Count	_____	3.	Urine analysis	_____	4.	Urea / Electrolytes	_____	5.	ECG / ECHO	_____	6.	X-Ray / Ultrasonography	_____	7.	Other Relevant Investigations	_____																					
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PART III: TO BE FILLED BY HOSPITAL

NAME OF HOSPITAL:	BED CHARGES:
CITY:	CONSULTATION CHARGES:
FAX NO.	NURSING CHARGES:
PROBABLE DATE OF ADMISSION:	INVESTIGATIONS CHARGES:
APPROX. DURATION OF STAY:	COST OF IMPLANTS:
CLASS OF ACCOMODATION:	MEDICINES:
PACKAGE CHARGES:	SURGERY:
	TOTAL APPROX CHARGES:

Declaration : Patient

I have "No Objection" to MDIndia obtaining the details of my treatment / collecting documents & hereby authorize MDIndia to settle the hospital bill and reimburse itself / receive the amount from my claim receivable from the insurance company. I / We agree to pay the cost of hospitalization if authorization given by TPA becomes null and void due to disclosure of wrong and incorrect information regarding the nature, duration and past history of all ailments. This consent is also final discharge for hospitalization part of the claim where it has affected the payment. I reserve the right to submit pre/post hospitalization claims separately and when required and as per the policy terms and conditions.

Patient's Signature / Thumb Impression _____ Contact No.: _____

Declaration : Hospital

MDIndia will not be held liable for the payment in the event of any discrepancy between the facts presented at the time of admission & in final documents submission.

Signature & Stamp of Treating Doctor: _____ Rubber Stamp Of Hospital & Signature _____