



Medi Assist India Pvt Ltd

TOLL FREE PHONE: 1600-4259-449

TOLL FREE FAX: 1600-4259-559

REQUEST FOR CASHLESS HOSPITALISATION / CLAIM FORM FOR MEDICAL INSURANCE POLICY

To be filled in block letters in black ink only / Please fill all the Columns Completely

A. TO BE FILLED BY TREATING DOCTOR (Columns 1 to 18)

Date: ___/___/___

(1).Name of Patient :										(2). Age _____		(3). Sex : <input type="checkbox"/> M / <input type="checkbox"/> F		
(4). Medi Assist ID: <input type="text"/>					5) Policy No / Corporate _____					(6) Emp ID _____				
(7).Name of treating doctor:& Mobile No.						(8). Dr. Qualification:				(9). Dr. Reg. No:				
10). Nature of ILLNESS / Disease with presenting complaints										11.(a) Duration of the present ailment				
(12). Relevant clinical findings:										11.(b) Earlier history of the present ailment if any				
(13).Provisional Diagnosis:					(14). ICD Code:									
(15).Proposed line of treatment: <input type="checkbox"/> Investigation <input type="checkbox"/> Intensive Care <input type="checkbox"/> Medical Management <input type="checkbox"/> Surgical Management														
15 (a) If Surgical, name of the Surgery & its details _____														
15 (b) For other treatments, please furnish details : _____														
In case of ACCIDENTS: Is it RTA <input type="checkbox"/> Y / <input type="checkbox"/> N Date of injury : _____										In case of MATERNITY:				
FIR Attached : <input type="checkbox"/> Y / <input type="checkbox"/> N Alcohol / Drug Intoxication <input type="checkbox"/> Y / <input type="checkbox"/> N										G ____ P ____ L ____ A ____				
Cause of injury : _____										LMP _____				

IMPORTANT

Please provide complete information on the PRE-EXISTING CONDITIONS of the patient. In the event of any variation between this form and the discharge summary, it is responsibility of the Hospital to recover treatment cost from the patient.

(16). History of any past illness relevant to present illness											
(17). Whether present ailment is a complication of any Pre-existing disease/operation										Yes / No	
(18). Past History of										If yes, duration	
a. Hypertension					<input type="checkbox"/> Y <input type="checkbox"/> N					Since when	
b. Diabetes Mellitus					<input type="checkbox"/> Y <input type="checkbox"/> N					Since when	
c. Cardiac Ailments					<input type="checkbox"/> Y <input type="checkbox"/> N					Since when	
d. Respiratory Ailments					<input type="checkbox"/> Y <input type="checkbox"/> N					Since when	
e. Any other Pre Existing Disease					<input type="checkbox"/> Y <input type="checkbox"/> N					Since when	

B. TO BE FILLED BY HOSPITAL (Columns 19 to 25)

(19) Name of Hospital :										(20)City:	
(21) Probable Date of Admission:										(22) Fax No:	
(23) Probable Date of Discharge:										(24) Class of Accommodation:	
(25) ESTIMATED HOSPITAL EXPENSES:											
a. Room Rent (Per Day) Rs _____				d .Professional Charges Rs _____							
b. Medicine & Consumables Rs _____				e. Investigation Charges Rs _____							
c. Surgical Expenses Rs _____				TOTAL EXPENSES Rs _____							

C. TO BE ANSWERED BY THE PATIENT / INSURED (Column 26)

(26). Are you presently covered under any other similar type & scheme like it Cancer Ins, Medical Ins / Health insurance (individual or Group) Yes / No. If yes ,Give details We confirm having read , understood and agreed to the declarations on the reverse of this form :											
Treating Doctors Name & Signature _____				Hospital Seal _____		Patients/Insured `s Name & Signature _____				Patient Contact No. _____	

All grey color indicates mandatory fields. Request will not be processed, if mandatory fields are not filled

HOSPITAL DECLARARTION

- 1. We have no objection to any authorized Medi Assist official verifying document pertaining to hospitalization.
- 2. All valid original documents **duly countersigned by the insured / patient** as per the checklist below will be sent to Medi Assist within 7 days of the patient's discharge.
- 3. All non –medical expenses and expenses not relevant to hospitalization or illness, which are not payable by Medi Assist will be collected from the patient.
- 4. **WE AGREE THAT MEDI ASSIST WILL NOT BE LIABLE TO MAKE THE PAYMENT IN THE EVENT OF ANY DISCREPANCY BETWEEN THE FACTS IN THIS FORM AND DISCHARGE SUMMARY**
- 5. The patient declaration has been signed by the patient or by his representative in our presence.
- 6. We will abide by the terms and conditions agreed in the MOU.

Hospital Seal

Doctor's Signature

PATIENTS DECLARATION

- 1. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Medi Assist 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 Medi Assist is not liable to settle the hospital bill, I take complete responsibility to settle the bill.
- 3. All non-medical expenses and expenses not relevant to current hospitalization and the amounts over & above the limit authorized by Medi Assist will be paid by me. In case any clarification is needed on payability of a particular item please contact Medi Assist Toll Free Number **1600 425 9449**
- 4. I hereby declare to abide by the rules and regulations 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 Medi Assist.
- 5. I agree and understand that Medi Assist is in no way warranting the service of the hospital & that Medi Assist 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\e under any other Medical Scheme or Insurance.

Patient`s/Insured`s Name _____

Patient`s/Insured`s Signature _____

Phone No: _____

DOCUMENTS TO BE PROVIDED BY THE HOSPITAL IN SUPPORT OF THE CLAIM

- 1. Detailed discharge Summary and all bills with receipts from the hospital
- 2. Cash Memos from the Hospitals / Chemists supported by proper prescription.
- 3. Receipts and Pathological test reports from Pathologists, supported by note from the attending Medical Practioner / Surgeon recommending such pathological Tests.
- 4. Surgeon's Certificate stating nature of operation performed and Surgeons bill and receipt.
- 5. Certificates from attending Medical practitioner / Surgeon that the patient is fully cured.