

MedSave HealthCare Ltd.

Request for Cashless Hospitalisation FAX US AT ---- 011-29521067 / 71 Mail: cashless@medsavegroup.com

To Be Filled By Treating Doctor

Date:

Name of Patient		Policy No:	
Age	Phone No	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Medsave ID No.
Name of treating Doctor:		Qualification:	Reg No.
Relation with Proposer/Employee:		Employee Code:	
Presenting Complaints with Duration		Duration of Ailment	
Relevant Clinical Findings		PROPOSED INVESTIGATIONS:	
		Blood	Pathology
		Urine	Microbiology
		Radiology	Biochemistry
		Sonography	Endoscopy
Provisional Diagnosis:		ICD CODE	Imaging
			Cardiac Temt
			Other

PROPOSED LINE OF TREATMENT

<input type="checkbox"/> Investigation	<input type="checkbox"/> Supportive Management	IN CASE OF R	IN CASE OF MATERNITY
<input type="checkbox"/> Medical Management	<input type="checkbox"/> Intensive Care	FIR	Obetretio History: G_ P_ L_ A
<input type="checkbox"/> Surgical Management		Alcohol Drug Intoxication	LMP _____ EDD _____
Past History: If yes please Mention YES NO		Duration	
Hypertension			If Yes Since
Diabetes Millitus			If Yes Since
Cardiac Ailment			If Yes Since
Respiratory Ailment			If Yes Since
Any Other Pre-Existing Disease			If Yes Since

TO BE FILLED BY HOSPITAL

ESTIMATED HOSPITAL EXPENSES		Name & Address of the Hospital:	
Room Rent(Per Day)	Rs	Probable Date of Admission:	
Medicine & Consumables	Rs	Accomodation:	
Surgical Expenses	Rs	Duration Of Stay:	
Professional Charges	Rs	City:	
Investigation Charges	Rs	Fax No.(MUST):	
Any Other	Rs	E-mail (if any):	
Total Expenses	Rs		

HOSPITAL DECLARATION		PATIENTS DECLARATION	
1. We have no objection to any authorised MedSave official to verify document pertaining to insured's hospitalisation.		1. I agree to submit all original documents to MedSave to enable them to process my claim at the earliest.	
2. All valid original documents countersigned as per the check list & will be dispatched at the earliest following discharge of the patient.		2. In case MedSave is not liable to settle the hospital bill due to discrepancy in the documentation I take complete to settle the bill.	
3. All non-medical expenses & expenses not relevant to the hospital or illness which is not payable by MedSave will be collected directly from the Patient.		3. All non-medical expenses and expenses incurred by me not relevant to the hospitalisation illness will be payable by me.	
4. MedSave will not be liable to pay the bill on finding any discrepancy in the documentation or reports.		4. I hereby declare to abide by the rules and regulation of the policy and if at any time the facts disclosed by me are found to be false or incorrect I forbid my right to the Claim.	
5. We will submit a claim form duly filled & signed by insured.		PATIENT SIGNATURE	
HOSPITAL SEAL DOCTORS SIGNATURES		Address _____	
		Contact No. _____ Mobile No. _____	

