

**PRE-AUTHORIZATION REQUEST FORM**  
**Park Mediclaim Consultants Pvt. Ltd.**  
**702, Vikrant Tower, Rajendra Place, New Delhi – 110008**  
**Tel. No. 25747454, 25747455, Fax. 51539390, Email: parkmediclaim@sify.com.**

Park Mediclaim Card no.: \_\_\_\_\_ Policy No.: \_\_\_\_\_

Name of the Hospital: \_\_\_\_\_

Name of the patient: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: Male / Female

Corporate / Group: \_\_\_\_\_

Employee Code: \_\_\_\_\_

Presenting Complaints	Duration

**Past History**

Disease	Duration	Disease	Duration
DM		COPD/TB	
HT		Similar Ailment	
IHD/CAD		Any other Ailment	

H/o Alcohol / Intoxicant: If Yes, Please provide the details:

In Maternity Claim:

No. of Live Children:

LMP:

EDD:

Relevant Clinical Findings:

Relevant Investigation reports:

Admitting Diagnosis:

Plan of treatment:

Date of hospitalization:

IPD No.

Room No.:

ICU/ICCU

Expected duration of stay:

.....Contd. Overleaf

Pre-authorization request amount / Estimated Expenses:

Name of Consultant:

Contact No.'s:

Signature of Consultant with Seal

**N.B: ANY CHANGE IN THE ADMISSIBILITY OF THE CLAIM DUE TO ANY DISCREPANCY IN THE INFORMATION PROVIDED BY THE HOSPITAL IN THE PRE AUTHORIZATION FORM AND DISCHARGE SUMMARY / HOSPITAL RECORD WOULD BE THE LIABILITY OF THE HOSPITAL.**

**THE CASHLESS FACILITY MAY NOT BE GRANTED, IF THIS FORM IS NOT FILLED COMPLETELY.**

**THE DENIAL OF THIS CASHLESS IS NOT THE DENIAL OF THE TREATMENT OR CLAIM.**

**CLAIM FORM CUM CONSENT / AUTHORIZATION BY INSURED**

**(To be filled in by the insured)**

Name of the Insurance Company:

Policy No.:

Date of injury sustained or Disease first detected:                      Date                      Month                      Year

Whether Cashless Facility / claim availed earlier, if yes please provide details:

Previous coverage details, if any:

**I HAVE 'NO OBJECTION' IN PARK MEDICLAIM CONSULTANTS PVT LTD. OBTAINING DETAILS OF MY TREATMENT / COLLECTING DOCUMENTS AND / OR VERIFYING HOSPITAL RECORDS.**

**I RESRVE THE RIGHT TO SUBMIT PRE / POST HOSPITALIZATION OR OTHER CLAIM SEPARATELY AS AND WHEN REQUIRED AND AS PER POLICY TERMS AND CONDITONS, WHICH I HAVE READ AND UNDERSTOOD.**

**IN CASE THE LETTER OF AUTHORIZATION IS NOT UTILIZED AT THE ABOVE HOSPITAL, I AGREE TO INFORM AND SURRENDER THE LETTER OF AUTHORIZATION TO THE PARK MEDICLAIM CONSULTANTS PVT LTD. I AM AWARE THAT PARK MEDICLAIM CONSULTANTS PVT. LTD. WILL UPDATE MY SUM INSURED ONLY AFTER RECEIPT OF THE LETTER (IN CASE OF NON UTILIZATION OF AUTHORIZATION LETTER).**

**I HEREBY WARRANT THE TRUTH OF THE FOREGOING PARTICULARS IN EVERY RESPECT AND I AGREE THAT IF I HAVE MADE OR SHALL MAKE ANY FALSE OR UNTRUE STATEMENT, SUPPRESS OR CONCEAL ANY MATERIAL FACT, THEN, MY RIGHT TO CLAIM REIMBURSEMENT OF THE SAID EXPENSES WOULD STAND FORFEITED. I FURTHER DECLARE THAT IN RESPECT OF THE ABOVE TREATMENT, NO BENEFITS ARE ADMISSIBLE UNDER ANY OTHER MEDICAL SCHEME OR INSURANCE.**

Signature (Insured / Claimant)

Name:

Address:

Contact No.:-