

# UNITEDHEALTHCARE INDIA (PVT.) LTD.

## PRE-AUTHORISATION FORM FOR HOSPITALISATION

To be faxed back to 022 -2491 46 46 e-mail nurseline@uhcindia.com

Credit may be denied if the details in the form are found incomplete or inaccurate

Name of employee			Employee ref. no.		
Name of patient			Relation <span style="float: right;">Age</span>		
Company Name					
Off. Tel		Mobile		Res. Tel	
Communication Address					
<b>Details of treating physician and hospital</b>					
Name of treating physician			Reg. no		
Qualification		Mobile		Tel. Clinic	
Name of hospital			Location		
Hospital registration no.			Tax approved Yes / No / Don't know		
Hosp.Tel. no.			Hosp. Fax no		
<b>Details of diagnosis</b>					
Detailed diagnosis		1°	2°		3°
Symptoms on admission					
Date of first onset of symptoms				Date of first diagnosis	
<b>For Maternity</b>					
LMP / /		EDD / /		Obstetric History <b>G P L A</b>	
Indication for LSCS					
<b>For RTA</b>					
H/O Alcohol during accident Yes/No			MLC/FIR done for RTA Yes / No		
<b>Treatment proposed (Please tick (✓) where applicable)</b>					
Date of admission		Expected length of stay		Less than 24 hrs. Yes / No	
	Inject. (✓)	Oral (✓)		Inject. (✓)	Oral (✓)
Antibiotics			Steroids		IV transfusions
Anti-inflam. Drugs			Nutrients		Chemotherapy
Neuro-musc. Drugs			Sedatives		Radiation
Cardiac Drugs			Diuretics		Blood & comp.
Respiratory Drugs			GI drugs		Continuous traction
Other* (please specify)					
<b>Investigations (enlist)</b>					
<b>Procedures /Surgical treatment (describe)</b>					
<b>Anesthesia GA / SA / LA / OTHERS* (please specify)</b>					
<b>Past History (Please specify duration)</b>					
	Since		(Please provide details for below if applicable)		Since
Hypertension			H/O surgery		
Dyslipidaemia			H/O similar/related complaints		
Diabetes			H/O of any cardiac ailment		
Personal H/O: Alcohol/Tobacco/Drug abuse					
<b>Estimate of expenses</b>					
Room rent / day	Rs.	Pharmacy	Rs.	Surgeon charge	Rs.
Investigations	Rs.	Physician charge	Rs.	Anesthetist charge	Rs.
Consumables	Rs.	Other	Rs.	<b>TOTAL</b>	Rs.

\*FOR RTA CASES MLC/FIR IS MANDATORY

\*FOR CATARACT CASES COST OF LENS IS MANDATORY

### DECLARATION

- I hereby declare that the information provided in the form is true to the best of my knowledge, and authorize UnitedHealthcare India to seek any further information from the treating doctor / hospital if needed
- I am aware that the liability of UnitedHealthcare for treatment is limited to facilitating credit and refusal of credit does not amount to rejection of claim
- I undertake that if cashless facility is availed, all original documents, including the discharge summary and investigation reports shall be handed over to the hospital at the time of discharge along with the signed claim form. I am aware that without these documents the claim cannot be processed and I am liable for the same
- I am aware of my health insurance cover and if the hospital expenses exceed the amount, I shall be liable to pay the remainder of the amount at the time of discharge
- I undertake to pay all non-medical expenses incurred in the hospital at the time of discharge
- **If the hospitalization comes under any of the policy exclusions & is not reimbursed by the insurance company, I undertake to pay the amount to UnitedHealthcare India who have kindly extended the hospital credit facility**

Date \_\_\_\_\_ Employee Signature \_\_\_\_\_

- As treating physician, I hereby declare that the medical information declared in the form is accurate to the best of my knowledge

Date \_\_\_\_\_ Hospital Stamp \_\_\_\_\_ Treating Physician Signature \_\_\_\_\_