



Vipul MedCorp Private Limited

515, Udyog Vihar, Phase V, Gurgaon, Haryana - 122016

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Pre-Authorisation Request Form

Part-I (To be filled by the Insured)

Policy No:- V.M.C I.D. No:- Corporate Name:-
Name of the Employee:- Age:- yrs Sex:- M / F
Phone No. (Office):- Phone No. (Res):-
Name of the Patient:- Age:- yrs Sex:- M / F
Relation to the Employee:- Self Spouse Child Parent Other- Please Specify:-

Your Claim may be rejected if these informations are not given

Part-II (To be filled in by the Hospital) All Columns are Compulsory

Name of the Treating Doctor:- Phone No.
Qualification:- Regis No.:- Clinic Add.:-
Name of the Hospital/Nursing Home:- Tel No.:-
Registration No.:- Add.:-
Presenting Complaints With Exact Duration:-

Relevant Clinical Findings:-

H/O Any Past Illness relevant to the present Illness:-

Whether present illness is a complication of any Pre-existing disease/ Operation/ Past- diseases:-

Positive findings of Investigations done:-

Provisional/Differential Diagnosis:-

Proposed line of Treatment:-

Whether First Consultation or regular patient Since

Past H/O HT N: Yes/No/Not Known : if Yes Since Diabetes : Yes/No/Not Known: if Yes Since

IHD: Yes/No/Not Known: if Yes Since Heart Disease: Yes/No/Not Known: if Yes Since

COPD/TB: Yes/No/Not Known: if Yes Since Asthma: Yes/No/Not Known: if Yes Since

Osteoarthritis: Yes/No/Not Known: if Yes Since Cancer: Yes/No/Not Known: if Yes Since

Glucoma: Yes/No/Not Known: if Yes Since Cataract: Yes/No/Not Known: if Yes Since

Pre-existing disease if any:- Duration:-

In case of R.T.A was patient under the influence of Alcohol/Any other Drugs Yes./No M L C No.:-

(Please Fax a copy of the M L C report)

In case of Maternity Claim:- No of live children:-

L.M.P:- E.D.D:- Gravida:- Para:- L:-

(For the above do attach the Doctor First Prescription)

Date of Admission:- Approx Length of Hospitalization:-

Approx Expenses (I N R):- Class of Accommodation:-

Room Rent Per-day:- Doctor/Surgeon Fees:-

Investigation Charges:- Surgical & Consumables:-

Package Rate:- Any other:-

Signature of Doctor:- Stamp of Hospital:-

Part-III (To be filled by the Insured) Insured Consent / Authorisation

I have 'No Objection' to Vipul MedCorp obtaining details of my treatment / collecting documents and also hereby authorize Vipul MedCorp to pay the hospital bill & reimburse itself / receive the amount from my claim receivable from my insurance company. If my claim is rejected, I hereby undertake to pay Vipul MedCorp the amount paid by them to the hospital. This consent is also final discharge for Hospitalization part of the claim where it has effected the payment. I reserve the right to submit pre / post hospitalization or other claims separately as and when required and as per the policy terms and conditions.

Previous policy details -Policy No. Insurance Company:

Previous claim details Ailment: Date: Amount

Concurrent Policy details:

Signature/s.: Name: