



Alankit HEALTH CARE LTD.
 Regd. Office: 205-208, Anarkali Complex, Jhandewalan Extn., New Delhi - 110055
 Corp. Office: Alankit House, 2E/21 Jhandewalan Extn., New Delhi - 110 055
 Phone: 42541256-60, Fax: 42541266-67, E-mail: health@alankit.com



PRE-HOSPITALIZATION FORM

1. Alankit Card No. _____ Insurer's Name _____ Policy No. _____

Sum Assured _____ Cum. Bonus _____ Previous Coverage Details _____ Fresh / Renewal _____

Name of the Insured _____ Contact No. Office _____ Residence _____ Mobile _____

Relationship with Patient (Self / Spouse / Son / Daughter / Parents / Others) _____

Name of the Patient: _____ Age _____ Sex _____ Contact No. _____

Name of the Family Doctor _____ Contact No. _____

Any claim in past (if yes, Provide Particulars of same) _____

Hospital Particulars: _____

Name & Address of the Hospital: _____ Regn. No. _____ IPD No. _____

Name of the Contact Person of Hospital _____ Designation _____ Contact No. / Mobile _____

Individual/Corporate / Group: _____ Employee Code _____ Contact No. _____

Presenting Complaints	Duration
Please attach Doctor's	
1st Prescription, details	
of Inves. & Treatment	

Past History Relevant to the Presenting Complaints: _____

Other Associated illnesses: _____

Disease	Yes / No	Duration	Disease	Yes / No	Duration
DM			Arthritis - Osteo / Rheumatoid		
HT			Carcinoma		
IHD/CAD			Cataract / Glaucoma		
COPD/TB/Asma			Blood Transfusion / HIV / Related Disease		
			Any Other Ailment		

3. In Maternity Claim: Obst. History _____ Any abnormality noticed _____ LSCS with indications _____

LMP EDD _____ No. of Live Children: _____

In Case of accident:- MLC No. _____ Non MLC _____ Influence of alcohol: _____ Yes / No _____

Relevant Positive Clinical Findings: _____

Relevant Positive Investigation reports: _____

Date & Time of hospitalization: _____

Indication for Admission: _____

Diagnosis: Provisional / Final _____

Plan of Treatment: Conservative / Surgical _____

Non - Package		Package	
Room Rent & Nursing Care		Investigation	
Consultation		Surgical Procedure Charges (Total)	
Medicines		Package	
Cost of implant		Package	

Please Note: All the above columns should be completely filled. No Slashes Allowed. Inadequate information would lead to delay in our response. Progress Reports required if stay is beyond 3 days regularly. If there is any Discrepancy in Pre-authorization & Discharge Summary, our Pre-authorization would automatically stand Cancelled & we are not liable to any payment.

If cashless facility is not availed hospital has to inform AHCL in writing only after which AHCL would update my Sum Insured Identity of the patient verified

Soil & Regn. No. _____ Contact No's: _____ Name & Signature of Consultant alongwith _____

DECLARATION

I solemnly declare that the information provided by me and my consultant is true & correct to the best of my knowledge. I have paid for my hospitalization. I hereby undertake to pay the Hospital / Alankit Health Care Ltd (AHCL) the expenses, they have paid for verification / authorization. I hereby authorize the hospital to release my medical record to AHCL for the purpose of Dated: _____ At: _____

Name & signature of the patient/claimant _____