

Genins India Ltd.

D - 60, Sector - 2, Noida - 201 301
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Pre - Authorisation / Pre - Hospitalization Form

Please read this carefully - It is very important that this form be filled in carefully, completely and correctly to facilitate the processing of medical claim without causing any delay or rejection. It also helps to offer better guidance and assistance at all stages of hospitalization & reimbursement.

Part A - To be Filled by Hospital / Nursing Home / Service Provider:

Hospital Name: _____ City _____
Complete address _____ Reg. No. _____ Tel No. _____
Name of the Patient: M _____ Age _____ Years Sex: M / F
I D No. (As mentioned on the ID card): _____ Policy No. _____
Name of Policy Holder _____ Employee Code (In case of Corporate) _____
Contact No. of Insured / Patient - Landline: _____ Mobile: _____
Proposed date of admission _____ Total estimated expenses _____
Approx. duration of stay _____ Room Charges _____
Class of accommodation _____ Investigation Charges _____
Operation Theater Charges _____ Doctor(s) / Surgeon(s) Fee _____
Name of the Treating doctor _____ Medicine & Drugs Charges _____
Contact No. _____ Others _____
Signature of the Doctor _____ Rubber Stamp _____

The cashless facility may not be granted, if this form is not filled completely.

The change in the admissibility of the claim due to discrepancies in the information provided by the hospital in the pre-authorization form and discharge summary / hospital records would be the liability of the hospital.

Part B - To be filled by the treating Doctor / consultant:

Advised admission / admitted under Dr. _____ Reg. No. _____ Qualification: _____
Date of first consultation: _____ Name of the Doctor 1st Consulted _____
Presenting Complaints with exact duration: _____
History of Presenting Complaints: _____
Relevant Clinical Findings: _____ Investigation Reports (If any) _____
Relevant Past History _____
Diagnosis: _____
Proposed line of treatment: _____
Details of past treatment: _____

Part C - History of the following:

Hypertension Yes / No, If Yes, Since When _____ Diabetes Mellitus Yes / No, If Yes, Since When _____
CAD / IHD Yes / No, If Yes, Since When _____ Bronchial Asthma / Koch's and any other _____
COPD / TB / Similar Ailment Yes / No, If Yes, Since When _____ Any other Ailment _____
Any surgeries in the past _____ In case of road traffic accident, please mention if the patient was under the influence of alcohol / any other drugs _____ Yes / No (Please enclose the FIR copy)
(Please FAX the MLC copy)
In maternity: Gravida status _____ LMP _____ EDD _____ Para _____ No. of living children _____

Please do inform the covered person that in case the cashless facility is not allowed, it is not the denial of treatment or claim. The claim can be submitted for re-imburement, for settlement on its merits.

Part D - Declaration:

I solemnly declare that the information provided by me is true and correct to the best of my knowledge, in case my claim is rejected; I hereby undertake to pay to _____ the expenses, which are incurred / paid for my hospitalization. I hereby authorize the hospital to release / give photocopies of my medical record to **Genins India Ltd.** for the purpose of verification / authorization / settlement of my claim. I also confirm that I have read and understood the terms and conditions as mentioned and are applicable.

Previous Policy Details: Policy No _____ Insurance Co. _____
Previous claim details ailment _____ Date _____ Amount _____
Concurrent Policy details _____
Name of the Patient / Relative _____ Relationship _____
Signature of Patient / Relatives _____