FORM:-1

MEDICARE T.P.A Services (I) Pvt. Ltd.

MEDICARE TPA SERVICE (I) Pvt. Ltd.

REQUEST FOR CASHLESS PAYMENT TO PROVIDER HOSPITALS

(FORM TO BE FILLED IN CAPITAL LETTERS only WHICH IS LEGIBLE)

(IMPORTANT) IF NOT: THE CLAIM WILL NOT BE PROCESSED

NAME :	
ADDRESS :	
AGE :	SEX : PHONE NUMBER:
CELL NUMBER :	
BANK NAME :	
BRANCH :	
ACCOUNT NO :	
POLICY NO :	
CURRENT POLICY PAPER TO BE ATTACHED FOR INSURED OF NEW INDIA / NATIONAL / ORIENTAL / UNITED INDIA INSURANCE COMPANY.	
MEMBERSHIP NO :	
NEW POLICY NUMBER :	YES NO RENEWAL POLICY : YES NO
PREVIOUS POLICY AND CLAIMS DETAILS :	
NAME OF THE ATTENDING DOCTOR :	
MOBILE NO :	
NAME OF THE HOSPITAL :	
AILMENT FOR WHICH CASHLESS SOUGHT :	
COMMENCEMENT OF AILMENT :	
PAST MEDICAL HISTORY :	
WHAT MEDICATIONS IS THE PATIENT TAKING NOW :	
PAST SURGICAL HISTORY :	
WHICH YEAR :	
IS THE PRESENT AILMENT COMPLICATION OF PAST MEDICAL OR SURGICAL AILMENT :	YES NO
IF YES SPECIFY :	

IS THERE HISTORY OF

HYPERTENSION :	YES NO IF YES IN YEARS : Mon
DIABETES :	YES NO IF YES IN YEARS : Mon
ISCHAEMIC HEART DISEASE / RHEUMATIC HEART DISEASE / VALVULAR HEART DISEASE :	YES NO IF YES IN YEARS : Mon
FOR ALL THE ABOVE THREE DISEASES FOLLOWING INVESTIGATION REPORTS ARE REQUIRED :	ECG ECHO FBS PPBS LIPIDS
COPD/BRONCHIAL ASTHMA :	YES NO IF YES IN YEARS : Mon
FOR THE ABOVE DISEASE FOLLOWING INVESTIGATION REPORTS ARE REQUIRED :	CXR C.T. SCAN FBS PPBS
ARTHRITIS :	YES NO IF YES IN YEARS : Mon XRAY MRI

Name : **Membership No :**

CANCER :	YES	NO	IF YES IN YEARS :	Mon	BIOPSY REPORT					
RENAL FALIURE :	YES	NO	IF YES IN YEARS :	Mon						
FOR THE ABOVE DISEASE FOLLOWING INVESTIGATION REPORTS ARE REQUIRED :	UREA	CREATININE	HB	FBS	PPBS					
SEIZURE DISORDER :	YES	NO	IF YES IN YEARS :	Mon						
FOR THE ABOVE DISEASE FOLLOWING INVESTIGATION REPORTS ARE REQUIRED :	EEG	CALCIUM LEVEL	FBS	PPBS						
IN CASE OTHER AILMENT :	YES	NO	IF YES IN YEARS :	Mon						
IN CASE OF MATERNITY :	LMP	GRAVIDA	EDD	USG	PARITY					
IN CASE OF ACCIDENT :	FIR	SELF DECLARATION	XRAY	C.T. SCAN						
ALCOHOL / DRUG ABSUSE :	YES	NO	IF YES IN YEARS :	Mon						
IN CASE C/O ACCIDENTS INFLUENCE OF ALCOHOL/ANY OTHER DRUGS :	YES	NO	WHETHER MLC DONE :	YES	NO					
LINE OF MANAGEMENT:										

DATE OF ADMISSION :		PROBABLE DURATION OF STAY :	
ESTIMATED COST :		PACKAGE CHARGE :	
ROOM RENT :		CLASS OF ACCOMODATION :	
INVESTIGATION CHARGES :		DOCTOR / SURGEONS FEES :	
NAME OF IMPLANT :		OT CHARGES :	
COST OF IMPLANT :		**TOTAL AMOUNT**	

FINDING OF ATTENDING DOCTOR ON THE FIRST CONSULTANT

PULSE :		BP :	/
TEMPERATURE :	.	CONSCIOUNESS :	
PER ABDOMEN :		RS :	
CVS :		CNS :	

REPORTS SUPPORTING PRESENT DIAGNOSIS TO BE ATTACHED

SIGNATURE OF DOCTOR : REG NO.

By (Name)

(in case member is seriously ill and unable to sign,next of kin may sign on his/her behaif).

I,the undersigned understand that cashless Service facility by Medicare TPA Services (I) Pvt. Ltd. is conditional and once cashless is pre authorized the same may be withdrawn by Medicare TPA Services (I) Pvt. Ltd. at any stage before or during hospitailzation.

I undertake to :

Pay directly to the medical establishment for all inadmissible items mentioned in the hospital bill.

Reimburse in full any amount paid by Medicare TPA Services (I) Pvt. Ltd. for and on my behalf to the medical institution for the current hospitalization,if the claim submitted by Medicare TPA Services (I) Pvt. Ltd. to the Insurance Company is repudiated by them or only part payment of the claim is found to be admissible.

Abide by interpretation of rules,regulation and conditions as is made by Insurance Co from time to time.

SIGNED :

DATE :

STAMP OF HOSPITAL

(THE SIGNATURE OF THE PATIENT WILL BE VERIFIED IN THE HOSPITAL. IF THIS DOES NOT TALLY WITH THE SIGNATURE ABOVE, MEDICARE TPA. WILL NOT BE LIABLE TO MAKE PAYMENT.)