REQUEST FOR CASHLESS HOSPITALISATION FOR MEDICAL INSURANCE POLICY

DETAILS OF THE THIRD PARTY ADMINISTRATOR **(To be filled in block letters)**

a) Name of TPA / Insurance Company : Raksha TPA Pvt. Ltd./
b) Toll free phone number : 1800 180 1444 , 0129 - 4289999
c) Toll free FAX: 0129 - 4289988

TO BE FILLED BY THE INSURED / PATIENT

a) Name of the Patient:

b) Gender: ☐ Male ☐ Female c) Age: Years ☐☐ Months ☐☐ d) Contact number:

e) Insured Card ID number: f) Policy Number / Corporate:

g) Employee ID: h) currently do you have any other Mediclaim / Health insurance: ☐ Yes ☐ No

i. Company Name: ii. Give Details :

ii. Policy No. : iv. Sum Insured : ☐☐☐☐☐☐☐

i) Name of the Family physician: j) Contact number:

TO BE FILLED BY THE TREATING DOCTOR / HOSPITAL

a) Name of the Treating Doctor: b) Contact number:

c) Nature of ILLNESS / Disease with presenting complaints: _____

d) Relevant Clinical Findings :_____

e) Duration of the Present ailment: ☐☐☐ Days I) Date of First Consultation: ☐☐ ☐☐ ☐☐
II)Past History of Present ailment if any: _____

f) Provisional diagnosis: _____ I) ICD 10 Code

g) Proposed line of Treatment: ☐ Medical Management ☐ Surgical Management ☐ Intensive care ☐ Investigation ☐ Non Allopathic Treatment

h) If Investigation & / or Medical Management Provide Details:_____
I) Route of drug administration: _____

i) If Surgical, Name of Surgery : _____ I) ICD 10 PCS Code:

j) If Other Treatments provide details:_____ k) How did injury occur:_____

In case of accident: I) Is it RTA: ☐ Yes ☐ No II) Date of Injury: ☐☐ ☐☐ ☐☐ III) Reported to Police : ☐ Yes ☐ No

IV) Injury / Disease caused due to substance abuse / alcohol consumption: ☐ Yes ☐ No V) Test Conducted to establish this: ☐ Yes ☐ No (If Yes, attach reports)

l) In case of Maternity: ☐ G ☐ P ☐ L ☐ A LMP ☐☐ ☐☐ ☐☐

Details of patient admitted

a) Date of admission: ☐☐ ☐☐ ☐☐ b) Time ☐☐ ☐☐

c) Is this an emergency / a planned hospitalization event ?: ☐ Emergency ☐ Planned

d) Expected no. of days stay in hospital : ☐☐☐ Days

e) Room Type :

f) Per Day Room Rent + Nursing & Service Charges + Patient's Diet: Rs.

g) Expected cost for Investigation + diagnostics : Rs.

h) ICU Charges : Rs.

i) OT Charges : Rs.

j) Professional fees Surgeon +Anaesthetist fees+consultation Charges: Rs.

k) Medicines + Consumables + Cost of Implants (if Applicable please specify). Other hospital Expenses if any : Rs.

l) All Inclusive package charges if any applicable Rs.

m) **Sum Total expected cost of hospitalization** **Rs.**

Mandatory: Past History of any chronic illness **if Yes, since (month/year)**

☐	Diabetes	☐☐ ☐☐
☐	Heart Disease	☐☐ ☐☐
☐	Hypertension	☐☐ ☐☐
☐	Hyperlididemias	☐☐ ☐☐
☐	Osteoarthritis	☐☐ ☐☐
☐	Asthma / COPD / Bronchitis	☐☐ ☐☐
☐	Cancer, Tumor, Cyst or growth of any kind	☐☐ ☐☐
☐	Alcohol or drug abuse	☐☐ ☐☐
☐	Any HIV or STD / Related ailments	☐☐ ☐☐
☐	Epilepsy or Tuberculosis	☐☐ ☐☐
☐	Any Physical Disablility or Disease of Eye	☐☐ ☐☐
☐	Depression, Mental or psychiatric condition	☐☐ ☐☐
☐	Disorder of bones, joints or muscles	☐☐ ☐☐

☐ Stroke, Anemia ,any Blood Disorder,Chest Pain**,** elevated cholesterol, disorder of kidney or genitor – urinary system, liver disorder, hepatitis (including hepatitis B carrier). ☐☐ ☐☐

☐ Any Disease or Disorder of Brain & Nervous System, Respiratory system, Digestive system or Circulatory system. ☐☐ ☐☐

☐ At any Stage During the past 5 years, have you either been prescribed medication (other than for cold or flu) or received medical treatment/advice on a regular basis. Details _____ ☐☐ ☐☐

Any other Ailment give Details :_____ ☐☐ ☐☐

DECLARATION **(PLEASE READ VERY CAREFULLY)**

We confirm having read understood and agreed to the Declarations on the reverse of this form

a) Name of treating doctor:

b) Qualification: c) Registration No. With State Code:

Signature of treating doctor | Hospital Seal (Must include Hospital ID) | Patient / Insured Name & Signature: