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: **Park Mediclaim TPA PVT. LTD.** **Hospital Name:**

b) Toll free phone number: 1800 115 533

c) Toll free Fax: 43191003-04, 41539390

TO BE FILLED BY THE INSURED / PATIENT

a) Name of the Patient:

b) Gender: Male Female c) Age Years Months d) Date of birth

e) Contact number: f) Contact number of attendingRelative g) Insured card ID number

h) Policy number / Name of Corporate i) Employee ID:

j) Currently do you have any other Mediclaim / Heath Insurance: Yes No Company Name:

Give details:

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:

d) Duration of 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 Code:

j) If Other treatment provide details:

k) How did injury occur:

k) In case of accident: i. Is it RTA: Yes No ii. Date of injury: iii. Reported to Police: Yes No iv. FIR No:

v. Injury / Disease caused due to substance abuse / alcohol consumption: ☐ Yes ☐ No vi. Test conducted to establish this: ☐ Yes ☐ No (If yes attach Reports)

I) In case of Maternity: ☐ G ☐ p ☐ L ☐ A Date of Delivery: ☐☐ ☐☐ ☐☐

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 + diagnostic: Rs.

h) ICU Charges: Rs.

i) OT Charges: Rs.

j) Professional fee Surgeon + Anesthetist 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	☐☐ ☐☐
☐ Hyperlipidemias	☐☐ ☐☐
☐ Osteoarthritis	☐☐ ☐☐
☐ Asthma/COPD/Bronchitis	☐☐ ☐☐
☐ Cancer	☐☐ ☐☐
☐ Alcohol or drug abuse	☐☐ ☐☐
☐ Any HIV or STD / Related ailments	☐☐ ☐☐

Any other ailment give details:

(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:**

Hospital Seal (Must include Hospital ID)

Patient / Insured Name & Signature: