PREAUTHORIZATION FORM

Request for Cashless Hospitalization for Health Insurance Policy

PART - C

Claim Intimation Number:	

SECTION A – DETAILS OF TPA/INSURER/HOSPITAL (to be filled in block letters)			
a) Name of insurance company	**GALAXY HEALTH INSURANCE COMPANY LIMITED**		
b) Toll-free phone number		c) Fax No./e-mail ID	
d) Name of the Hospital			
1. Address			
2. ROHINI ID			
3. Email ID			

SECTION B – DETAILS OF PATIENT ADMITTED (to be filled by insured/patient)			
a) Name of the patient			
b) Gender	☐ Male ☐ Female ☐ Third Gender		
c) Age	M M Y Y Y Y	d) Date of Birth	D D M M Y Y Y Y
e) Contact number			
f) Contact number & name of attending relative			
g) Insured card ID number/employee ID		h) ABHA ID No.	
i) Current address of insured patient			
j) Occupation of insured patient			
k) Policy number/name of corporate			
l) Currently, do you have any other mediclaim/health insurance: ☐ Yes ☐ No 1. Company Name: _____ 2. Give Details: _____			
m) Do you have a family physician: ☐ Yes ☐ No			
1. Name of the family physician: _____ 2. Contact number, if any: _____			

(Please complete the declaration of this form)

SECTION C – DETAILS OF AILMENTS DIAGNOSED (to be filled by treating doctor/hospital)	
a) Name of the treating doctor	
b) Contact number	
c) Nature of illness/disease with presenting complaint	
d) Relevant clinical findings	
e) Duration of present ailment	days
1. Date of first consultation	M M Y Y Y Y
2. Past history of present ailment, if any	
f) Provisional diagnosis	
1. ICD 10 Code	
g) Proposed Line of Treatment	☐ Medical Management ☐ Surgical Management ☐ Intensive Care ☐ Investigation ☐ Non-allopathic treatment

Unique No.: GHI / PF001

h) If investigation & / or medical management, provide details: _____					
1. Route of drug administration: _____					
i) If surgical, name of surgery					
1. ICD-10-PCS Code					
j) If other treatment, provide details					
k) How did injury occur?					
l) In case of accident	1. Is it RTA	☐ Yes ☐ No	2. Date of injury	D D M M Y Y Y Y	
	3. Reported to police	☐ Yes ☐ No	4. FIR No.		
	5. Injury/disease caused due to substance abuse/alcohol consumption	☐ Yes ☐ No	6. Test conducted to establish this (if yes, attach report)	☐ Yes ☐ No	
m) In case of maternity	☐ G ☐ P ☐ L ☐ A		1. Expected date of delivery	D D M M Y Y Y Y	

SECTION D – DETAILS OF PATIENT ADMITTED

a) Date of admission D D M M Y Y Y Y				b) Time of admission HH:MM			
c) Is this an emergency/planned hospitalization event				☐ Emergency ☐ Planned			
d) Mandatory past history of of any chronic illness If yes, (since month/year)	1. Diabetes	☐ Yes ☐ No M M Y Y Y Y	2. Heart disease	☐ Yes ☐ No M M Y Y Y Y	3. Hypertension	☐ Yes ☐ No M M Y Y Y Y	
	4. Hyperlipidemia	☐ Yes ☐ No M M Y Y Y Y	5. Osteoarthritis	☐ Yes ☐ No M M Y Y Y Y	6. Asthma/COPD/ Bronchitis	☐ Yes ☐ No M M Y Y Y Y	
	7. Cancer	☐ Yes ☐ No M M Y Y Y Y	8. Alcohol / drug abuse	☐ Yes ☐ No M M Y Y Y Y	9. Any HIV/STD related ailment	☐ Yes ☐ No M M Y Y Y Y	
	10. Liver / Kidney disease	☐ Yes ☐ No M M Y Y Y Y	11. Any other ailment, give details				
e) Expected number of days/stay in hospital _____ Day(s)			f) Days in ICU _____ Day(s)				
g) Room Type :							
h) Per day room rent + RMO + nursing and service charges (INR):							
i) Expected cost of diagnosis + investigation (INR):							
j) ICU Charges (INR):			k) OT Charges (INR):				
l) Professional fees Surgeon + Anaesthetist Fees + Consultation Charges (INR):							
m) Medicines + Consumables + Cost of Implants (if applicable, please specify) (INR):							
n) Other hospital expenses, if any:							
o) All-inclusive package charges, if any applicable (INR):							
p) Sum total expected cost of hospitalization (INR):							

SECTION E – DECLARATION (please read very carefully)

We confirm having read, understood, and agreed to the declarations within this form

Name of the treating doctor _____

Qualification _____

Registration number with state code _____

Hospital Seal (must include hospital network ID)	Signature of treating doctor	Patient/insured Name and Sign

Declaration by the patient/representative

1. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the insurer/TPA after the discharge. I agree to sign the final bill and the discharge summary, before my discharge.
2. Payment to the hospital is governed by the terms and conditions of the policy. In case the insurer/TPA is not liable to settle the hospital bill, I undertake to settle the bill as per the terms and conditions of the policy.
3. All non-medical expenses, and expenses not relevant to the current hospitalization; and the amounts over & above the limit authorized by the insurer/TPA not governed by the terms and conditions of the policy will be paid by me.
4. In case any clarification is needed on admissibility of a particular item, I shall contact TPA at the Toll Free Number on the reverse of this form
5. I hereby declare to abide by the terms and conditions of the policy and if at any time the facts disclosed by me are found to be false or incorrect, I forfeit my claim and agree to indemnify the insurer/TPA.
6. I agree and understand that TPA is in no way warranting the service of the hospital and that the insurer/TPA is in no way guaranteeing that the services provided by the hospital will be of a particular quality or standard.
7. I hereby warrant the truth of the foregoing particulars in every respect, and I agree that if I have made or shall make any false or untrue statements, suppression, or concealment with respect to the claim, my right to claim reimbursement of the said expenses shall be absolutely forfeited.
8. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the insurer/TPA.
9. "I/we authorize the insurance company/TPA to contact me/us through mobile/email for any update on this claim".
10. I am admitted to your hospital _____ from _____

I hereby authorize Galaxy Health Insurance Co. Ltd. and its representatives, who is my health insurer to seek any medical information/records from you or from the medical practitioners who have attended on me in connection with the above ailment and the treatment given. In case they seek any such information/Records/Indoor case papers, kindly oblige.

a) Patient's/Insured's Name:_____ c) Contact Number: _____

b) Email ID (optional):_____ d) Patient's Signature: _____

Date : _____ Time : _____

Hospital declaration

1. We have no objection to any authorized TPA/insurance company official verifying documents pertaining to hospitalization.
2. All valid original documents duly countersigned by the insured/patient as per the check-list below will be sent to TPA/insurance company within 7 days of the patient's discharge.
3. We agree that TPA/Insurance Company will not be liable to make the payment in the event of any discrepancy between the facts in this form and the discharge summary or other documents.
4. All non-medical expenses or expenses not relevant to Hospitalisation or illness, or expenses disallowed in the Authorisation Letter of the Insurance Company OR arising out of incorrect information in the pre authorisation form will be collected from the patient.
5. The patient's declaration has been signed by the patient or by his representative in our presence.
6. We agree to provide clarifications for the queries raised regarding this hospitalization and we take sole responsibility for any delay in offering clarifications.
7. We will abide by the terms and conditions agreed upon or agreed to MOU.
8. We confirm that no additional amount would be collected from the insured in excess of agreed package rates, except costs towards non-admissible amounts (including additional charges due to opting for higher room rent than eligibility/choosing a separate line of treatment which is not envisaged/considered in the package).
9. We confirm that no recoveries would be made from the deposit amount collected from the insured, except for costs toward non-admissible amounts (including additional charges due to opting for higher room rent than eligibility/ choosing a separate line of treatment, which is not envisaged/considered in the package).
10. In the event of unauthorized recovery of any additional amount from the Insured in excess of agreed package rates, the authorized TPA / Insurance Company reserves the right to recover the same from us (the network provider) and/or take necessary action, as provided under the MOU or applicable laws.

Hospital Seal Doctor's Signature

Date : _____ Time : _____

DOCUMENTS TO BE PROVIDED BY THE HOSPITAL IN SUPPORT OF THE CLAIM

1. Detailed discharge summary and all bills from the hospital.
2. Cash Memos from the Hospitals/Chemists supported by proper prescription.
3. Receipts and pathological test reports from pathologists, supported by a note from the attending medical practitioner/surgeon recommending such pathological tests.
4. Surgeon's Certificate stating nature of operation performed and Surgeon's Bill and Receipt.
5. Certificates from attending medical practitioner/surgeon that the patient is fully cured.

SECTION F – ANNEXURE FOR PREAUTH CLAIMS	
Dear Policyholder, Please fill out the following information along with the cashless form for your medical insurance policy.	
1. Policy No.	
2. Membership Number	
3. Hospital ID (to be filled by the hospital)	

DOCUMENT CHECKLIST:

1. Copy of photo ID, address proof, and recent photo of patient. (For valid proof of documents, kindly refer to the KYC document list) KYC document list includes PAN Card/Driving License/Voter ID Card/Aadhar Card.
2. Past illness records (with duration of symptoms) if any
3. First and subsequent consultation paper along with admission note.
4. Complete medical history along with supporting investigation reports.
5. In case of accident, MLC/FIR copy (if applicable)
6. Claim consent letter.

All documents mentioned above to be submitted along with the completed filled cashless form. The insurer may require further documents to process the request.

1. Name of the Proposer / Insured	
2. Contact No.	

Signature

1. Name of the TPA coordinator			
2. Date	D D M M Y Y Y Y	3. Place	

Signature

SECTION G – Consent Letter

To,

Date:

Medical Superintendent

_____

_____

_____

I, Mr./Ms _____ Age _____ Resident of _____

State _____

Hereby give my willful consent to a representative of Galaxy Health Insurance Company Limited to verify and collect necessary documents and statements including but not limited to certified copies of medical records from your esteemed hospital for the purpose of settlement of my insurance claim.

My other relevant details are provided below;

Details of Insured

Date of Admission	
Date of Discharge	
MRD / Indoor / IP No.	
Policy No.	

I request you to provide all the information/documents as required by Galaxy Health Insurance Company Ltd.

Name

Signature/thumb Impression

Witness Name & Signature