MEDICARE
T.P.A Services(I) Pvt. Ltd.
6B, Paul Mansions, Bishop Lefroy Road,
Kolkata 700 020, West Bengal, India

REQUEST FOR CASHLESS HOSPITALISATION FOR MEDICAL INSURANCE POLICY

Name of the Hospital :

Hospital Location :

Hospital Fax No :

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

a) Name of the TPA / Insurance Company : **Medicare TPA Services (I) Private Limited** b) Contact Ph No : **033-4007994** c) Fax No : **033-22893385**

To Be filled in By Insured / Patient

a) Name of the patient :

b) Gender : Male /Female c) Age : Years Y Y Months M M d) Date of birth (DD/MM/YYYY) : D D M M Y Y Y Y

e) Contact No :

f) Insured Member ID card No : g) Employee ID :

h) Policy No/Corporate Name :

i) Currently do you have any Mediclam/Health Inrasurance : Yes /No

j) Company Name :

Give details :

k) Do you have a family physician : Yes /No l) Name of the family physician :

j) Contact No., if any : **PLEASE COMPLETE DECLARATION ON THE REVERSE SIDE OF THIS FORM**

To Be filled by the Treating Doctor / Hospital

a) Name of treating doctor :

b) Contact No :

c) Name of ILLNESS / Disease with presenting complaints :

f) Duration of present ailment : Days

i) Date of first consultation : D D M M Y Y

d) Relevant clinical findings :

ii) Past history of present aliment, if any :

e) Relevant clinical findings :

g) Provisional Diagnosis :

iii) ICD 10 Code :

h) Proposed line of treatment : Medical Management Surgical management Intensive Care Investigation Non allopathic treatment

i) Investigational &/Medical Management provide details :

j) Route of drug administration :

k) If Surgical name of surgery :

l) If Surgical name of surgery :

m) ICD 10 Code :

n) If other treatment provide details :

o) How did injury occur :

p) In case of Accident : i) Is it RTA Yes /No ii) Date of injury : D D M M Y Y Y Y

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 report

q) In case of maternity : G [ ] P [ ] L [ ] A [ ] Date of delivery : [D][D][M][M][Y][Y][Y][Y]

Details of patient admitted

a) Date of admission : [D][D][M][M][Y][Y] b) Time : [H][H][M][M]

c) Is this a 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 + Anesthetist + 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	[M][M][Y][Y]
[ ] Heart Disease	[M][M][Y][Y]
[ ] Hypertension	[M][M][Y][Y]
[ ] Hyperlipidemias	[M][M][Y][Y]
[ ] Osteoarthritis	[M][M][Y][Y]
[ ] Asthma/ COPD/Bronchitis	[M][M][Y][Y]
[ ] Cancer	[M][M][Y][Y]
[ ] Alcohol or drug abuse	[M][M][Y][Y]
[ ] Any HIV or STD / Related ailments	[M][M][Y][Y]

Any other Ailment Give details :

DECLARATION

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

Name of the treating doctor : [ ]

Qualification : [ ]

Registration no with state code : [ ]

Hospital Seal (Must include Hospital ID) : [ ]

Patient / Insured Name & Signature : [ ]

IMPORTANT: Please Turn Over