DHFL GENERAL INSURANCE

FORM - C

PLEASE FAX/SCAN PAGE 1 ONLY

REQUEST FOR CASHLESS HOSPITALISATION FOR MEDICAL INSURANCE POLICY

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

a) Name of the TPA/Insurance Company:

b) Toll free phone no: c) Toll free FAX:

TO BE FILLED BY INSURED/PATIENT

a	Name of the patient		
b	Gender Male Female	c	Age Years Y Y Months M M
d	Contact Number		
e	Insured Member ID card no	f	Policy No/Corporate
g	Employee ID	h	Currently do you have any Mediclaim/Health Insurance Yes No
i	Company Name	ii	Give details
iii	Policy No	iv	Sum Insured
i	Name of the family physician	j	Contact Number

(PLEASE COMPLETE DECLARATION ON THE REVERSE SIDE OF THE FORM)

TO BE FILLED BY TREATING DOCTOR/HOSPITAL

a	Name of treating doctor	b	Contact Number
c	Nature of illness/Disease with presenting complaints	d	Relevant clinical findings
e	Duration of present ailment Days Date of first consultation D D M M Y Y Y Y		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 Unit / Investigation / Non allopathic treatment		
h	Investigational &/or Medical Management provide details	i	Route of drug administration
I	If surgical name of surgery	I	ICD 10 PCS code
j	If other treatment provide details	k	How did injury occur
i	In case of Accident	ii	Is it RTA Yes No
iii	Date of injury D D M M Y Y Y Y	iv	Reported to Police Yes No
	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
I	In case of Maternity G P L A		LMP D D M M Y Y Y Y

Details of patient admitted		Mandatory: Past history of any chronic illness	If yes, since Months/Years
a	Date of admission D D M M Y Y Y Y; b Time H H M M	Diabetes	M M Y Y
c	Is this a emergency/a planned hospitalisation event? Emergency Planned	Heart Disease	M M Y Y
d	Expected no of days stay in hospital Days; e Room Type	Hypertension	M M Y Y
f	Per Day Room Rent + Nursing & Service Charges + Patient's Diet Rs	Hyperlipidemias	M M Y Y
g	Expected cost for investigation + diagnostics Rs	Osteoarthritis	M M Y Y
h	ICU Charges Rs	Asthma / COPD / Bronchitis	M M Y Y
i	OT Charges Rs	Cancer	M M Y Y
j	Professional fees Surgeon + Anesthetist Fees + consultation Charges Rs	Alcohol or drug abuse	M M Y Y
k	Medicines + Consumables + Cost of Implants (if applicable please specify). Other hospital expenses if any Rs	Any HIV or STD / Related ailments	M M Y Y
l	All inclusive package charges if any applicable Rs	Any other Ailment give details:	
m	Sum Total expected cost of hospitalization Rs		

(PLEASE READ VERY CAREFULLY)

DECLRATION

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

a	Name of the treating doctor		
b	Qualification	c	Registration no with state code

Signature of Treating Doctor	Hospital Seal (Must include Hospital ID)	Patient/Insured Name & Signature

(IMPORTANT PLEASE TURN OVER)

Insurance is the subject matter of solicitation. For more details on risk factors, terms and conditions, please read sales brochure carefully before concluding a sale.

IRDAI Registration Number: 155 CIN: U66000MH2016PLC283275 GSTIN: 27AAFCD7985H1Z4

Registered & Corporate Office: 2nd Floor, DHFL House, 19, Sahar Road, Off Western Express Highway, Vile Parle (East), Mumbai - 400 099.

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 on the Final Bill & the Discharge Summary, before my discharge.
2. Payment to 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 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. 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.
4. 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.
5. I agree and understand that TPA is in no way warranting the service of the hospital & that the Insurer / TPA is in no way guaranteeing that the services provided by the hospital will be of a particular quality or standard.
6. I hereby warrant the truth of the forgoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppression or concealment, my right to claim reimbursement of the said expenses shall be absolutely forfeited. I further declare that, in respect of the above treatment no benefits are admissible under any other Medical Schemes or Insurance.
7. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer / TPA.

Patient's/Insured's Name _____ Patient's/Insured's Signature _____

Contact No: _____

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 checklist below will be sent to TPA / Insurance Company within 7 days of the patient's discharge.
3. All non-medical expenses OR expenses not relevant to hospitalization or illness, OR expenses disallowed in the Authorisation Letter of the TPA/Insurance Co, OR arising out of incorrect information in the pre-authorisation form will be collected from the patient.
4. 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 DISCHARGE SUMMARY OR OTHER DOCUMENTS.
5. The patient 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 the sole responsibility for any delay in offering clarifications.
7. We will abide by the terms and conditions agreed in the MOU.

Hospital Seal	Doctor's Signature

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 note from the attending Medical Practitioner I 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.

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