PLI PLI	FASE FAX / SCAN PAGE 1 ONLY			
	ESS HOSPITALISATION FOR MEDICAL INSURANCE POLICY			
Name of the Hospital Hospital Location Hospital Fax No. H	Hospital ID (To be Filled in block letters)			
	I PLAN INSURANCE TPA LIMITED			
b)Toll Free Phone Number:	TENTINGON WOLLING			
c) Toll Free FAX Number: TO BE FILLED BY THE	INSURED / PATIENT			
f) Contact number of	Dateof birth D D M M Y Y Y Y e) Contact number:			
Attending Relative	h)EmployeeID:			
	panyName			
i) Do youhave a family physician Yes No j) Name of the family physician k) Contact number, if any:	(PLEASE COMPLETE DECLAR ATION ON THE REVERSE SIDE OF THIS FORM)			
a) Name of the treating doctor: c) Name of ILLNESS / Disease with presenting complaints	d) Relevant clinical findings:			
e) Duration of the present ailments Days I) Date of first consultation D M f) Provisional diagnosis:	M Y Y ii. Past history of present ailment if any:			
Proposed Line of treatment: Medical Management Surgical Management Management provide details:	ement Intensivecare Investigation Nonallopathic treatment i.Routeof drug administration:			
i) If Surgical, nameof surgery:	i.ICD10PCS Code:			
j) If other treatmentsprovide details:	k)How did injury occur:			
I) In case of accident: I. Is it RTA: Yes No ii. Date of injury: M M 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. 7	Test conducted to establish this: Yes No (If Yes attachreports)			
m) In case of Maternity: G P L A	Date of Delivery/ LMP:			
Details of the patient admited	Mandatory: Past history of any choronic illness If yes, since (Month / Year)			
a) Dateofadmission: D D M M Y V b)Time H H C) Is thisan emergency/a planned hospitalization even! Emergency Planned	M M Y Y Heart Disease M 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:	Hyperlipidemias M M Y Y			
g) Expected cost for investigation + diagnostics:	Osteoarthritis M M Y Y			
h) ICU Charges:	Asthma/ COPD / Bronchitis			
i) OT Charges:	Cancer M M Y Y			
j) Professional fees Surgeon+ Anesthetist Fees + Consultation Charges:	Alcohol or drug abuse			
k) Medicines+ Consumables Cost of Implants(if applicable please Rs.	AnyHIV or STD / Related ailments			
specify).Other hospital expensesif any: I) All inclusive package chargesif any applicable: Rs.	Anyother Ailment give details:			
m) Sum Total expected cost of hospitalization Rs.				
DECLAR	(PLEASE READ VERY CARREPULLY)			
DECLARATION We confirm having read understood and agreed to the Declaration on the reverse of this form.				
We confirm having read understood and agreed to the Declaration on the reverse of this form				
a) Name of the treating doctor: SURNAME FI				
b) Qualification:				

Hospital Seal (Must include Hospital ID)

Patient/ InsuredName & Signature:

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 amount over & above the limit authorized by the Insurer/T.P.A. not governed by the terms and conditions of the policy will be paid by me.
- 4. I hereby declare to abide by the terms and conditions of the policy and if at any facts disclosed by me are found to be false or incorrect I forfeit my claim and agree to indemnify the insurer / T.P.A.
- 5. I agree and understand that T.P.A. is in no way warranting the service of the hospital & that the Insurer / TPA is 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 with respect to the claim, my right to claim reimbursement of the said expenses shall be absolutely forfeited.
- 7. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the insurer / TPA.

a) Patient's / Insured's Name:	
b) Contact Number:	c) Patient's / Insured's Signature:
b) Contact Number	c) Patients / insured's Signature

HOSPITAL DECLARATION

- 1. We have no objection to any authorized TPA / Insurance Company official verifying documents pertaing to hospitalization
- 2. All valid original documents duly countersigned by the insured / patient as per the checklist below will be sent TPA / Insurance Company within 7 days of the patient's discharge.
- 2. All non medical expenses, OR expenses not relevant to hospitalization or illness, OR expenses disallowed in the Authorization 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 represent in our presence.
- 6. We agree provide clarification 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 / 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.