

PRE-AUTHORISATION REQUEST FORM

Name of Proposer/Employer _____ CARD No.*: _____ Policy No*: _____
 Name of Patient _____
 Product Name _____ Relation _____ Age/DOB [DDMMYYYY]
 Group/Company Name of the employee _____
 Employee Code _____ Mobile _____ Tel No. _____
 Communication Address _____ Email ID _____

Hospital Details

Name of Hospital* _____ Hosp. code _____ Location _____
 Hospital Registration No. _____ Address _____
 Hosp. Tel. No. _____ Hosp. Fax No. _____ Hosp. Email ID _____

Treating Doctor Details

Name of Treating Doctor: _____ Reg. No. _____
 Qualification: _____ Mobile: _____ Clinic Tel. _____

Details of Diagnosis

Symptoms on Admission _____ Date of first Onset of symptoms [DDMMYYYY]
 Ailment* _____ Date of First Diagnosis [DDMMYYYY] Type Of Admission* ☐ Emergency ☐ Planned
 Differential Diagnosis* _____ Investigation Findings _____
 Date of Admission [DDMMYYYY] Expected Date of Discharge [DDMMYYYY]

Past History (Please Specify Duration)

	Since	Remarks		Since	Remarks
Hypertension			H/O surgery		
Dyslipidaemia			H/O Similar/Related Complaints		
Diabetes			H/O of any Cardiac Ailment		
If others specify			H/O: Alcohol/Drug abuse		

Conservative (Please Select)

Antibiotics	<input type="checkbox"/> Inject <input type="checkbox"/> Oral	IV Transfusions	<input type="checkbox"/> Inject <input type="checkbox"/> Oral
Neuro-musc. Drugs	<input type="checkbox"/> Inject <input type="checkbox"/> Oral	Chemotherapy	<input type="checkbox"/> Inject <input type="checkbox"/> Oral
Cardiac Drugs	<input type="checkbox"/> Inject <input type="checkbox"/> Oral	Continuous Traction	<input type="checkbox"/> Inject <input type="checkbox"/> Oral
Respiratory Drugs	<input type="checkbox"/> Inject <input type="checkbox"/> Oral	Radiation	<input type="checkbox"/> Inject <input type="checkbox"/> Oral

Other* (please specify): _____

Surgical

Date of surgery [DDMMYYYY] Type of Anesthesia ☐ LA ☐ GA ☐ Epidural ☐ Spinal ☐ Regional Block Other*: _____
 Procedure Name _____

Maternity

Last Menstrual Period [DDMMYYYY] Expected Date of Delivery [DDMMYYYY]
 Mode of Delivery: Normal/LSCS/Abortion/Others _____ Indication for LSCS _____
 Obstetric History* Gravida _____ Para _____ Abortion _____ Live _____

Road Travel Accident

H/O Alcohol during accident ☐ Yes ☐ No MLC/FIR done for RTA ☐ Yes ☐ No MLC/FIR No _____

Estimate of Expenses (Please Select From Below) (Accommodation Type -Room / ICU)

Room Category* ☐ General Ward ☐ Twin Sharing ☐ Single Non AC ☐ Single AC ☐ Deluxe/Suite ☐ Others
 ICU Category ☐ ICU ☐ NICU ☐ MICU ☐ SICU ☐ PICU ☐ NICU

Length of Stay	No of Visits	Room No	Bed No
Room Rent / Day	Rs.	Pharmacy	Rs.
Investigations	Rs.	Physician Charge	Rs.
Package	Rs.	Nursing	Rs.
Other	Rs.	OT charges	Rs.
TOTAL*		Surgeon charge	Rs.
		Asst. Surgeon charge	Rs.
		Anesthetist	Rs.
		Consumables	Rs.

Total in words _____

*For RTA cases - MLC/FIR is mandatory *For CATARACT cases - Type & cost of LENS is mandatory *Any Implant/Stent/Sticker Invoice Mandatory

DECLARATION

I hereby declare that the information provided in the form is true to the best of my knowledge, and authorize HDFC ERGO to seek any further information from the treating doctor / hospital if needed. I undertake that if cashless facility is availed, all original documents, including the discharge summary and investigation reports shall be handed over to the hospital at the time of discharge along with the signed claim form. I am aware that without these documents the claim cannot be processed and I am liable for the same. I undertake to pay all non-medical expenses incurred in the hospital at the time of discharge. If the hospitalization comes under any of the policy exclusions & should this authorization become null and void due to wrong and/or misleading and/or incorrect information & is not reimbursed by the insurance company, I undertake to pay the amount to HDFC ERGO who have kindly extended credit facility to the hospital

Date [DDMMYYYY]

Signature & Stamp of Treating Dr./ Hospital _____

Patient/Relative's Sign _____