

# STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED

Regd. & Corporate Office: 1, New Tank Street, Valluvar Kottam High Road, Nungambakkam, Chennai - 600 034.

Corporate Office - Claims Dept.: KRM Center, 6th Floor, No 2 Harrington Road, Chetpet, Chennai - 600 031.

Toll free Phone No: 1800 425 2255 Toll free Fax No: 1800 425 5522 Website: www.starhealth.in

Annexure - 1

## REQUEST FOR CASHLESS HOSPITALISATION FOR MEDICAL INSURANCE POLICY

PLEASE FAX / SCAN (To be filled in block letters) DETAILS OF THE THIRD PARTY ADMINISTRATOR a) Name of TPA / Insurance company: b) Toll free phone number: c) Toll free FAX: TO BE FILLED BY THE INSURED / PATIENT a) Name of the Patient: d) Date of Birth DDMMYYY Male Female c) Age: Years Y Y Months M M h) Gender f) Contact no. of Attending Relative e) Contact number: a) Insured card ID number: h) Policy number / Corporate: i ) Currently do you have any other Mediclaim / Health insurance: Yes ☐ No ii. Give details: i. Company Name iii. Policy No iv. Sum Insured k) Contact number: j) Name of the family physician: (PLEASE COMPLETE DECLARATION ON THE REVERSE SIDE OF THIS FORM) TO BE FILLED BY THE TREATING DOCTOR / HOSPITAL a) Name of the treating doctor: b) Contact number: b) Contact number: c) Nature of ILLNESS / Disease d)Relevant clinical findings with presenting complaints Y Y II) Past history e) Duration of the present ailment: Days I) Date of first consultation: D D M M of present ailment if any: f) Provisional diagnosis: I) ICD 10 Code: g) Proposed line of treatment : Medical Management Intensive care Surgical Management Investigation Non allopathic treatment i) Route of drug administration h) If Investigation & / or Medica i) If Surgical, name of surgery I) ICD 10 PCS Code: j) If other treatments provide k) How did injury occur 1) In case of accident: II) Is it RTA: Yes No III) Date of injury: D D M M 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 reports) Date of Delivery D D M M Y Y Πв ПР Пι Па I) In case of Maternity: Details of the patient admitted Mandatory: Past History of any chronic illness If yes, since (month / year) b) Time: H H : M M M M D D M M Diabetes YY c) Is this an emergency / a planned hospitalization event?: Emergency M M YY Planned Heart Disease d) Expected no. of days stay in hospital: Days e) Room Type: M M Hypertension YY f) Per Day Room Rent + Nursing & Service Charges + Patient's Diet M YY Hyperlipidemias g) Expected cost for investigation + diagnostics. : M Osteoarthritis M M h) ICU Charges: YY Asthma / COPD / Bronchitis i) OT Charges: M M Rs. YY i) Professional fees Surgeon + Anesthetist Fees + consultation Charges: M M YY Rs. Alcohol or drug abuse k) Medicines + Consumables + Cost of Implants (if applicable please specify) . Other hospital expenses if any: M YY Any HIV or STD / Related ailments Any other Ailment give details: I) All inclusive package charges if any applicable m) Sum Total expected cost of hospitalization (PLEASE READ VERY CAREFULLY) DECLARATION I We confirm having read understood and agreed to the Declarations on the reverse of this form a) Name of the treating doctor: SURNAME FIRST NAME MIDDLE NAME b) Qualification: c) Registration No. with State Code: Hospital Seal (Must include Hospital ID) Signature of treating doctor Patient / Insured Name & Signature

(IMPORTANT: PLEASE TURN OVER)



#### DECLARATION BY THE PATIENT / REPRESENTATIVE

- 1. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Insurer/T.P.A 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/T.P.A 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 T.P.A 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 / T.P.A
- 5.1 agree and understand that T.P.A 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
- a) Patient's / Insured's Name:

  b) Contact number: \_\_\_\_\_\_ d) Patient's / Insured's Signature:

### HOSPITAL DECLARATION

 $1. We have no objection to any authorized TPA/ \\ \textit{Insurance Company official verifying documents pertaining to hospitalization.}$ 

7. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer / TPA.

- 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 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 representative in our presence.
- 6. We agree to provide darifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering darifications.
- 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.
- $5. \ Certificates \ from \ attending \ Medical \ Practitioner \ / \ Surgeon \ that \ the \ patient \ is \ fully \ cured.$