CHOLAMANDALAM MS GENERAL INSURANCE COMPANY LIMITED
Registered Office: 2nd Floor, "DARE House", 2, N.S.C. Bose Road, Chennai - 600 001.
Toll free: 1800 208 9100 | website: www.cholainsurance.com
Pre Authorization Request: faxhealth@cholams.murugappa.com | **Queries & Complaints:** customercare@cholams.murugappa.com

REQUEST FOR CASHLESS HOSPITALISATION FOR MEDICAL INSURANCE POLICY

BASIC INFORMATION - (TO BE FILLED IN BLOCK LETTERS)			
Rohini ID		Patient ABHA ID	
Hospital Facility Registry (HFR) ID			

2) TO BE FILLED BY THE INSURED/ PATIENT			
a) Name of the Patient			
b) Gender	☐ Male ☐ Female ☐ Third Gender		c) Age Years ☐ Months ☐
d) Contact Number		Contact Number of attending Relative	
e) Insured card ID number		Policy number/ Corporate	
g) Employee ID		h) Currently do you have any other Medi claim / Health insurance	
i) Company Name		1) Give details	
2) Sum Insured		3) Contact number	
j) Name of the family physician			
K) Current Address of Insured Patient			
l) Occupation of Insured Patient		m) PAN	

Note : PAN No. Mandatory , Incase of Non availability of PAN CARD – FORM 60 as per the annexure need to be provided.

3) TO BE FILLED BY THE TREATING DOCTOR / HOSPITAL			
a) Name of the Patient		b) Contact Number	
c) Nature of Illness/ Disease with Presenting Complaints		d) Relevant Clinical Findings	
e) Duration of the Present Ailment	Days		
1) ICD 10 Code		2) Past history of present ailment if any	
f) Proposed line of treatment ☐ Medical Management ☐ Surgical Management ☐ Intensive care ☐ Investigation ☐ Non Allopathic Treatment			
g) If Investigation& / or Medical Management provide details		h) Route of drug administration	
i) If Surgical, name of surgery		j) ICD 10 PCSCode	

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k) If other treatments provide details	l) How did injury occur

m) In case of accident
1) Is it RTA ☐ Yes ☐ No 2) Reported toPolice ☐ Yes ☐ No
3) Injury / Disease caused due to substance abuse/ alcohol consumption ☐ Yes ☐ No
Test conducted to establish this ☐ Yes ☐ No (If Yes, attach reports)

m) In case of Maternity:	LMP

Details of the patient admitted		**Past History of any chronic illness**	**If yes, since (month/year)**
a) Date admission b) Time		Diabetes	
c) Is this an emergency / a planned hospitalization event? ☐ Emergency ☐ Planned		Heart Disease	
d) Expected no. of days stay in hospital Days		Hypertension	
e) Room Type f) Days in ICU		Hyperlipidemia	
g) Per Day Room Rent + Nursing & Service Charges + Patient's Diet	₹	Osteoarthritis	
h) Expected cost for Investigation + Diagnostics	₹	Asthma / COPD / Bronchitis	
i) ICU Charges	₹	Cancer	
j) OT Charges	₹	Alcohol or drug abuse	
k) Professional fees Surgeon+Anaesthetist Fees + Consultation Charges	₹	Any HIV or STD I Related ailments	
l) Medicines + Consumables + Cost of Implants (if applicable please specify)	₹	Any other Ailment give details	
m) Other hospital expenses if any	₹		
n) All inclusive package charges if any applicable	₹		
o) Sum Total expected cost of hospitalization	₹	(PLEASE READ VERY CAREFULLY)	

4) DECLARATION

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

d) Healthcare Professionals Registry (HPR) ID

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

(IMPORTANT: PLEASE TURN OVER)

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PAGE 2: NOT TO BE FAXED/SCANNED

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. I agree and understand that T.P.A is in no way warranting the service of the hospital & that the Insurer / IPA 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 fate 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 Scheme or Insurance
7. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer / TPA.
8. I confirm that I had already received the Customer Information Sheet along with the Policy Document and all the terms and conditions of the Policy / claim process/ coverage and exclusions, amongst other terms, were understood by me.

Patient's/ Insured's Name _____

Contact number _____ Patient's / Insured's Signature _____

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 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 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.
8. We confirm that no additional amount would be collected from the insured in excess of Agreed Package Rates except costs towards

non-admissible amounts (including additional charges due to opting higher room rent than eligibility/ choosing separate line of treatment which is not envisaged/ considered in package).

9. We confirm that no recoveries would be made from the deposit amount collected from the Insured except for costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility/ choosing separate line of treatment which is not envisaged/ considered in package).

10. In the event of unauthorized recovery of any additional amount from the Insured in excess of Agreed Package Rates, the authorized TPA / Insurance Company reserves the right to recover from the same from us (the Network Provider) and / or take necessary action, as provided under the MOU or applicable laws.

Hospital Seal | **Doctor's Signature**

Date | **Time**

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 Ihe Hospitals / Chemists supported by proper prescription.
3. Receipts and Pathological Test Reports from Pathologists, supported by note from the attending Medical Practitione- / 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.
6. Original Final Bills has to be signed by the Patient/ Insured.

DOCUMENTS TO BE PROVIDED BY THE PATIENT/ INSURED IN SUPPORT OF THE CLAIM

1. Aadhar card copy (Optional).
2. Pan card copy.
3. In case of Non availability of PAN CARD - FORM 60 as per the annexure need to be provided.

Income-tax Rules, 1962

FORM NO. 60

[See second proviso to rule 114B]

Form for declaration to be filed by an individual or a person (not being a company or firm) who does not have a permanent account number and who enters into any transaction specified in rule 114B

First Name			
Middle Name			
Surname			
Date of Birth / Incorporation of Declarant	DD:MM:YYYY		
Father's Name (in case of individual)			
First Name			
Middle Name			
Surname			
Flat/ Room No.		Floor No.	
Name of premises		Block Name/No.	
Road/ Street/ Lane		Area/ Locality	
Town/ City		District	
State		Pin code	
Telephone Number (with STD code)		Mobile Number	
Amount of Transaction (Rs.)			
Date of Transaction	DD:MM:YYYY		
In case of transaction in joint names, number of persons involved in the transaction			
Mode of transaction	☐ Cash, ☐ Cheque, ☐ Card, ☐ Draft/Banker's Cheque, ☐ Online transfer, ☐ Other		
Aadhaar Number issued by UIDAI (if available)			
If applied for PAN and it is not yet generated enter date of application and acknowledgement number			
If PAN not applied, fill estimated total income (including income of spouse, minor child etc. as per section 64 of Income-tax Act, 1961) for the financial year in which the above transaction is held			
a. Agricultural income (₹)			
b. Other than agricultural income (₹)			

Details of document being Document produced in support of identify in Column 1 (Refer Instruction overleaf)	Document Code	Document Identification Number	Name and address of the authority issuing the document
Details of document being produced in support of address in Columns 4 to 13 (Refer Instruction overleaf)	Document Code	Document Identification Number	Name and address of the authority issuing the document

Verification

I, _____ do Hereby declare that whatis stated above is true to the best of my knowledge and belief. I further declare that I do not have a Permanent Account Number and my/ our estimated total income (including income of spouse, minor child etc. as per section 64 of Income-tax Act, 1961) computed in accordance with the provisions of Income-tax Act, 1961 for the financial year in which the above transaction is held will be less than maximum amount not chargeable to tax.

Verified today, the _____ day of _____ 20 _____

Place _____ (Signature of declarant)