ICICI Lombard Health Care

REQUEST FOR CASHLESS HOSPITALISATION FOR HEALTH INSURANCE POLICY PART - C (Revised)

ICICI Lombard GENERAL INSURANCE

(TO BE FILLED IN BLOCK LETTERS)

DETAILS OF THE THIRD PARTY ADMINISTRATOR/ INSURER/ HOSPITAL

Name of TPA/Insurance company : ICICI Lombard GIC Limited **Toll free phone number:** 1800 2666 **Toll free fax:** 1800 209 8880

Email ID IL: cashlessrequest@icicilombard.com

Name of Hospital

Address

Rohini ID

E-mail ID of Hospital

IL NT Code **Fax number**

TO BE FILLED BY INSURED/PATIENT

Name of the Patient

Gender: Male Female Third Gender Age Date of Birth D D M M Y Y Y Y

Contact number Contact number of attending Relative

Insured Health ID Card Number

Email ID of Customer

Policy number/Name of Corporate Employee ID

Current Address of Insured Patient

Occupation of Insured Patient

Do you have a family Physician: Yes No Name of the Family Physician

Contact number, if any

Currently do you have any other mediclaim /health insurance: Yes No

Company name

Policy number/Health ID Card

Covid Vaccination Status Yes No **Name of the Vaccination** Covishield Covaxin Sputnik Others _____

Dosage of Vaccination 1st Dose 2nd Dose

Govt Recognised Age/ID Proof of Patient

ID Name _____ ID Number _____

TO BE FILLED BY TREATING DOCTOR/HOSPITAL

Name of the treating Doctor

Contact number

Nature of lllness/Disease with presenting complaint

Relevant Critical Findings

Duration of the present ailment days Date of First consultation D D M M Y Y Y Y

Past history of present ailment, if any

Provisional diagnosis ICD l0 code

Proposed line of treatment:

Medical Management Surgical Management Intensive care Investigation Non-allopathic treatment

If investigation and,/or Medical Management, provide details

Route of Drug Administration

lf surgical, name of surgery **ICD l0 PCS code**

If other treatment, provide details

How did injury occur _____

ln case of accident

Is it RTA Yes No

Date of lnjury D D M M Y Y Y Y

Report to Police Yes No

FIR no.

Injury /Disease caused due to substance abuse/alcohol consumption Yes No

Test conducted to establish this (if yes, attach report) Yes No

In case of Matemity **G** **P** **L** **A**

Expected date of Delivery D D M M Y Y Y Y

DETAILS OF PATIENT ADMITTED

Date of admission D D M M Y Y Y Y **Time of admission** H H M M

Is this Emergency ☐ Planned ☐

Expected number of Days/stay in hospital _____ **Days**

Days in ICU _____ **Day**

Room Type _____

Per day room rent + nursing and service charges	₹	
Expected cost of investigation + diagnostic	₹	
ICU charges	₹	
OT charges	₹	
Professional fees Surgeon + Anesthetist Fees + consultation Charges	₹	
Medicines + Consumables + Cost of Implants (if applicable please specify)	₹	
Other hospital expenses if any	₹	
All-inclusive package charges if any applicable	₹	
Sum Total expected cost of hospitalization	₹	

Mandatory Past History of any chronic illness	**If yes, Since (month/year)**
☐ Diabetes	M M / Y Y
☐ Heart disease	M M / Y Y
☐ Hypertension	M M / Y Y
☐ Hyperlipidemias	M M / Y Y
☐ Osteoarthritis	M M / Y Y
☐ Asthma./COPD/Bronchitis	M M / Y Y
☐ Cancer	M M / Y Y
☐ Alcohol/Drug abuse	M M / Y Y
☐ Any HIV or STD Related ailment	M M / Y Y
☐ Any other ailment, give details _____	

_____

_____

DECLARATION BY THE PATIENT / REPRESENTATIVE

a. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the lnsurer/T.P.A after the discharge. I agree to sign on the Final Bill & the Discharge Summary, before my discharge.

b. 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.

c. All non-medical expenses and expenses not relevant to current hospitalization and the amounts over & above the limit authorized by the lnsure/T.P.A not governed by the terms and conditions of the policy will be paid by me.

d. 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

e. I 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.

f. 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.

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

h. "I/We authorize Insurance Company/TPA to contact me/us through mobile/email for any update on this claim".

Date D D M M Y Y Y Y Time: H H M M Patient's / lnsured's Signature:_____

HOSPITAL DECLARATION

a. We have no objection to any authorized TPA / Insurance Company official verifying documents pertaining to hospitalization.

b. All valid original documents duly countersigned by the Insured/Patient/Representative of patients as per the checklist below will be sent to TPA / Insurance Company within 7 days of the patient's discharge.

c. 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.

d. The patient declaration has been signed by the patient or by his representative in our presence.

e. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications.

f. We will abide by the terms and conditions agreed in the MOU.

g. 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).

h. 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).

HOSPITAL DECLARATION

i. In the event of unauthorized recovery of any additional amount from the Insured in excess of Agreed Package Rates, the authorized TP A/ Insurance Company reserves the right to recover the same from us (the 1etwork Provider) and/or take necessary action, as provided under the MOU or applicable laws.

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

Name of the treating doctor

Qualification

Registration number with State code

Hospital Seal (Must include Hospital ID)	Signature of treating doctor	Patient/lnsured Name and Sign

Date D D M M Y Y Y Y Time H H M M

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. Receipt and Pathological Test Reports from Pathologists, supported by note from the attending Medical Practitioner/Surgeon recommending such pathologial Test.
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.