FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

PRE-AUTHORIZATION FORM

FGH Hospital ID 503

FGH-PAF-03

FUTURE GENERALI Health

----------TO BE FILLED BY THE INSURED/PATIENT----------

Patient Name: _____ Health Card No._____

Gender: ☐ Male ☐ Female Age: _____ (yrs) DOB: _____ Policy No:_____

Patient/Attendant Mobile No. _____ Employee ID _____ Company Name _____

Currently do you have any other Mediclaim / Health Insurance ☐ Yes ☐ No (if yes, provide other insurance details)

Insurance Co. Name_____ Policy No:_____

Sum Insured _____ since how long you have this cover_____

Do you have Family Physician ☐ Yes ☐ No. Name of Family Physician: _____ Mobile No: _____

----------TO BE FILLED BY THE TREATING DOCTOR /HOSPITAL----------

Name of the Hospital: BREACH CANDY HOSPITAL TRUST City: Mumbai

Type of hospitalization: ☐ Emergency ☐ Planned Expected Admission Date: _____ Time of Admission _____

Expected Length of Stay: _____ (days) Name of Treating Doctor: _____ Mobile No: _____

Nature of Illness / Disease with Presenting Complaints: _____

_____

Relevant Clinical Findings: _____

Duration of present Ailment: _____ Years _____ Months _____ Days Date of First Consultation: _____

Past History of Present Ailment if any _____

Provisional Diagnosis: _____ ICD Code: _____

Proposed Line of Treatment during Hospitalization: ☐ Medical ☐ Surgical ☐ Intensive ☐ Investigation ☐ Non Allopathic treatment

If Investigation & /or Medical Management, provide details: _____

_____

Route of Drug Administration:_____ If Surgical, Name of Surgery:_____

Type of Anesthesia: ☐ Local ☐ General ☐ Regional ☐ Dissociative ICD PCS Code: _____

If other treatments provide details: _____

In case of Accident / Injury: ☐ RTA ☐ Intentional Self Injury Date of Accident / Injury: _____

How did injury occur: _____

_____

Injury / Diseases caused due to Substance Abuse / Alcohol Consumptions: ☐ Yes ☐ No

Test conducted to establish this: ☐ Yes ☐ No Reported to Police: ☐ Yes ☐ No FIR / MLC No: _____

In case of Maternity: G _____ P _____ L _____ A _____ LMP Date: _____ Date of Delivery_____

Mode of Delivery: ☐ VD ☐ LSCS

PAST HISTORY OF ANY CHRONIC ILLNESS WITH DURATION:

Disease / Ailment					Duration (Specify Year / Month / Days)
Hypertension	Yes		No		
Hyperlipidemia	Yes		No		
Cancer	Yes		No		
Osteoarthritis	Yes		No		
Diabetes	Yes		No		
Cardiovascular Diseases	Yes		No		
Asthma / COPD / Bronchitis	Yes		No		
Any Surgery / Hospitalization	Yes		No		
Any Other Disease / Disability	Yes		No		
Congenital	Yes		No		Internal / External
Any HIV or STD/Related Ailments	Yes		No		

FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

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FUTURE GENERALI Health

Alcohol or Drug Abuse	Yes		No		

Expense Head	Amount (Rs.)	Expense Head	Amount (Rs.)
Room Rent per day + Nursing/Service charges + Diet		Investigations + Diagnostics	
ICU charges per day		Medicines / Consumables	
Doctor / Consultant visit charges		Equipment / Monitor etc	
Surgeon charges + Anesthetist		Miscellaneous (specify)	
Operation Theatre Charges		Implant Charges (If any)	
Package Charges			

Estimate of Expenses: Total Amount of Rs. _____Class of accommodation: _____

----------**DECLARATION**----------

I have completed this form and will be responsible for correctness of the medical information certified by me. I agree that Future Generali shall not be liable to make payment in case of any discrepancy between the preauthorization form and discharge summary.

Name of the treating Dr. _____

Qualification_____MCI Registration No. with state code_____

Signature of the treating Dr. _____stamp/seal of the hospital: _____

BENEFICIARY CONSENT / AUTHORISATION I have 'No Objection' to Future Generali obtaining details of my treatment / collecting documents and also hereby authorize Future Generali to pay the hospital bill from the sum insured of my insurance policy. I also undertake to pay all non medical / non authorized expenses in the hospital bill directly to the hospital at the time of discharge. In case Future Generali issues "Denial of cashless facility" to the provider, I have 'No objection' in paying the hospital bill for the treatment given. All information provided above is true and I agree that if I have provided any false or untrue information, my right to claim the expenses shall be absolutely forfeited.

Name of the Insured _____Signature of Insured_____

Insured mail id_____Insured mobile number_____

Declaration by the patient/representative

I agree to allow the hospital to submit all original documents pertaining to hospitalization to the insurer after the discharge. I agree to sign on the final bill and the discharge summary before my discharge. Payment to hospital is governed by the terms and conditions of the policy. In case the insurer is not liable to settle the hospital bill, I undertake to settle the bill as per the terms and conditions of the policy. All non medical expenses and expenses not relevant to current hospitalization and the amounts over and above the limit authorized by the insurer 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 insurer at the toll free no on the reverse of the form. I hereby declare to abide by the terms and conditions of the policy and it 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. I agree and understand that insurer is in no way warranting the services of the hospital and the insurer is in no way guaranteeing that the services provided by the hospital will be of a particular quality or standard. I hereby warrant the truth of the forgoing particulars in every respect and I agree that if I 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 scheme or insurance. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the insurer.

Patient's/Insure's Name _____Contact No._____Patient's/Insure's Signature_____

Hospital Declaration

We have no objection to any authorized insurance company official verifying documents pertaining to hospitalization. All valid original documents duly counter singed by the insured/patient as per the check list below will be sent to insurance company within 7 days of the patient's discharge. All non medical expenses or expenses not relevant to hospitalization/illness, or expenses disallowed in the authorization letter of the insurance company, or arising out of incorrect information in the preauthorization form will be collected from the patient.
WE AGREE THAT 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. The patient declaration has been signed by the patient or by his / her representative in our presence. We agree to provide clarification for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications. We will abide by the terms and conditions agreed in the MOU.

Hospital Seal _____Doctor's Signature_____

Documents to be provided by hospital in support of claim;
1. FGH Authorization Letter 2. Original Detailed Discharge Summary 3. Original hospital main bill with breakup
4. All Original Pharmacy Bills and Investigation Bill if any 5. All Investigation Reports Prescriptions Including OT Notes

BREACH CANDY HOSPITAL TRUST

CONSENT FORM - CASHLESS CLAIM

List of Documents to be carry with the pre-authorization Form

1) Fully Filled pre-authorization form (provided by the hospital).
2) Pan card & Adhaar card of the Patient.
3) Relevant Investigation Reports.
4) Valid Insurance ID.
5) Cancelled Cheque of Patient Account.

Highlights:

- For all planned cases the pre-authorization form has to be processed a week prior to hospitalization. For emergency admissions the pre-authorization form has to be submitted to the TPA desk within 24 hours of hospitalization.
- In the absence of a valid initial authorization letter, the patient will be admitted as a Cash patient and will be required to pay the requisite deposit on admission as per the protocol.
- At the time of submission of the pre-authorization form the patient has to pay Rs. 30,000/- as a deposit towards admission. This deposit is adjustable/refundable depending upon the final bill and the final approval amount of the patient.
- If a TPA inpatient undergoes an additional procedure which is not mentioned in the Preauthorisation form then the additional documents will be processed by the TPA desk. If the approval is not received before the surgery the patient will be treated as a Cash patient & 90% of the estimated amount needs to be paid as a deposit.
- In case of an Emergency/Unplanned surgery the patient will be treated as a Cash patient & 90% of the estimated amount needs to be paid as a deposit within 24 hours of the surgery.
- On the day of discharge once all required documents are sent to the Insurance Co. / TPA, it takes up to 4 hrs. for the approval to come. Patient can be physically discharged only after final approvalis received by the hospital.
- At the time of discharge the hospital will retain 5% of the Final Approval amount as a Security deposit which will be refunded to the patient after the final settlement from the Insurance Company, the duration of which is variable (minimum is 45 days).

Consent:

I declare that I have been explained all the above mentioned points and I agree to the same.

Patient Name : _____ BH No. : _____

Name of Person Submitting Claim Documents : _____

Signature of Person Submitting Claim Documents : _____

Date : _____

For Office Use Only

Received by : _____ Date & Time : _____

BREACH CANDY HOSPITAL TRUST

IMPORTANT INFORMATION REGARDING YOUR CASHLESS CLAIM

1. For all planned cases the pre-authorization form has to be processed a week prior to hospitalization. For emergency admissions the pre-authorization form has to be submitted to the TPA desk within 24 hours of hospitalization.
2. Admission will be on the basis of the authorization letter received from the TPA/Insurance Company which is only a provisional authorization. Please show a copy of this letter on the Admission Desk at the hospital at the time of Admission.
3. In the absence of a valid initial authorization letter, the patient will be admitted as a Cash patient and will be required to pay the requisite deposit on admission as per the protocol.
4. If any query is raised before or during the hospitalization which requires to furnish additional information of the Medical condition of the patient then the clarification will be provided by the Consultant/Surgeon and may be delayed depending upon the availability of the Consultant/Surgeon.
5. If the query requires to provide any details which are non-medical in nature the TPA desk will reply to them as soon as possible which may require help from the patient relative.
6. At the time of submission of the pre-authorization form the patient has to pay Rs. 30,000/- as a deposit towards admission. This deposit is adjustable/refundable depending upon the final bill and the final approval of the patient.
7. In a single hospitalization one can avail cashless only with one TPA/Insurance Company, if the patient has more than one policy they can avail the reimbursement facility. Please contact the TPA Desk for further details.
8. For knowing the coverage of any particular (Medical/Surgical) condition under your Policy, please read the T & C of your policy document or speak to your agent.
9. For Room Eligibility of the patient please contact your agent for criterion of admission as per the policy of the patient.
10. If a TPA inpatient undergoes an additional procedure which is not mentioned in the Preauthorisation form then the additional documents will be processed by the TPA desk. If the approval is not received before the surgery the patient will be treated as a Cash patient & 90% of the estimated amount needs to be paid as a deposit.
11. In case of an Emergency/Unplanned surgery the patient will be treated as a Cash patient & 90% of the estimated amount needs to be paid as a deposit within 24 hours of the surgery.
12. On the day of discharge once we send all required documents to Insurance Co. / TPA, it takes up to 4 hrs. for approval to come . The patient can be physically discharged only after approval comes as per the policy.
13. Half day charges will be levied for patients if the discharge process is initiated between 11.00 am to 1.00 pm. All discharges processed after 1.00 pm will attract full day charges.
14. The original reports and bill will be handed over to the TPA/Insurance Company for processing of the claim. A copy of all the reports will be available at the reports counter, 7 days after the discharge.
15. A copy of the Discharge Summary will be provided to the patient at the time of discharge.
16. At the time of discharge the hospital will retain 5% of the Final Approval amount as a Security deposit which will be refunded to the patient after the final settlement from the Insurance Company, the duration of which is variable(minimum is 45 days).
17. Any deductions toward non-medical items, exclusions, class based billing etc. will have to be borne by the patient (this will not be adjusted against the security deposit).
18. Please submit a cancelled cheque to get the refund into your account directly.
19. In case of denial of the cashless claim (due to withdrawal or rejection of the claim) during the hospitalization or at the time of discharge the patient will be treated as a cash patient and will be expected to clear the entire bill of the hospital and proceed for the reimbursement process.
20. Only approval letters received on the Email or the Portal will be considered valid.
21. There may be a delay in receiving the approval on Public Holidays or Sundays.

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