

**Pre Auth Form Annexure B**

**Name & Address of Hospital/Nursing Home:** \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Pin code: \_\_\_\_\_ Hospital Code: \_\_\_\_\_

Treating Dr. Name: \_\_\_\_\_ Contact/Mobile No \_\_\_\_\_

Contact No: \_\_\_\_\_ Fax No: \_\_\_\_\_ TPA desk No \_\_\_\_\_ Email id: \_\_\_\_\_

<b>Name of the Patient</b>											
Mobile	0									Email:	

(All updates regarding the case will be sent on the above mentioned contact details: mobile and email)

<b>Policy No</b>																				
<b>Card No</b>																				

Age  Sex  Expected date of admission  Expected length of stay  Days

Details of presenting complaint / Relevant clinical findings:

\_\_\_\_\_

\_\_\_\_\_

Provisional Diagnosis \_\_\_\_\_ Duration of Ailment (From the date of admission) \_\_\_\_\_

Date of First Diagnosis: \_\_\_\_\_ (please attach first consultation paper) Investigations Report (if any): \_\_\_\_\_  
(Please attach a copy of report)

PAST HISTORY OF THE FOLLOWING	Yes	No	DURATION/OTHER DETAILS
Hypertension			
Diabetes			
Cardiovascular diseases			
Asthma/COPD			
Any surgery/hospitalization			
Any other disease / disability			
Intentional Self Injury/Alcohol/drug abuse			

**IN CASE OF RTA/INJURY**

Circumstances of Injury: \_\_\_\_\_

H/O Alcohol/drug abuse if any Y  N  Date of injury \_\_\_\_\_

MLC/FIR: Y  N  (Please attach the copy of report)

**IN CASE OF MATERNITY**

Obstetric History G P L A D

No of living Children: \_\_\_\_\_

EDD \_\_\_\_\_ LMP \_\_\_\_\_

In case of LSCS  
(Indication for surgery)

Details of treatment prior to hospitalization: \_\_\_\_\_

Proposed detail line of treatment during hospitalization:  Oral  Parental/I.V  Rectal

Details of treatment: \_\_\_\_\_

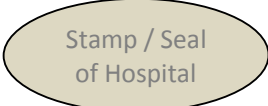
Proposed Surgery if any: \_\_\_\_\_

Expense Head	Amount (Rs.)	Expense Head	Amount (Rs.)
Room Rent Per Day		Investigations	
ICU Rent Per Day		Medicines/Consumables	
Doctor / Consultant Visit Charges per day		Implant Charges	
Surgeon Charges		Package Charges (Including All If Any)	
Operation Theatre Charges		Miscellaneous (Specify)	

Estimate of Expenses: Total Amount Rs. \_\_\_\_\_ Class of accommodation: \_\_\_\_\_

*I have 'No Objection' to Bajaj Allianz obtaining details of my treatment / collecting documents and also hereby authorize Bajaj Allianz to pay the hospital bill & reimburse itself / receive the amount from my claim receivable from the insurance company. In case Bajaj Allianz issues "Denial of cashless facility" note to the provider, I have 'No objection' in paying the hospital bill for the treatment given.*

NAME OF INSURED \_\_\_\_\_ SIGNATURE OF INSURED: \_\_\_\_\_



I have completed this form and will be responsible for correctness of the medical information certified by me.

Signature of Doctor: \_\_\_\_\_ Contact details: \_\_\_\_\_