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:** _____

Name of the Patient													
Mobile	0										Email:		

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

Policy No																								
Card No																								

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:** _____

Stamp / Seal of Hospital

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

Signature of Doctor: _____ **Contact details:** _____

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