

PRE-AUTHORIZATION REQUEST FORM

Please use Reliance Provider Portal to communicate with us - <https://provider.reliancegeneral.co.in/>

Part 1	Insured Details	Insured Name: [_____] Claim No [_____] Mobile No.: [_____] Policy No.: [_____] E-mail Id [_____] If Group Policy, Company Name: [_____] Employee id [_____] PAN No. [_____] UID Aadhar No. [_____] Source of Funds <input type="checkbox"/> Business <input type="checkbox"/> Profession <input type="checkbox"/> Salary <input type="checkbox"/> Agricultural Income <input type="checkbox"/> Savings <input type="checkbox"/> Others Monthly Income: <input type="checkbox"/> Upto ₹ 20,000 <input type="checkbox"/> ₹ 20,001 to ₹ 50,000 <input type="checkbox"/> ₹ 50,001 to ₹ 1,00,000 <input type="checkbox"/> ₹ 1,00,001 and above																										
Part 2	Patient Details	Patient Name: [_____] Patient UHID [_____] Age: [_____] yrs DOB: [dd/mm/yy] Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Patient Mobile No.: [_____] Patient Email id: [_____] Relation with insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Others [_____] Address: [_____] City: [_____] Pin Code [_____] Attendant Name: [_____] Attendant Mobile no.: [_____] Attendant email id [_____]																										
Part 3	Service Provider Details	Hospital Name: [_____] Hospital Code: [_____] Hospital Address: [_____] City: [_____] Pin Code [_____] <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:50%;">Contact Details (Hospital Employee)</th> <th style="width:50%;">Treating Doctor Detail</th> </tr> <tr> <td>Name: [_____]</td> <td>Name: Dr. [_____]</td> </tr> <tr> <td>Telephone no./Mobile no. [_____]</td> <td>Qualification: [_____]</td> </tr> <tr> <td>Fax No.: [_____]</td> <td>Registration No.: [_____]</td> </tr> <tr> <td>E-mail Id [_____]</td> <td>Mobile No.: [_____]</td> </tr> </table>	Contact Details (Hospital Employee)	Treating Doctor Detail	Name: [_____]	Name: Dr. [_____]	Telephone no./Mobile no. [_____]	Qualification: [_____]	Fax No.: [_____]	Registration No.: [_____]	E-mail Id [_____]	Mobile No.: [_____]																
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Part 4	Case Information (filled by treating doctor)	Presenting Complaint [_____] Duration [_____] Date of first onset/Consult [_____] H/O of past illness related to present complaint [_____] Relevant Clinical findings [_____] Investigation findings [_____] <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%;"> Provisional Diagnosis [_____] Treatment Plan : <input type="checkbox"/> Medical <input type="checkbox"/> Surgical In case of Maternity Obstetric History G____ P____ L____ A____ LMP____ EDD____ In case to Injury/RTA/Self Injury Under Influence of Alcohol/Drug abuse <input type="checkbox"/> Yes <input type="checkbox"/> No Attached Copy of <input type="checkbox"/> MLC <input type="checkbox"/> FIR <input type="checkbox"/> PI MLC/FIR Number: [_____] Place: [_____] </td> <td style="width:50%;"> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:60%;">Past Medical History</th> <th style="width:40%;">Duration/Details</th> </tr> <tr> <td>HTN <input type="checkbox"/> Y <input type="checkbox"/> N</td> <td>[_____]</td> </tr> <tr> <td>IHD/CAD <input type="checkbox"/> Y <input type="checkbox"/> N</td> <td>[_____]</td> </tr> <tr> <td>Diabetes <input type="checkbox"/> Y <input type="checkbox"/> N</td> <td>[_____]</td> </tr> <tr> <td>Asthma/COPD/TB <input type="checkbox"/> Y <input type="checkbox"/> N</td> <td>[_____]</td> </tr> <tr> <td>Paralysis/CVA/Epilepsy <input type="checkbox"/> Y <input type="checkbox"/> N</td> <td>[_____]</td> </tr> <tr> <td>Arthritis <input type="checkbox"/> Y <input type="checkbox"/> N</td> <td>[_____]</td> </tr> <tr> <td>Cancer/Tumor/Cyst <input type="checkbox"/> Y <input type="checkbox"/> N</td> <td>[_____]</td> </tr> <tr> <td>STD/HIV <input type="checkbox"/> Y <input type="checkbox"/> N</td> <td>[_____]</td> </tr> <tr> <td>Alcohol/Drug abuse <input type="checkbox"/> Y <input type="checkbox"/> N</td> <td>[_____]</td> </tr> <tr> <td>Psychiatric condition <input type="checkbox"/> Y <input type="checkbox"/> N</td> <td>[_____]</td> </tr> <tr> <td>Others <input type="checkbox"/> Y <input type="checkbox"/> N</td> <td>[_____]</td> </tr> </table> </td> </tr> </table>	Provisional Diagnosis [_____] Treatment Plan : <input type="checkbox"/> Medical <input type="checkbox"/> Surgical In case of Maternity Obstetric History G____ P____ L____ A____ LMP____ EDD____ In case to Injury/RTA/Self Injury Under Influence of Alcohol/Drug abuse <input type="checkbox"/> Yes <input type="checkbox"/> No Attached Copy of <input type="checkbox"/> MLC <input type="checkbox"/> FIR <input type="checkbox"/> PI MLC/FIR Number: [_____] Place: [_____]	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:60%;">Past Medical History</th> <th style="width:40%;">Duration/Details</th> </tr> <tr> <td>HTN <input type="checkbox"/> Y <input type="checkbox"/> N</td> <td>[_____]</td> </tr> <tr> <td>IHD/CAD <input type="checkbox"/> Y <input type="checkbox"/> N</td> <td>[_____]</td> </tr> <tr> <td>Diabetes <input type="checkbox"/> Y <input type="checkbox"/> N</td> <td>[_____]</td> </tr> <tr> <td>Asthma/COPD/TB <input type="checkbox"/> Y <input type="checkbox"/> N</td> <td>[_____]</td> </tr> <tr> <td>Paralysis/CVA/Epilepsy <input type="checkbox"/> Y <input type="checkbox"/> N</td> <td>[_____]</td> </tr> <tr> <td>Arthritis <input type="checkbox"/> Y <input type="checkbox"/> N</td> <td>[_____]</td> </tr> <tr> <td>Cancer/Tumor/Cyst <input type="checkbox"/> Y <input type="checkbox"/> N</td> <td>[_____]</td> </tr> <tr> <td>STD/HIV <input type="checkbox"/> Y <input type="checkbox"/> N</td> <td>[_____]</td> </tr> <tr> <td>Alcohol/Drug abuse <input type="checkbox"/> Y <input type="checkbox"/> N</td> <td>[_____]</td> </tr> <tr> <td>Psychiatric condition <input type="checkbox"/> Y <input type="checkbox"/> N</td> <td>[_____]</td> </tr> <tr> <td>Others <input type="checkbox"/> Y <input type="checkbox"/> N</td> <td>[_____]</td> </tr> </table>	Past Medical History	Duration/Details	HTN <input type="checkbox"/> Y <input type="checkbox"/> N	[_____]	IHD/CAD <input type="checkbox"/> Y <input type="checkbox"/> N	[_____]	Diabetes <input type="checkbox"/> Y <input type="checkbox"/> N	[_____]	Asthma/COPD/TB <input type="checkbox"/> Y <input type="checkbox"/> N	[_____]	Paralysis/CVA/Epilepsy <input type="checkbox"/> Y <input type="checkbox"/> N	[_____]	Arthritis <input type="checkbox"/> Y <input type="checkbox"/> N	[_____]	Cancer/Tumor/Cyst <input type="checkbox"/> Y <input type="checkbox"/> N	[_____]	STD/HIV <input type="checkbox"/> Y <input type="checkbox"/> N	[_____]	Alcohol/Drug abuse <input type="checkbox"/> Y <input type="checkbox"/> N	[_____]	Psychiatric condition <input type="checkbox"/> Y <input type="checkbox"/> N	[_____]	Others <input type="checkbox"/> Y <input type="checkbox"/> N	[_____]
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An ISO 9001:2008 Certified Company

RCare Health: Reliance General Insurance, No.1-89/3/B/40 to 42/ks/301, 3rd floor, Krishe Block, Krishe Sapphire, Madhapur, Hyderabad 500081.

IRDAI Registration No. 103. Reliance General Insurance Company Limited. Registered Office: H Block, 1st Floor, Dhirubhai Ambani Knowledge City, Navi Mumbai - 400710. **Corporate Office:** Reliance Centre, South Wing, 4th Floor, Off. Western Express Highway, Santacruz (East), Mumbai - 400 055. Corporate Identity Number U66603MH2000PLC128300. Trade Logo displayed above belongs to Anil Dhirubhai Ambani Ventures Private Limited and used by Reliance General Insurance Company Limited under License. RGI/MCOM/CO/MI-14/PRE-AUTHORIZATION REQUEST FORM /VER. 1.4/301017.

Part 5 Billing details (filled by hospital)	Room Type: <input type="checkbox"/> Single AC <input type="checkbox"/> Single NON AC <input type="checkbox"/> Twin Sharing AC <input type="checkbox"/> Twin Sharing NON AC <input type="checkbox"/> Multi-bed <input type="checkbox"/> Others	If Package not applicable, Room Rent + Nursing Charges _____
	Hospital Room Name.: _____	Surgeon/Assistant Surgeon Charges _____
	Type of Admission: <input type="checkbox"/> Planned <input type="checkbox"/> Emergency	Anesthesia/Anesthetist Charges _____
	Expected DOA: <input type="text" value="dd/mm/yy"/> Length of Stay: _____ Days	Operation theatre Charges _____
	Package Rate: <input type="checkbox"/> Yes <input type="checkbox"/> No	Doctor's Visit Charges _____
	If Yes, Package Charges _____	Investigation Charges _____
	Implant Charges _____	Pharmacy Charges _____
Remarks (if Any) _____	Implant Cost(if any) _____	
	Total Cost of Hospitalization _____	

Please note: In case the Health Gain Policy under which the cashless claim is being lodged has been taken on installment basis then in the event of cashless claim being admissible, the company will deduct the balance installments due if any, from the claim approved amount and pay the balance due to the Policyholder. In the event of the claim assessed amount being lower than the Balance installment due then the Policyholder is liable to pay the balance premium installments due immediately by cheque or DD, failing which the said Claim would be treated as inadmissible and the Policy shall stand cancelled immediately and no liability shall be admissible under the Policy for any Claims liability in future or in period elapsed.

Consent by the Patient/Insured/Beneficiary: I/We understand that Cashless facility is not automatically guaranteed by RGICL. I/We have no objection to RGICL RCare Health Officials visiting the Hospital/Nursing Home to check the details of treatment and are authorized to collect documents pertaining to my treatment from the Hospital/Nursing Home.

I/We have provided the necessary information accurately to the best of my/our knowledge. I/We agree to pay the cost of the hospitalization, if authorization given by RGICL RCare Health becomes null and void, due to wrong and incorrect information.

Patient Signature: _____

Treating Doctor's Signature: _____

Date & Place: _____

Stamp of Hospital: _____

Declaration	I hereby agree, affirm and declare that, the statements/information given/stated by me/us in this claim form is true, correct and complete. No material information which is relevant to the processing of the claim or which in any manner has a bearing on the claim has been withheld or not disclosed. If I have given/made any false or fraudulent statement/information, or suppressed or concealed or in any manner failed to disclose material information, the policy shall be void & that I shall not be entitled to all/any rights to recover there under in respect of any or all claims, past, present or future. The receipt of this claim form/other supporting/related documents does not constitute or be deemed to constitute an agreement by the Company of the claim and the Company reserves the right to process or reject or require further/additional information in respect of the claim.	
	I hereby provide my consent and authorize Reliance General Insurance Company Ltd to seek any medical information from any hospital/Medical Practitioner who has at any time attended on the insured person.	
	Place: _____	_____
	Date: <input type="text" value="d d m m y y y y "/>	(Signature of Claimant)

IMPORTANT INFORMATION FOR HOSPITALS:

1. The Pre-authorization Request Form should be filled with due care including the unique number received by the Insured/member/beneficiary. All columns are required to be filled in block letters.
2. Completed Pre-authorization Request Form should be faxed to RCare-Health on 1800 3010 3001, or emailed at rgicl.rcarehealth@relianceada.com by the provider hospital. It should reach us at least 4 days prior to likely date of admission. In case of emergency admission Pre-Authorisation Request Form should be sent within 4 hours of admission.
3. Authorisation may be denied if complete information is not provided or queries are not replied to.
4. Discrepancy in the information provided by the hospital records found at the time of claim may render the authorisation given null and void and the amount claimed by the hospital would have to be settled by the Insured to the hospital.
5. Any changes in Diagnosis/Treatment plan should be intimated before discharge of the patient.
6. All queries raised by us need to be replied at the earliest & maximum within 24hrs.
7. Request for authorisation/enhancement will not be entertained after discharges of the patient.
8. We shall share the authorization denial letter to the concerned hospital within 24 hours of complete and correct information being provided.
9. If clinical details provided are insufficient, there may be a delay in the authorisation or denial for cashless.
10. As per IRDAI any claimed amount above 1lac, copy of PAN card/form 60 of the insured/Policy holder/Proposer is mandatory and for below 1lac, Photo identity proof (For eg- Aadhar card, Driving license, Election card, Passport etc) is mandatory.

Email: rgicl.rcarehealth@relianceada.com, Help line: 1800 3009 (Toll free) 022 - 39898282 (Charges Apply)
Fax No.: 180030103001 (Toll free)

IRDAI Registration No. 103. UIN of Reliance HealthGain Policy: IRDA/NL-HLT/RGI/P-H/V.I/318/13-14.

UIN of Reliance HealthWise Policy : IRDA/NL-HLT/RGI/P-H/V.I/315/13-14

UIN of Group Medclaim: UIN: IRDA/NL-HLT/RGI/P-H/V.I/317/13-14.

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) Pan card & Adhaar Card of Primary Insured.
- 4) Relevant Investigation Reports.
- 5) Valid Insurance ID.
- 6) 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 4hrs. for the approval to come. Patient can be physically discharged only after final approval is 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 am fully aware of the details mentioned in the co-morbidities/pre-existing illness/past history diseases section of my insurance claim form filled in by me. If there is any difference in the information filled in the claim form as against the past history filled in the Initial Assessment form at the time of admission then the hospital shall not be liable for any issues with regards to getting the approval from the insurance. I will not hold hospital responsible if the Insurance/TPA denies the entire claim for this reason and I shall settle the entire bill.

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

Patient Name : _____ BH No. _____ DOA : _____

Name & 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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