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		

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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

PRE-AUTHORIZATION FORM

FGH Hospital ID 503

FGH-PAF-03

Future Generali India Insurance Company Limited
Registered office address : Indiabulls Finance Centre, Tower 3, 6th Floor, Senapati Bapat Marg, Elphinstone (W), Mumbai - 400 013
Corporate Identity No (CIN) : U66030MH2006PLC165287 Telephone No 022 4097 6666 and Fax No 22 4097 6900
Email : fgcare@futuregenerali.in website address www.futuregenerali.in

BREACH CANDY HOSPITAL TRUST

Cashless Consent Form – Third Party Administrator (TPA)

- I have been explained in details about the cashless facilities at Breach Candy Hospital Trust. I undertake not to hold the hospital responsible for any delay in getting approval or extensions from TPA.

- I have understood that such approvals are my responsibility and the hospital renders this service as a value addition only.

- I will be admitted on the basis of authorization letter received from the insurance Co / TPA which is only a provisional authorization.

- In the absence of an authorization letter, I would be admitted as a "Cash" patient. I would be required to pay the requisite deposit on admission & subsequently clear all hospital bills.

- In case of emergency admission, if the authorization is not received from the insurance Co. / TPA, then I would undertake to clear the bills of the hospital.

- I would have to clear all bills related to exclusions as stated by the Insurance Co. / TPA

- I am aware that subsequent to the pre-authorization and admission a request for confirmation of claim payable is sent to TPA. Only on confirmation from TPA, I will be treated as TPA (Cashless Facility)

- In case I undergo treatment for which the Insurance Co / TPA withdraws authorization or rejects the claim, then I would clear all hospital bills of the hospital.

- I would be required to pay security deposit 48 hrs before the admission. The same will be refunded on settlement from the Insurance Co/ TPA.

- The hospital is not responsible for refusal on part of TPA for reimbursement of my claims.

- I am aware that the original reports and original discharge card are handed over to the Insurance Co/ TPA.

- I am aware that I have to show the copy of the pre-authorization form at the reception on the day of admission to get the cashless benefit.

- I am aware that in planned admission I have to submit the pre-authorization form one week prior to admission and in emergency within 24 hrs. of admission.

- I agree to pay the over and above bill of the approval amount and that I will not seek reimbursement for the same.

Signature of the Patient _____ Signature of the Relative _____

Name of the Patient _____ Name the of Relative _____