RELIANCE
General Insurance

1800 3009 (toll free)
www.reliancegeneral.co.in

PRE-AUTHORIZATION REQUEST FORM (RCARE-HEALTH TEAM)

Insured Details

Insured Name:
Mobile no.: Policy No.:
E-mail Id
If Group Policy, Company Name: Employee id

Patient Details

Patient Name:
Patient UHID Age: DOB: dd/mm/yy Gender: ☐ Male ☐ Female
Patient Mobile no.:
Relation with insured: ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Son ☐ Daughter ☐ Others
Address:
City; Pin Code
Attendant Name:
Attendant Mobile no.:
Attendant email id

Service Provide Details

Hospital Name: Hospital Code:
Hospital Address:
City: Pin Code

Contact Details (Hospital Employee)	Treating Doctor's Details
Name:	Name: Dr.
Telephone no./Mobile no.	Qualification:
Fax No.:	Registration No.:
E-mail Id	Mobile No.:

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

Case Information (filled by treating doctor)

Provisional Diagnosis
Treatment Type : ☐ Medical ☐ 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 ☐ Yes ☐ No
Attached Copy of ☐ MLC ☐ FIR ☐ PI
MLC/FIR Number: Place:

Past Medical History			Duration/Details
HTN			
IHD/CAD	☐ Y	☐ N	
Diabetes	☐ Y	☐ N	
Asthma/COPD/TB	☐ Y	☐ N	
Paralysis/CVA/Epilepsy	☐ Y	☐ N	
Arthritis	☐ Y	☐ N	
Cancer/Tumor/Cyst	☐ Y	☐ N	
STD/HIV	☐ Y	☐ N	
Alcohol/Drug abuse	☐ Y	☐ N	
Psychiatric condition	☐ Y	☐ N	
Others	☐ Y	☐ N	

Billing details (filled by hospital)

Room Type: ☐ Single AC ☐ Single NON AC ☐ Twin Sharing AC ☐ Twin Sharing NON AC ☐ Multi-bed ☐ Others
Hospital Room Name.: Type of Admission: ☐ Planned ☐ Emergency

Expected DOA: dd/mm/yy
Length of Stay: Days

Package Rate: ☐ Yes ☐ No
If Yes, Package Charges
Implant Charges

Remarks (if Any)

If Package not applicable,

Room Rent + Nursing Charges	
Surgeon/Assistant Surgeon Charges	
Anesthesia/Anesthetist Charges	
Operation theatre Charges	
Doctor's Visit Charges	
Investigation Charges	
Pharmacy Charges	
Implant Cost(if any)	
Total Cost of Hospitalization	

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 regarding the duration of ailments.

Patient Signature: Treating Doctor's Signature:

Date & Place: dd/mm/yy Stamp of Hospital:

Email:RCARE-Health Team.rgicl@relianceada.com
RCARE-Health: Reliance General Insurance Company Limited, 4-1-327 to 333, Sagar Plaza, Abids Road, Hyderabad - 500001, Andhra Pradesh

Insurance is a subject matter of solicitation. IRDA Registration No. 103.
Reliance General Insurance Company Limited.
Registered Office: 19, Reliance Centre, Walchand Hirachand Marg, Ballard Estate, Mumbai 400001.
Corporate Office: 570, Rectifier House, Naigaum Cross Road, Next to Royal Industrial Estate, Wadala (W), Mumbai 400031.

An ISO 9001:2008
Certified Company

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IMPORTANT INFORMATION FOR HOSPITALS:
(THIS PAGE IS NOT TO BE FAXED TO RCARE-HEALTH)

1. The member &/or the relative must notify the claim by calling RGICL call centre on Toll Free Voice : 1800-103-1999 for “Claims Intimation”.
2. The call centre would take basic information about hospitalisation and upon successful registration generate a unique “Claim No.” which would be informed to the Insured/member/beneficiary immediately followed by a confirmatory SMS sent to the registered mobile number of the Insured.
3. The Pre-authorisation Request Form should be filled with due care including the unique “Claim No.” received by the Insured/member/beneficiary. All columns are required to be completed in block letters.
4. Completed Pre-authorization Request Form should be faxed to “ R CARE-Health on 1800-301-3001 (toll free), 022-39197849 (charges apply)” or emailed at hcmt.rgicl@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.
5. Authorisation may be denied if complete information is not provided or queries are not replied to.
6. 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.
7. Any changes in Diagnosis/Treatment plan should be intimated before discharge of the patient.
8. All queries raised by us need to be replied at the earliest & maximum within 24hrs.
9. Request for authorisation/enhancement will not be entertained after discharges of the patient.
10. We promise to fax the authorisation denial letter to the concerned hospital within 24 hours of complete and correct information being provided.
11. If clinical details provided are insufficient, there may be a delay in the authorisation or denial for cashless access.

RGI/MCOM/RCARE/PRE-AUTH-RF/Ver1.2/170214

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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 _____