National Insurance Company Limited

Regd. Office 3, Middleton Street, Post Box 9229, Kolkata 700 071

National Young India Mediclaim Policy

PLEASE FAX / SCAN PAGE 1 ONLY

REQUEST FOR CASHLESS HOSPITALISATION FOR MEDICLAIM INSURANCE POLICY

(To be filled in block letters)

DETAILS OF THE THIRD PARTY ADMINISTRATOR

a) Name of TPA / Insurance Company:
b) Toll free phone number:
c) Toll free Fax:
d) Name of Hospital:
i. Address:
ii. ROHINI ID: iii. E-mail ID:

TO BE FILLED BY THE INSURED / PATIENT

a) Name of the patient:
b) Gender : M F TG c) Age: years months d) Date of Birth:
e) Contact number: f) Contact number of attending relative
g) Insured card ID number:
h) Policy number / Name of corporate: i) Employee ID:
j) Currently do you have any other Mediclaim / Helath Insurance: Yes No Company Name:
Give details:
k) Do you have a family physician? Yes No l) Name of the family physician:
m) Contact number, if any:
n) Current address of insured person
o) Occupation of insured person: (PLEASE COMPLETE DECLARATION ON THE REVERSE SIDE OF THIS FORM)

TO BE FILLED BY THE TREATING DOCTOR / HOSPITAL

a) Name of the treating doctor: b) Contact number:
c) Nature of illness/ disease with presenting complaints d) Relevant clinical findins:
e) Duration of the present ailment: Days i. Date of first consultation: D D M M Y Y Y Y ii. Past history of present ailment, if any
f) Provisional diagnosis: i. ICD 10 Code
g) Proposed line of treatment: Medical Management Surgical Management Intensive Care Investigation Non allopathis Treatment
h) If investigation & / or Medical Management, provide details i. Route of drug administration:
i) If Surgical, name of surgery: i. ICD 10 PCS Code
j) If other treatments, provide details k) How did the injury occur?
l) In case of accident: i. Is it RTA? Yes No ii. Date of injury: iii. Reported to Police: Yes No iv. FIR No.:
v. Injury / Disease caused due to substance abuse / alcohol consumption: Yes No vi. Test conducted to extablish this? Yes No (If yes attach reports)
m) In case of maternity: G P L A Expected date of Delivery:

Details of the patient admitted

a) Date of admission: b) Time: :
c) Is this an emergency / a planned hospitalization event? Emergency Planned
e) Expected no. of days in hospital: Days f) Days in ICU: Days
g) Room Type:
h) Per Day Room Rent + Nursing & Service Charges + Patient's Diet: INR
i) Expected cost of investigation + diagnostics: INR
j) ICU Charges: INR
k) OT Charges: INR
l) Professional fees Surgeon + Anesthetist Fees + consultation charges: INR
m) Medicines + Consumables + Cost of implants (if applicable, please INR
n) Other hospital expenses, if any: INR
o) All inclusive package charges, if any applicable: INR
Sum Total **INR**

d) Mandatory : Past history of any chronic illness — If Yes, since (month / year)

- Diabetes
- Heart Disease
- Hypertension
- Hyperlipidemia
- Osteoarthritis
- Asthma / COPD / Bronchitis
- Cancer
- Alcohol or drug abuse
- Any HIV or STD / Related ailments

Any other Ailment, give details:

(PLEASE READ VERY CAREFULLY)

DECLARATION

We confirm having read, understood and agreed to the Declaration on the reverse of this form
a) Name of the treating doctor:
b) Qualification: c) Registration No. with state code:

Hospital Seal (must contain hospital ID)

Patient / Insured Name & Signature

(IMPORTANT: PLEASE TURN OVER)

PAGE 2: NOT TO BE FAXED/SCANNED

DECLARATION BY THE PATIENT / REPRESENTATIVE

a. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Insurer/T.P.A after the discharge. I agree to sign on the Final Bill & the Discharge Summary, before my discharge.

b. Payment to hospital is governed by the terms and conditions of the policy. In case the Insurer / TPA is not liable to settle the hospital bill, I undertake to settle the bill as per the terms and conditions of the policy.

c. All non-medical expenses and expenses not relevant to current hospitalization and the amounts over & above the limit authorized by the Insurer/T.P.A 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 T.P.A at the Toll Free Number on the reverse of this form.

d. I hereby declare to abide by the terms and conditions of the policy and if 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 / T.P.A

e. I agree and understand that T.P.A is in no way warranting the service of the hospital & that the Insurer / TPA is in no way guaranteeing that the services provided by the hospital will be of a particular quality or standard.

f. I hereby warrant the truth of the forgoing particulars in every respect and I agree that if I have 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

g. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer / TPA.

h. I/We authorize Insurance Company/TPA to contact me/us through mobile/email for any update on this claim.

a) Patient/ Insured's Name: _____

b) Contact number: _____ **c) E-mail ID:** _____

d) Patient/ Insured's Signature: _____

Date: _____ **Time:** _____

HOSPITAL DECLARATION

a. We have no objection to any authorized TPA / Insurance Company official verifying documents pertaining to hospitalization.

b. All valid original documents duly countersigned by the insured / patient as per the checklist below will be sent to TPA / Insurance Company within 7 days of the patient's discharge.

c. We agree that TPA / 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.

d. The patient declaration has been signed by the patient or by his representative in our presence.

e. we agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications.

f. We will abide by the terms and conditions agreed in the MOU.

g. We confirm that no additional amount would be collected liom the insured in excess of Agreed Package Rates except costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibilityi choosing separate line oftreatment which is not envisaged/considered in package).

h. We confirm that no recoveries would be made from the d€posit amount collected from the Insured except for costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility/ choosing separate line oftreatment which is not envisaged/considered in package).

i. In the event ofunauthorized recovery ofany additional amount from the Insured in excess of Agreed Package Rates, the adhorized TPA / Insurance Company reserves the right to recoverthe same from us (the Network Provider) and,/or take necessary action, as provided under the MoU or applicable laws.

Hospital Seal _____ **Doctor's Signature** _____

Date: _____ **Time:** _____

DOCUMENTS TO BE PROVIDED BY THE HOSPITAL IN SUPPORT OF THE CLAIM

1. Detailed Discharge Summary and all Bills from the hospital
2. Cash Memos from the Hospitals / Chemists supported by proper prescription.
3. Receipts and Pathological Test Reports from Pathologists, supported by note from the attending Medical Practitioner / Surgeon recommending such pathological Tests.
4. Surgeon's Certificate stating nature of operation performed and Surgeon's Bill and Receipt.
5. Certificates from attending Medical Practitioner / Surgeon that the patient is fully cured.