Pre Authorization for Hospital

Anmol Medicare Ltd.

Request for Cashless Hospitalization	Fax Us at 079-40009990	Mail: cashless@anmolmedicare.com
To be filled by Treating Doctor		Date:
Name of Patient		Policy No:
Age	Phone No	Sex M□ F□
		Anmol ID NO:
ame of treating Doctor:	Qualification:	Reg No.
Relation with Proposer/Employee:		Employee code:

Resenting Complaints with Duration	Duration of Ailment		
	PROPOSED		
	Blood		Pathology
Relevant Clinical Findings	Urine		Microbiology
	Radiology		Biochemistry
	Sonography		Endoscopy
Provisional Diagnosis: / ICD CODE	Imaging		Other
	Cardiac Temt		

PROPOSED LINE OF TREATEMENT

□ □	In Case of RT	In case of Maternity	
□ □		FIR	Obeterio History: G_P_L_A
□		Alcohol Drug Intoxication	LMP EDD

Past History: If yes please mention	YES	NO		Duration
Hypertension				If yes Since
Diabetes Mellitus				If Yes Since
Cardiac Ailment				If Yes Since
Respiratory Ailment				If Yes Since
Any other Pre-existing Disease				If Yes Since

TO BE FILLED BY HOSPITAL

ESTIMATED HOSPITAL EXPENSES		Name & Address of the Hospital:
Room Rent (Per Day)	Rs.	
Medicine & Consumables	Rs.	Probable Date of Admission:
Surgical Expenses	Rs.	Accommodation:
Professional Charges	Rs.	Duration of Stay:
Investigation Charges	Rs.	City:
Any Other	Rs.	Fax No. (Must):
Total Expenses	Rs.	E-mail (if any):

HOSPITAL DECLARATION	PATIENTS DECLARATION
1. We have no objection to any authorized AML official to verify document pertaining to insured's hospitalization.	**1.** I agree to submit all original documents to AML enable them to process my claim at earliest.
2. All valid original documents countersigned as per the checklist & will be dispatched at the earliest following discharge of the patient.	**2.** In case AML is not liable to settle the hospital bill due to discrepancy in the documentation I take complete to settle the bill.
3. All non – medical expenses & not relevant to the hospital or illness which is not payable by AML will be collected directly from the Patient.	**3.** All non-medical expenses and incurred by me not relevant to the hospitalization illness will be payable by me.
4. AML will not be liable to pay the bill on finding any discrepancy in the documentation or reports.	**4.** I hereby declare to abide by the rules and regulation of the policy and if at any time the facts disclosed by me are found to be false or incorrect I forbid my right to the Claim.
5. We will submit a claim form duly filled & signed by insured.	**PATIENT SIGNATURE**
HOSPITAL SEAL DOCTORS SIGNATURES	**Address** ____________________ ____________________ Contact No.______________ Mobile No.____________