Genins India TPA Ltd
Third party administrator in Health Insurance

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Pre Authorization/ Pre – Hospitalization Form

Please read this carefully it is very important that this form be filled in carefully, completed and correctly to facilitate the processing of medical claim without causing and delay or rejection. It also helps to offer better guidance and assistance at all stages of hospitalization & reimbursement.

Part A – **To be Filled by the Hospital/ Nursing Home/ Service Provider:** (Please write full name and address)

Hospital Name: ______________________________ **City** ______________
Complete Address ______________________________ Reg. No. ____________ Tel No. ______________
Name of the patient ______________________________ Age ____________ Years ____________ Sex: M / F
ID No. (As mention on the ID card): ______________________________ Policy No. ______________
Name of the Policy Holder ______________________________ Employee Code (In case of Corporate) ________
Contact No. of Insured / Patient – Landline: ______________________________ Mobile: ______________
Proposed date of Admission ______________________________ Total estimated expenses ______________
Approx. Duration of stay ______________________________ Room Charges ______________
Class of accommodation ______________________________ Investigation Charges ______________
Operation Theater Charges ______________________________ Doctor(s) / Surgeon(s) Fee ______________
Name of the Treating Doctor ______________________________ Medicine & Drugs Charges ______________
Contact No. ______________________________ Others ______________
Signature of the Doctor ______________________________ Rubber Stamp______________

The cashless facility may not be granted, if this form is not filled completely.

The change in the admissibility of the claim due to discrepancies in the information provided by the hospital in the preauthorization form and discharge summary/ hospital records would be the liability of the hospital.

Part B – **To be filled by the treating Doctor/ Consultant**:

Advised admission/ admitted under Dr. ______________________________ Reg. No. ______________ Qualification: ______________
Date of first consultation: ______________________________ Name of the Doctor 1st Consulted ______________________________
Presenting Complaints with exact duration: ______________________________
History of Presenting Complaints: ______________________________
Relevant Clinical Findings: ______________________________ Investigation Reports (If any) ______________
Relevant Past History ______________________________
Diagnosis: ______________________________
Proposed line of treatment: ______________________________
Details of past treatment: ______________________________

Part C – **History of the following**

Hypertension ______________ Yes / No, if Yes, Since When ______________ Diabetes Mellitus Yes / No, If Yes, Since When __________
CAD / IHD ______________ Yes / No, If Yes, Since When ______________ Bronchial Asthma / Koch's and any other ______________
COPD / TB / Similar Aliment_____ Yes / No, Since When ______________ Any other Aliment ______________
Any surgeries in the past ______________________________ in case of road traffic accident, please mention if the patient was under the influence of alcohol / any other drugs ______________________________ yes / No (Please enclosed the FIR copy) (Please FAX the MLC copy)
In maternity: Gravida status ____________ LMP ____________ EDD ____________ Para ____________ NO. of living children __________.

Please do information the covered person the in case the cashless facility is not allowed, it is not the denial of treatment or claim. The claim can be submitted for re-imbursement, for settlement on its merits.

Part D – **Declaration**

I solemnly declare that the information provided by me is true and correct to the best of my knowledge, in case my claim is rejected; I hereby undertake to pay to ________________________ the expenses, which are incurred / paid for my hospitalization. I hereby authorized the hospital to release / give photocopies of my medical record to **Genins India TPA Ltd.** for the purpose of verification / authorization / settlement of my claim. I also confirm that I have read and understood the terms and conditions as mentioned and are applicable.
Previous Policy Details: Policy No ______________________________ Insurance Co. ______________________
Previous claim details ailment ______________________________ Date ____________ Amount ______________
Concurrent Policy details ____________________ Name of the Patient / Relative ______________ ____ Relationship ______________

Signature of Patient / Relative ______________________________