

# HERITAGE HEALTH SERVICES PVT. LTD.

## Pre-Authorisation Form

### Patients Details (To be filled by patient/relative)

Name: \_\_\_\_\_ Age: \_\_\_\_\_ yrs Sex : Male/Female  
 HHSPL ID: \_\_\_\_\_ Corp. Name/Employee Code: \_\_\_\_\_ Current Policy No.: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Previous Policy No.: \_\_\_\_\_ Insurance Company: \_\_\_\_\_ Claims if any: Yes / No  
 Previous Claim Amount: \_\_\_\_\_ Disease: \_\_\_\_\_ Date: \_\_\_\_\_  
 Simultaneous Mediclaim policy held with other Insurance Company/ies: Yes/No. Insurance Co: \_\_\_\_\_ S.I. \_\_\_\_\_

### Doctor's Diagnosis (To be filled in by Doctor)

Name: Dr. \_\_\_\_\_ Tel No: \_\_\_\_\_ Specialisation: \_\_\_\_\_  
 Hospital Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Present Complaint \_\_\_\_\_ Duration \_\_\_\_\_ History of Similar event in Past \_\_\_\_\_  
 Pulse rate: \_\_\_\_\_ B.P: \_\_\_\_\_ CNS: \_\_\_\_\_ (for Cardiac patients only).  
 Provisional / Differential Diagnosis: \_\_\_\_\_  
 D/o 1<sup>st</sup> Occurrence/Detection/Consultation: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

(Please attach primary investigation reports and proposed treatment plan along with separately)

### Is the patient suffering From any of the following? ... If yes since when?

Disease	Yes/No	Since	Disease	Yes/No	Since
Hypertension			Cancer		
Osteo Arthritis			Alcohol/Drug		
Diabetes			COPD/Asthma		
IHD			Any other		
If Cardiac Disease D/o 1 <sup>st</sup> Episode: / /			Maternity History In Females		
If Accidents influence of Drugs/Alcohol/chemicals etc : Yes / No (Please enclose the FIR Copy)			Gravida	Para	Living LMP
Particular	Details		Particular	Details	
Date of Admission			Accommodation charges		
Approx. Duration of Stay			Medicine/Drugs Charges		
Class of Accommodation			Investigation charges		
Approx. Package Rate			Doctor/Surgeon fees		
			<b>Total Charges (Approx):</b>		

- Documents Required For Cashless Facility
1. First Prescription with Provisional Diagnosis & Medical History
  2. All relevant positive radiological & pathological reports
  3. Advice for hospitalization by a registered medical practitioner

Stamp of the Hospital

Sign & Reg. No of Attending Doctor

The above information is true & correct to the best of my knowledge & information. I don't have any objection or reservation in personal visits at the hospital of any Doctor or Authorised representative of Heritage and/or review of my personal medical records. If any claim is rejected under policy terms & conditions, or excess payment is made over insured amount available in the Policy, I hereby undertake to pay HHSPL and/or Insurance Company the amount paid by them to the Hospital against preauthorization requested by me.

### Details of Relative (if details filled by relative)

Name of Relative: \_\_\_\_\_  
 Relationship: \_\_\_\_\_

Signature of Patient / Relative