



STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED

Toll free No. 1800 425 2255 Board No. 044 - 28263300

Regd. & Corporate Office Corporate Office : 1, New Tank Street, Valluvarkottam High Road, Chennai - 600 034. Phone : 044 -28288800 Fax No. 044- 28288826 Website : www.starhealth.in

PRE-AUTHORISATION REQUEST FORM PART - I (TO BE FILLED BY THE INSURED)

Policy No. I.D. No. Name of the Patient Age Yrs. Sex : M F Patient Tel. No. (Office) Fax Mobile No. Res. No. If Corporate, Name of the Employee Corporate Name Relation to the Proposer / Employee (In case of Corporate) Spouse Child Parent Siblings, please specify (others) Name of the Family Physician Tel. No. Mobile No.

Your Claim may be rejected, if these information's are not given.

PART - II (TO BE FILLED BY THE HOSPITAL) - ALL COLUMNS ARE COMPULSORY

A. Hospital and Treating Doctor details :

Name of Hospital / Nursing Home Tel. No. Address of Provider Name of Treating Doctor Tel. No. Mobile No. Regn. No. Qualification

B. Clinical Data

Presenting Complaints with exact duration Relevant Clinical Findings (Present illness)

General Examination: CVS RS GI CNS PA PR PV OTHERS

C. MEDICAL HISTORY

Table with 5 columns: Sl. No, Particulars, Yes/No, If yes, Since, If yes, remarks. Rows include Diabetes, Hypertension, Heart Disease, Br. Asthma, COPD, Osteo Arthritis, Cancer, Glaucoma / Cataract, Any other Pre Existing Disease, STD related Diseases.

H/O past illness relevant to present illness Whether present illness is a complication of any pre-existing disease/operation/past diseases

D. Any Evidence of Alcohol / Drug addiction & intoxication

E. Positive findings of investigation done

F. Provisional Diagnosis

G. Plan of Treatment

In case of R.T.A. was the patient under the influence of Alcohol/Any other Drugs Yes No M.L.C. No (Please fax a copy of the M L C Report) In case of Maternity, No of Live Children OBSTETRICALHISTORY LMP E.D.D Probable duration of stay :Room ICU/REASON Total

(Attach Doctors First Prescription) Signature of Treating M.O with seal QUALIFICATION

H. Admission and Financial details:

Admission: Planned Emergency Date of Admission Time of Admission Class of Accommodation Cost Estimation Break-ups: Room rent Investigation Surgeon Fees Doctor Fees Consumables/Implants Packages Approximate Total Exps Whether Telephonic intimation given to Star Health Yes No If yes, Date Time

Signature of Billing Head Stamp of Hospital Date Time

PART - III (TO BE FILLED BY THE INSURED) - INSURED CONSENT / AUTHORISATION

I hereby declare that I am having Medical Insurance Policy since without any break from Insurance Company. My previous year Policy No. from period to issued by office.

Consent by the patient / insured / beneficiary:

I/we have NO OBJECTION to STAR officials visiting hospitals/nursing home to verify details of treatment/obtain copies of necessary documents from the hospital/nursing home. I/we have provided the information to the best of my knowledge. I/we agree to pay cost of hospitalization, if authorization given by STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED becomes null and void due to wrong and incorrect information regarding the duration of ailments and past history. This consent is also final discharge for hospitalization part of the claim where it has effected the payment. I reserve the right to submit pre and post hospitalization or other claims separately as and when required and as per the policy terms and conditions.

Signature of the Patient / Relative(s) (Name of the Signatory / Relationship with the Patient)