Vipul MedCorp TPA Private Limited

515, Udyog Vihar, Phase V, Gurgoan, Haryana - 122016
Tel No: +91 124 2438270-75, 4699600 Toll Free : 1800 18011 66/77
Fax No : +91-124-4699611, 4699612, 4308211, 2438276

Pre-Authorisation Request Form

Part-I (To be filled by the Insured)

Policy No:- _____ V.M.C I.D. No:- _____ Corporate Name:- _____
Name of the Employee:- _____ Age:- _____ yrs Sex:- M / F
Phone No. (Office):- _____ Phone No. (Res):- _____
Name of the Patient:- _____ Age:- _____yrs Sex:- M / F
Relation to the Employee:- ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other- Please Specify:- _____

Photo ID Proof is compulsory for Hospitalisation.
Your Claim <u>may be rejected</u> if these informations are not given

Part-II (To be filled in by the Hospital) All Columns are Compulsory

Name of the Treating Doctor:- _____ Phone No. _____
Qualification:- _____ Regis No.:- _____ Clinic Add.:- _____
Name of the Hospital/Nursing Home:- _____ Tel No.:-_____
Registration No.:-_____ Add.:-_____
Presenting Complaints With Exact Duration:- _____
_____
Relevant Clinical Findings:-_____
_____
H/O Any Past Illness relevant to the present Illness:- _____
Whether present illness is a complication of any Pre-existing disease/ Operation/ Past- diseases:-_____
_____
Positive findings of Investigations done:-_____
_____
Provisional/Differential Diagnosis:- _____
Proposed line of Treatment:- _____
_____
Whether First Consultation_____ or regular patient _____ Since_____
Past H/O HT N: Yes/No/Not Known : if Yes Since _____ Diabetes : Yes/No/Not Known: if Yes Since_____
IHD: Yes/No/Not Known: if Yes Since _____ Heart Disease: Yes/No/Not Known: if Yes Since_____
COPD/TB: Yes/No/Not Known: if Yes Since_____ Asthma: Yes/No/Not Known: if Yes Since_____
Osteoarthritis: Yes/No/Not Known: if Yes Since _____ Cancer: Yes/No/Not Known: if Yes Since_____
Glucoma: Yes/No/Not Known: if Yes Since _____ Cataract: Yes/No/Not Known: if Yes Since_____
Pre-existing disease if any:-_____ Duration:-_____
In case of **R.T.A** was 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 Claim**:- No of live children:-_____
L.M.P:- _____ E.D.D:- _____ Gravida:- _____ Para:- _____ L:- _____

(For the above do attach the Doctor First Prescription)

Date of Admission:- _____ Approx Length of Hospitalization:- _____
Approx Expenses (I N R):- _____ Class of Accommodation:- _____
Room Rent Per-day:- _____ Doctor/Surgeon Fees:- _____
Investigation Charges:- _____ Surgical & Consumables:- _____
Package Rate:- _____ Any other:- _____
Signature of Doctor:- _____ Stamp of Hospital:- _____

Part-III (To be filled by the Insured) Insured Consent / Authorisation

I have 'No Objection' to Vipul MedCorp obtaining details of my treatment / collecting documents and also hereby authorize Vipul MedCorp to pay the hospital bill & reimburse itself / receive the amount from my claim receivable from my insurance company. If my claim is rejected, I hereby undertake to pay Vipul MedCorp the amount paid by them to the hospital. 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 / post hospitalization or other claims separately as and when required and as per the policy terms and conditions.

Previous policy details –Policy No._____ Insurance Company: _____
Previous claim details Ailment: _____Date: _____Amount_____
Concurrent Policy details: _____
Signature/s.:_____ Name: _____