ICICI Pru ClaimCare

PRE-AUTHORIZATION REQUEST FORM

Form: P

ICICI PRUDENTIAL LIFE INSURANCE

Contact us: 1860 266 7766 | Fax us: 1800 - 103 - 4778 / 022 - 42492828

PART - I (To be filled in by Claimant/Patient/Life Assured)

Mandatory Documents Attached (Please tick the relevant box)

Photo ID Proofs: ☐ Pan Card ☐ Passport ☐ Driving License ☐ Election Card ☐ Others(Pls specify)_____

1. Name of Patient/ Life Assured
2. Policy Number: (8 Digit Number)
3. Address: (Incl. state, city, pin code)
4. Age:
5. Gender: ☐ M ☐ F
6. Tel / Mobile No:

PART – II (To be filled in by the Doctor/Hospital)

7. Clinic/Hospital Name:
8. Fax No:
9. Clinic/Hospital Address: (incl. State, City, Pin Code)
10. Tel No & Email ID:
11. Chief Complaints:
12. Ailment Duration:
13. Clinical Findings:
14. Treatment Plan: ☐ Medical ☐ Surgical
15. Provisional Diagnosis:
16. Treatment Details:
17. Name of treating Doctor:
18. Doctor Mobile No:
19. Any past illness relevant to present ailment:
20. Doctor Sign & Date: (x)

21. Expected Date & Time of Admission: D D M M Y Y Y Y (_____:_____Hrs)

23. Emergency/ or Planned Hospitalization? ☐ Emergency ☐ Planned

24. Expected length of stay (in days): ☐ Non ICU ☐ ICU

25. Class of accommodation: _____

26. Room Rent + Nursing Costs (per day): Rs.

27. Expected Cost: Rs.
(Investigation + Medicines + Consumables & Other Hospital expenses)

28. Doctor Fee: Rs.
(Surgeon + Asst surgeon + Anesthetist + Doctor Visit Charges)

29. Package Rate (if any): Rs.

30. Cost of Implants (if applicable pls specify): Rs.

31. Total Expected Cost of Hospitalization: Rs.

22. Past history of any illness:

			Since when:
a) Diabetes:	Yes	No	
b) Hypertension:	Yes	No	
c) Heart Disease:	Yes	No	
d) Br. Asthma:	Yes	No	
e) Osteo Arthritis:	Yes	No	
f) Cancer:	Yes	No	
g) HIV or STD:	Yes	No	
h) Any h/o alcohol/ substance abuse:	Yes	No	
i) Any other Ailment/Surgery:	Yes	No	

32. Maternity Details: a) Menstrual History: b) Obstetric History: c) LMP: EDD:

d) NORMAL / LSCS Expected: e) G: P: A: L:

33. Accident: a) H/O Alcohol Abuse: Yes ☐ No ☐ b) Circumstances: _____

c) MLC / FIR Copy: Yes ☐ No ☐ d) MLC/FIR No:
(MLC- Medico Legal Certificate) (FIR- First Information Report)

Authorization / Declaration

The above details provided with respect to complaints and past illnesses are true, complete and correct to the best of my knowledge and belief. I understand and agree that in the event that any of the details are found to be untrue or incorrect, ICICI Prudential Life Insurance Company (Company) may refuse my preauthorization request or where the authorization has already been given, refuse payment in respect of the same. I further understand and agree that I shall be responsible and agree to bear the hospitalization expenses in any of the aforesaid event / circumstances. I hereby authorize the Company to obtain any medical records or seek additional/ related information pertaining to my claim from the Hospital / Nursing Home.

Hospital ID: _____

(x) Patient/Life Assured Signature

OR

(x) Claimant's Signature

HOSPITAL STAMP

Name of Claimant: _____

Relationship with Patient/Life Assured: _____

Instructions: 1.The Company will not be held liable for payment in the event of any discrepancy in information provided by the hospital at the time of admission & network settlement (in final document submission) 2. If any details provided are insufficient / incorrect, there may be a delay / denial of pre - authorization (cashless) request. All queries raised by the Company should be replied within 24 hours. 3. Denial of cashless does not mean denial of treatment. 4. Any change in the diagnosis / Treatment plan / Length of stay should be intimated to the company before discharge of the life assured. 5. Any request for authorization / enhancement made by the hospital after discharge of the life assured will not be considered