FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

Hospital Id: = H648003

Phone: 1800 209 1016 / 1800 103 8889
Fax: 1800 209 1017 / 1800 103 9998
Email: fgh.cashless@futuregenerali.in

FGH-PAF-04

------TO BE FILLED BY THE INSURED/PATIENT------

Patient Name: ______ Health Card No. ______

Gender: ☐ Male ☐ Female Age: ______ (yrs) DOB: ______ Policy No: ______

Patient/Attendant Mobile No. ______ Employee ID ______ Company Name ______

Occupation of Insured Person: ______

Currently do you have any other Mediclaim / Health Insurance ☐ Yes ☐ No (if yes, provide other insurance details)

Insurance Co. Name ______ Policy No: ______

Sum Insured ______ since how long you have this cover ______

Do you have Family Physician ☐ Yes ☐ No. Name of Family Physician: ______ Mobile No: ______

------TO BE FILLED BY THE TREATING DOCTOR /HOSPITAL------

Name of the Hospital: KANCHI KAMAKOTI CHILDS TRUST HOSPITAL City: CHENNAI

Address: Email ID: ROHIN ID:

Type of hospitalization: ☐ Emergency ☐ Planned Expected Admission Date: ______ Time of Admission ______

Expected Length of Stay: ______ (days) Name of Treating Doctor: ______ Mobile No: ______

Nature of Illness / Disease with Presenting Complaints: ______

______

Relevant Clinical Findings: ______

Duration of present Ailment: ______ Years ______ Months ______ Days Date of First Consultation: ______

Past History of Present Ailment if any ______

Provisional Diagnosis: ______ ICD Code: ______

Proposed Line of Treatment during Hospitalization: ☐ Medical ☐ Surgical ☐ Intensive ☐ Investigation ☐ Non Allopathic treatment

If Investigation & /or Medical Management, provide details: ______

Route of Drug Administration: ______ If Surgical, Name of Surgery: ______

Type of Anesthesia: ☐ Local ☐ General ☐ Regional ☐ Dissociative ICD PCS Code: ______

If other treatments provide details: ______

In case of Accident / Injury: ☐ RTA ☐ Intentional Self Injury Date of Accident / Injury: ______

How did injury occur: ______

Injury / Diseases caused due to Substance Abuse / Alcohol Consumptions: ☐ Yes ☐ No

Test conducted to establish this: ☐ Yes ☐ No Reported to Police: ☐ Yes ☐ No FIR / MLC No: ______

In case of Maternity: G ______ P ______ L ______ A ______ LMP Date: ______ Expected Date of Delivery ______

Mode of Delivery: ☐ VD ☐ LSCS

PAST HISTORY OF ANY CHRONIC ILLNESS WITH DURATION:

Disease / Ailment					Duration (Specify Year / Month / Days)
Hypertension	Yes		No		
Hyperlipidemia	Yes		No		
Cancer	Yes		No		
Osteoarthritis	Yes		No		
Diabetes	Yes		No		
Cardiovascular Diseases	Yes		No		
Asthma / COPD / Bronchitis	Yes		No		
Any Surgery / Hospitalization	Yes		No		
Any Other Disease / Disability	Yes		No		
Congenital	Yes		No		Internal / External
Any HIV or STD/Related Ailments	Yes		No		

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Alcohol or Drug Abuse	Yes		No	

Expense Head	Amount (Rs.)	Expense Head	Amount (Rs.)
Room Rent per day + Nursing/Service charges + Diet		Investigations + Diagnostics	
ICU charges per day		Medicines / Consumables	
Doctor / Consultant visit charges		Equipment / Monitor etc	
Surgeon charges + Anesthetist		Miscellaneous (specify)	
Operation Theatre Charges		Implant Charges (If any)	
Package Charges			

Estimate of Expenses: Total Amount Rs. ______________________________ Class of Accommodation: ____________________

--DECLARATION--

I have completed this form and will be responsible for correctness of the medical information certified by me. I agree that Future Generali shall not be liable to make payment in case of any discrepancy between the preauthorization form and discharge summary.

Name of the treating Doctor: ____Qualification:__________________________

MCI Registration No with State Code: _____________________________

Signature of Doctor: ____Stamp / Seal of Hospital ____________________

BENEFICIARY CONSENT / AUTHORISATION I have 'No Objection' to Future Generali obtaining details of my treatment / collecting documents and also hereby authorize Future Generali to pay the hospital bill from the sum insured of my insurance policy. I also undertake to pay all non medical / non authorized expenses in the hospital bill directly to the hospital at the time of discharge. In case Future Generali issues "Denial of cashless facility" to the provider, I have 'No objection' in paying the hospital bill for the treatment given. All information provided above is true and I agree that if I have provided any false or untrue information, my right to claim the expenses shall be absolutely forfeited.

NAME OF INSURED: ____ SIGNATURE OF INSURED: ____________________________

INSURED Email ID: ____ INSURED Mobile No: _________________________________

Declaration by the patient/representative

I agree to allow the hospital to submit all original documents pertaining to hospitalization to the insurer after the discharge. I agree to sign on the final bill and the discharge summary before my discharge. Payment to hospital is governed by the terms and conditions of the policy. In case the insurer is not liable to settle the hospital bill, I undertake to settle the bill as per the terms and conditions of the policy. All non medical expenses and expenses not relevant to current hospitalization and the amounts over and above the limit authorized by the insurer not governed by the terms and conditions of the policy will be paid by me. In case any clarification is needed on admissibility of a particular item I shall contact insurer at the toll free no on the reverse of the form. I hereby declare to abide by the terms and conditions of the policy and it at any time the facts disclosed by me are found to be false or incorrect I forfeit my claim and agree to indemnify the insurer. I agree and understand that insurer is in no way warranting the services of the hospital and the insurer is in no way guaranteeing that the services provided by the hospital will be of a particular quality or standard. I hereby warrant the truth of the forgoing particulars in every respect and I agree that if I made or shall make any false or untrue statement, suppression or concealment, my right to claim reimbursement of the said expenses shall be absolutely forfeited. I further declare that, in respect of the above treatment, no benefits are admissible under any other medical scheme or insurance. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the insurer.

Patient's /Insured's Name _______________________Contact No: _________________Patient's / Insured's Signature ________________

Hospital Declaration

We have no objection to any authorized insurance company official verifying documents pertaining to hospitalization. All valid original documents duly counter singed by the insured/patient as per the check list below will be sent to insurance company within 7 days of the patient's discharge. All non medical expenses or expenses not relevant to hospitalization/illness, or expenses disallowed in the authorization letter of the insurance company, or arising out of incorrect information in the preauthorization form will be collected from the patient.

WE AGREE THAT INSURANCE COMPANY WILL NOT BE LIABLE TO MAKE THE PAYMENT IN THE EVENT OF ANY DISCREPANCY BETWEEN THE FACTS IN THIS FORM AND DISCHARGE SUMMARY OR OTHER DOCUMENTS. The patient declaration has been signed by the patient or by his / her representative in our presence. We agree to provide clarification for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications. We will abide by the terms and conditions agreed in the MOU.

Hospital Seal: **Doctor's Signature:**

Documents to be provided by the hospital in support of the claim

1. Authorization Letter
2. Original Detailed Discharge Summary
3. Original Hospital Main Bill and Detailed Break Up
4. All Original Pharmacy Bills and Investigation Bill if any
5. All Investigation Reports & Prescriptions Including OT Notes