UNITEDHEALTHCARE INDIA (PVT.) LTD.

PRE-AUTHORISATION FORM FOR HOSPITALISATION

To be faxed back to 022 -2491 46 46 e-mail nurseline@uhcindia.com

Credit may be denied if the details in the form is found incomplete or inaccurate

Name of employee						Employee ref. no.	
Company name				Email:			
Off. Tel. Fax		Mobile				Res. Tel	
Name of patient						Relation	
Communication Address:							
Details of treating physician and hospital							
Name of treating physician						Reg. no.	
Qualification		Mobile				Tel. Clinic	
Name of hospital						Location	
Hospital registration no.				Tax approved Yes / No / Don't know			
Hosp. Tel. no.				Hosp. Fax no.			
Details of diagnosis							
Detailed diagnosis	1º			2º		3º	
Symptoms on admission							
Date of first onset of symptoms				Date of first diagnosis			
For maternity only	LMP			EDD			
Treatment proposed (Please tick (√) where applicable)							
Date of admission				Expected length of stay		Less than 24 hrs. Yes / No	
	Inject. (√)	Oral (√)		Inject. (√)	Oral (√)		(√)
Antibiotics			Steroids			IV transfusions	
Anti-inflam. drugs			Nutrients			Chemotherapy	
Neuro-musc. drugs			Sedatives			Radiation	
Cardiac drugs			Diuretics			Blood & comp.	
Respiratory drugs			GI drugs			Continuous traction	
Other* (please specify)			*			*	
Procedures (describe)							
Surgical treatment (describe)							
Anesthesia							
Past History (Please specify duration)							
	Since		(Please provide details for below if applicable)				Since
Hypertension			History of surgery				
Dyslipidaemia			History of similar complaints				
Diabetes			History of related ailments				
Estimate of expenses							
Room rent / day	Rs.		Pharmacy.	Rs.		Surgeon charge	Rs.
Investigations	Rs.		Physician charge	Rs.		Anesthetist charge	Rs.
Consumables	Rs.		Other	Rs.		**TOTAL**	Rs.

DECLARATION

- I hereby declare that the information provided in the form is true to the best of my knowledge, and authorize UnitedHealthcare India to seek any further information from the treating doctor / hospital if needed
- I am aware that the liability of UnitedHealthcare for treatment is limited to facilitating credit and refusal of credit does not amount to rejection of claim
- I undertake that if cashless facility is availed, all original documents, including the discharge summary and investigation reports shall be handed over to the hospital at the time of discharge along with the signed claim form. I am aware that without these documents the claim cannot be processed and I am liable for the same
- I am aware of my health insurance cover and if the hospital expenses exceed the amount, I shall be liable to pay the remainder of the amount at the time of discharge
- I undertake to pay all non-medical expenses incurred in the hospital at the time of discharge
- If the hospitalization comes under any of the policy exclusions & is not reimbursed by the insurance company, I undertake to pay the amount to UnitedHealthcare India who have kindly extended the hospital credit facility

Date _____ Employee Signature_____

- As treating physician, I hereby declare that the medical information declared in the form is accurate to the best of my knowledge

Date _____ Hospital Stamp Treating Physician Signature _____