

Shriram General Insurance Company Limited



PLEASE FAX/SCAN PAGE 1 ONLY REQUEST FOR CASHLESS HOSPITALISATION FOR MEDICAL INSURANCE POLICY

(All fields are mandatory and fill in CAPITALS only)
DETAILS OF THE THIRD PARTY ADMINISTRATOR

a) Name of the TPA/Insurance Company: _____
b) Toll free Customer Helpline number: _____
c) Toll free FAX/ Email: _____

HOSPITAL DETAILS

a) Name : _____
b) Address: _____
c) Rohini ID: _____
d) Email ID: _____

TO BE FILLED BY INSURED/PATIENT

a) Name of the Patient: _____
(First Name) (Middle Name) (Last Name)
b) Gender: ☐ Male ☐ Female c) Age: Years Y Y Months M M d) Date of birth: D D M M Y Y Y Y
e) Contact Number: _____ f) Occupation: _____
g) Insured/Patient/Address: _____
h) Insured/Patient Email ID: _____ I) Contact number of attending relative: _____
j) Insured Member ID card No: _____ k) Policy No./Corporate Name: _____
m) Employee ID _____ n) Currently do you have any Mediciam/Health Insurance: ☐ Yes ☐ No
o) Company Name: _____
p) Give details: _____
q) Do you have a family physician: ☐ Yes ☐ No r) Name of the family physician: _____
s) Contact No, if any _____ (PLEASE COMPLETE DECLARATION ON THE REVERSE SIDE OF THE FORM)

TO BE FILLED BY TREATING DOCTOR/HOSPITAL

a) Name of the Treating Doctor: _____ b) Contact Number: _____
c) Nature of illness/ Disease with presenting complaints _____ d) Relevant clinical findings _____
e) Duration of present ailment: _____ Days f) Date of first consultation: D D M M Y Y Y Y g) Past history of present ailment, if any _____
h) Provisional Diagnosis _____ I) ICD Code: _____
j) Proposed line of treatment ☐ Medical Management ☐ Surgical Management ☐ Intensive Care Unit ☐ Investigation ☐ Non allopathic treatment
k) Investigational &/or Medical Management provide details _____ m) Route of drug administration _____
n) If surgical name of surgery _____ o) ICD 10 PCS code _____
p) If other treatment provide details _____ q) How did injury occur _____
r) In case of Accident: I. Is RTA: ☐ Yes ☐ No ii. Date of injury: D D M M Y Y Y Y iii. Reported to police: ☐ Yes ☐ No iv. FIR No.: _____
v) Injury/Disease caused due to substance abuse/alcohol consumption: ☐ Yes ☐ No vi) Test conducted to establish this: ☐ Yes ☐ No (If yes, attach report)

DETAILS OF PATIENT ADMITTED

a) Date of admission: D D M M Y Y Y Y b) Time of admission: H H : M M
c) Is this a emergency/a planned hospitalisation event?: Emergency ☐ Planned ☐
d) Expected No. of days stay in hospital: _____ Days e) Room Type _____
f) Per Day Room Rent + Nursing & Service Charges + Patient's Diet Rs. _____
g) Expected cost for investigation + diagnostics Rs. _____
h) ICU Charges Rs. _____
I) OT Charges Rs. _____
j) Professional fees Surgeon + Anesthetist Fees + consultation Charges Rs. _____
k) Medicines + Consumables + Cost of Implants (if applicable please specify). Other hospital expenses if any Rs. _____
l) All inclusive package charges if any applicable Rs. _____
m)Sum Total expected cost of hospitalization Rs. _____

MANDATORY:

Past history of any chronic illness If yes, since (month/year)

☐ Diabetes	D D M M
☐ Heart Disease	D D M M
☐ Hypertension	D D M M
☐ Hyperlipidemias	D D M M
☐ Osteoarthritis	D D M M
☐ Asthma/ COPD/ Bronchitis	D D M M
☐ Cancer	D D M M
☐ Alcohol or drug abuse	D D M M
☐ Any HIV or STD / Related ailments	D D M M

Any other Ailment give details: _____

Dear Policyholder,

Please fill the following information along with the cashless form for your medical insurance policy.

Policy No.

Membership Number

Hospital Id
(To be filled by hospital)

DOCUMENT CHECKLIST:

- I. Copy of Photo ID, address proof and recent photo of patient. (for Valid proof of documents kindly refer KYC documents list) KYC documents list includes PAN Card/Driving License/Voter Id. Card/ Aadhar Card
- II. Past illness records (With duration of symptoms) if any
- III. First and subsequent consultation paper along with admission note.
- IV. Complete medical history along with supporting investigation reports.
- V. In case of accident, MLC/FIR copy (if applicable)
- VI. Claim consent letter

All documents mentioned above to be submitted along with the completed filled cashless form. Insurer may require further documents to process the request.

Name of the Proposer/insured

Contact No.

Signature

Name of the TPA coordinator

Date:
Place:

Signature

CONSENT LETTER

To, / Date /

Medical Superintendent

I, Mr./Ms Age Resident
of State Hereby
give my willful consent to Mr/ Dr of Shriram General

Insurance Company Limited to verify and collect necessary documents/ statements including but not limited to
certified copies of medical records from your esteemed hospital for the purpose of settlement of my Insurance
claim.

My other relevant details are provided below;

Detail of Insured:-

DOA:-

DOD:-

MRD/ Indoor/ IP No:-

Policy No:-

I request you to provide all the information/documents as required by Shriram General Insurance Company Ltd.

Name

Signature/ Thumb Impression

Witness Name & Signature