FAMILY HEALTH PLAN LIMITED

PREAUTHORISATION FORM / ADMISSION REQUEST NOTE

Member's Details (* compulsory fields)
Patient's Name: Sex: Age:
*Patient UHID Number:
*Policy Number:
Name of the main member
If Corporate, name of the corporate:

Network Hospital Details	
Name of the Hospital:	
City:	
Phone:	Fax:
Name of the first Dr. consulted:	

To be filled in by the patient / family member / attendant:

If the policy is a renewal policy year in which the policy was first taken:

Have you ever made any claim: Yes / No. If Yes, the claim was settled / rejected (Please tick the appropriate)

INSURED CONSENT/AUTHORIZATION

I have 'No Objection' to FHPL obtaining details of my treatment / collecting documents and also hereby authorize FHPL to pay the hospital bill and reimburse itself / receive the amount from my claim receivable from my Insurance company. If my claim is rejected, I here by undertake to pay FHPL the amount paid by them to the hospital. The Consent is also final discharge for hospitalization part of the claim where it has affected the payment. I reserve the right to submit pre /post hospitalization to other claims separately as and when required and as per the policy terms and conditions.

Date & Place Signature of insured

****Please Note that hospitalization for treatment of following conditions is not payable.**
Convalescence, general debility, rundown condition or rest cure, congenital external disease or defects or anomalies, sterility, venereal disease, intentional self injury and use of intoxicating drugs/ alcohol. All conditions directly or indirectly caused to or associated with any syndrome or condition commonly referred to as AIDS. Admission for Investigation / Evaluation is not covered.

To be filled in by the treating doctor:

Present complaint / ailments with duration:	
History of past illness relevant to present illness:	
Whether present complaint / ailment is a complication of pre-existing disease / surgery: Yes / No (Please tick the appropriate)	If Yes, please specify:
Personal History: Alcoholism / Smoking / Tobacco chewing / Ghutka Chewing (Please tick the appropriate) Since:	
Provisional / Differential diagnosis:	Proposed line of treatment:
Is the patient suffering from any of the following: (Please tick the appropriate) a. Diabetes: Yes/No If yes, since: b. Hypertension: Yes/No If yes, since: c. Heart Disease: Yes/No If yes, since: d. COPD: Yes/No If yes, since: e. Any other chronic ailment: (Please specify): If yes, since:	To be filled in for maternity cases: a. Gravida: b. Para: c. Living Children: d. Abortions: e. Death: LMP: EDD:
Clinical Findings: BP: P/R: Temp: CVS: RS: CNS: P/A: Others;	Likely date of admission: Approximate duration of stay: Class of accommodation: Approximate Expense:
In case of RTA: Is the patient under the influence **of alcohol / any other narcotic substance**: Yes / No (Please tick the appropriate). **Please enclose the MLC copy.**	
Signature of Treating Doctor: Name: Registration Number: Phone Number(s):	Rubber Stamp:

N.B: Additional information may be called for before authorising facility for cashless treatment

Toll Free Number: 1800-425-4033

IF THE SPACE IS INSUFFICIENT PLEASE ATTACH ADDITIONAL SHEETS ON HOSPITAL / CONSULTANT LETTERHEAD