PRE-AUTHORIZATION REQUEST FORM

TO BE FILLED BY PATIENT PARTY

Patient Name:

National ID No.: A

Date of Birth: D D M M Y Y Y Y

Gender: Male Female

Contact Person:

Contact Number:

Relation with Patient:

TO BE FILLED BY TREATING DOCTOR / HOSPITAL

Doctor's Name:

Date of First Consultation: D D M M Y Y Y Y

Relevant Clinical Findings:

Provisional Diagnosis: (With presenting complains)

History of Present Illness (If Any):

Final Diagnosis:

ICD 10 Code:

Expected Duration of Present Illness: **DAYS**

Proposed Line of Treatment: Medical Management | Surgical Management | Intensive Care | Investigation

Details of the Selected Line of Treatment(s):

Route of Drug Admission:

In case of Accident (Please Specify Assessment Details):

Tests Conducted? Yes No (If yes, please attach the reports)

Date of Injury: D D M M Y Y Y Y

In Case of Maternity G: P: L: A:

Date of LMP: D D M M Y Y Y Y

Date of Delivery: D D M M Y Y Y Y

Details of Admitted Patient:

Date of Admission: D D M M Y Y Y Y

Admission Type: IP OP

Room Type:

Duration of Stay: (Estimated) **DAYS**

Emergency? Yes No

Estimated Cost for the Interventions:

RS.

RS.

RS.

Sum of Total Charges:
(Please attach the break down bill with this form)

RS.

PATIENT DECLARATION

1. I agree to allow hospital to submit all original documents pertaining to hospitalization to Aasandha Company Ltd.
2. I agree to sign on the final bill & discharge summary before discharge procedure.
3. Payment to hospital is governed by terms and conditions of Aasandha Company Ltd. All non-medical expenses not governed by terms and conditions of the policy will be paid by patient party.
4. I agree and understand that T.P.A is not warranting the services provided by the hospital & Aasandha Company Ltd.
5. T.P.A is in no way of guaranteeing that the services provided by the hospital will be of a particular quality or standard.
6. I agree to pay all the expenses inquired to hospital which are not reimbursed by Aasandha Company Ltd.

HOSPITAL DECLARATION

1. We have no objection with Aasandha Company Ltd. verifying the official documents pertaining to hospitalization.
2. All valid documents duly countersigned by insured/patient will be sent to Aasandha Company Ltd. Within 7 days of patient's discharge.
3. We agree to provide clarification for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in clarifications.
4. The patient's declaration has been signed by the patient or by his/her representative in our presence.
5. All disallowed expenses in the authorization letter of Aasandha Company Ltd. will be collected from the patient party.
6. WE AGREE THAT AASANDHA 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.

Signature of the Patient/Insured/Guardian | **Signature of the Doctor** | **Hospital Seal**