TAMILNADU NEW EMPLOYEES HEALTH INSURANCE SCHEME

MDINDIA HEALTHCARE SERVICES (TPA) PVT. LTD

TOLL FREE NO. – 1800 233 5666, CASHLES FAX NO : 044 28297252

REQUEST FOR CASHLESS AUTHORIZATION **DATE: ____ / ____ / _____**

PART I: TO BE FILLED BY PATIENT **TOLL FREE FAX 1860-233-4449**

NAME OF PATIENT : **Corporate Name:**_____ **Emp. ID** _____	**MDI ID NO.** **PHOTO ID MANDATORY Y / N**
AGE: _____ **SEX: M** ☐ **F** ☐ **PHONE NO.** **FAX NO.**	**INSURANCE COMPANY: United India Insurance Company Limited**

PART II: TO BE FILLED BY TREATING DOCTOR

NAME OF TREATING DOCTOR: **PHONE NO.** **MOBILE NO.**	**PRESENTING COMPLAINT WITH DURATION:**
P / H: **YES** **NO** **SINCE** HYPERTENSION: Y N _____ DIABETES: Y N _____ CARDIAC AILMENTS: Y N _____ ASTHMA / COPD: Y N _____ OSTEO ARTHRITIS: Y N _____ CANCER: Y N _____ HIV: Y N _____ OTHERS: Y N _____	**RELEVANT CLINICAL FINDINGS:** **CVS -** **BP -** **RS -** **P/A -** **CNS -** **GYNAEC -** **OTHERS -**
Is the disease self inflicted? **YES / NO** **Are the diseases / injury caused directly / indirectly due to use of alcohol / drugs?** **YES / NO** **IN CASE OF RTA: FIR / MLC** **YES / NO**	**History of any past illness relevant to present disease:** **YES / NO** **Details:** **Whether present ailment is a complication of any pre-existing disease / operation?** **YES / NO**
DIAGNOSIS: **DETAILS OF TREATMENT RECEIVED:** **PROPOSED LINE OF TREATMENT:**	**DETAILS OF INVESTIGATIONS TO CONFIRM THE DIAGNOSIS:**

NO	INVESTIGATION	RESULT
1.	BSL	
2.	Complete Blood Count	
3.	Urine analysis	
4.	Urea / Electrolytes	
5.	ECG / ECHO	
6	X-Ray / Ultrasonography	
7	Other Relevant Investigations	

PART III: TO BE FILLED BY HOSPITAL

NAME OF HOSPITAL:	**BED CHARGES:**
PROVIDER CODE:	**CONSULTATION CHARGES:**
CITY:	**NURSING CHARGES:**
FAX NO.	**INVESTIGATIONS CHARGES:**
PROBABLE DATE OF ADMISSION:	**COST OF IMPLANTS:**
APPROX. DURATION OF STAY:	**MEDICINES:**
CLASS OF ACCOMODATION:	**SURGERY:**
PACKAGE CHARGES:	**TOTAL APPROX CHARGES:**

Declaration: Patient

I have "No Objection" to MDIndia obtaining the details of my treatment / collecting documents & hereby authorize MDIndia to settle the hospital bill and reimburse itself / receive the amount from my claim receivable from the insurance company. I / We agree to pay the cost of hospitalization if authorization given by TPA becomes null and void due to disclosure of wrong and incorrect information regarding the nature, duration and past history of all ailments. This 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 claims separately and when required and as per the policy terms and conditions.

Note: Kindly submit the Preauth form along with scanned copy of Employee card or PF card with seal and signature of the Hospital.

Declaration: Hospital MDIndia will not be held liable for the payment in the event of any discrepancy between the facts presented at the time of admission & in final documents submission.

Signature & Stamp of Treating Doctor: _____**Rubber Stamp of Hospital & Signature** _____

***Patient's* Signature /** Thumb Impression _____ **Contact No.:** _____