HEALTH CARE TPA LTD.
Corp. Office: Alankit House, 2E/21 Jhandewalan Extn., New Delhi –110 055
Phone: 42541256-60, Fax: 42541266-67, E-mail: health@alankit.com

PRE–HOSPITALIZATION FORM

1. Alankit Card No. ____________________ Insurer's Name _____________________________ Policy No.______________________
Sum Assured ___________ Cum. Bonus__________ Previous Coverage Details____________________ Fresh / Renewal_________
Name of the Insured ______________________ Contact No. Office __________ Residence ____________ Mobile ______________
Relationship with Patient (Self / Spouse / Son / Daughter / Parents / Others)____
Name of the Patient: ___________________________________ Age______ Sex _____ Contact No. __________________________
Name of the Family Doctor ______________________________ Contact No. __________________________________
Any claim in past (if yes, Provide Particulars of same)____

2. **Hospital Particulars:**
Name & Address of the Hospital: ________________________________ Regn. No. _________________ IPDNo. _______________
Name of the Contact Person of Hospital ____________________ Designation ______________ Contact No. / Mobile ___________
Individual/Corporate / Group: ________________________________ Employee Code_________________ Contact No. _________

Presenting Complaints	Duration

Please attach Doctor's Ist Prescription, details of Inves. & Treatment.

Past History Relevant to the Presenting Complaints: ____

3. **Other Associated illnesses:**

Disease	Yes / No	Duration	Disease	Yes / No	Duration	Disease	Yes / No	Duration
DM			Arthritis - Osteo / Rheumatoid			Alcohol intake		
HT			Carcinoma			Similar Ailment		
IHD/CAD			Cataract / Glaucoma			Any surgery in Past		
COPD/TB/ Asthma			Blood Transfusion / HIV / Related Disease			Any Other Ailment		

In Maternity Claim: Obst. History Any abnormality noticed No. of Live Children:
LMP EDD Mode of Delivery - Normal LSCS with indications

In Case of accident:- MLC No. Non MLC Influence of alcohol: Yes / No

Relevant Positive Clinical Findings:
Relevant Positive Investigation reports:
Date & Time of hospitalization: Expected duration Room No:
Indication for Admission: Estimated Expenses
Diagnosis: Provisional / Final Plan of Treatment: Conservative / Surgical

4.	Non – Package				Package	
Room Rent & Nursing Care	**Investigation**	**Consultation**	**Surgical Procedure Charges (Total)**	**Medicines**	**Package**	**Cost of implant**

Please Note: All the above columns should be completely filled. *No Slashes Allowed*. Inadequate information would lead to delay in our response. Progress Reports required if stay is beyond 3 days regularly. If there is any Discrepancy in Pre-authorization & Discharge Summary, our Pre-authorization would automatically stand Cancelled & we are not liable to any payment.

If cashless facility is not availed hospital has to inform AHCL in writing only after which AHCL would update my Sum Insured
Identity of the patient verified

Seal & Regn. No. Contact No's: Name & Signature of Consultant alongwith

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DECLARATION

I solemnly declare that the information provided by me and my consultant is true & correct to the best of my knowledge. In case my claim is rejected, I hereby undertake to pay the Hospital / Alankit Health Care Ltd (AHCL) the expenses, they have paid for my hospitalization. I hereby authorize the hospital to release my medical record to AHCL for the purpose of verification / authorization / settlement of my claim.

Dated: At: Name & signature of the patient/claimant