STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED

Regd. & Corporate Office: 1, New Tank Street, Valluvar Kottam High Road, Nungambakkam, Chennai - 600 034.
Corporate Office - Claims Dept. : No.15, Balaji Complex, Whites Lane, 1st Floor, Royapettah, Chennai - 600 014.
Toll free Phone No: 1800 425 2255 Toll free Fax No: 1800 425 5522
CIN : U66010TN2005PLC056649 Email:support@starhealth.in Website: www.starhealth.in IRDAI Regn. No: 129

REQUEST FOR CASHLESS HOSPITALISATION FOR HEALTH INSURANCE

POLICY PART – C (Revised)

(TO BE FILLED IN BLOCK LETTERS)

DETAILS OF THE THIRD PARTY ADMINISTRATOR/INSURER/HOSPITAL.:

a. Name of TPA/Insurance company : STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED

b. Toll free phone number: _____

c. Toll free fax: _____

d. Name of Hospital: _____

I.Address _____

ii.Rohini ID _____

iii.e-mail id _____

TO BE FILLED BY INSURED/PATIENT

A. Name of the Patient : _____

B. Gender: ☐ Male ☐ Female ☐ Third Gender

C. Age: _____ (Years) / (Month)

D. Date of Birth: _____ (DD/MM/YYYY)

E. Contact number: _____

F. Contact number of attending Relative: _____

G. Insured Card ID number: _____

H. Policy number/Name of Corporate: _____

I. Employee ID : _____

J. Currently do you have any other mediclaim / health insurance: Yes ☐ No ☐

i.Company Name: _____

ii.Give Details: _____

K. Do you have a family Physician: Yes ☐ No ☐

L. Name of the family Physician: _____

M. Contact number, if any: _____

N. Current Address of Insured Patient: _____

O . Occupation of Insured Patient: _____

(PLEASE COMPLETE DECLARATION OF THIS FORM)

TO BE FILLED BY TREATING DOCTOR/HOSPITAL

A. Name of the treating Doctor: _____

B. Contact number:: _____

C. Nature of illness/Disease with presenting complaint : _____

D. Relevant Critical Findings: _____

E. Duration of the present ailment _____ Days

iv. Date of First consultation _____ (DD/MM/Y'YYY)

v. Past history of present ailment, if an _____

F. Provisional diagnosis:

ICD l0 code _____

G. Proposed line of treatment:

I. Medical Management ( )
II. Surgical Management ( )
III. Intensive care ( )
IV. Investigation ( )
V. Non-allopathic treatment ( )

H. If investigation and/or Medical Management, provide details:

i. Route of Drug Administration _____

I. lf surgical, name of surgery:

i. ICD l0 PCS code _____

J. If other treatment, provide details: _____

K. How did injury occur: _____

L. In case of accident:

i.	Is it RTA	Yes	☐	No ☐
ii.	Date of injury	Yes	☐	No ☐
iii.	Report to Police	Yes	☐	No ☐
iv.	FIR NO	Yes	☐	No ☐
v.	Injury/Disease caused due to substance			
vi.	abuse/alcohol consumption	Yes	☐	No ☐
vii.	Test conducted to establish this (if yes, attach report)		☐	No ☐

M. In case of Maternity:

I. expected date of Delivery _____ (DD/MM/Y'YYY)

DETAILS OF PATIENT ADMITTED

A. Date of admission : (DD/MM/YYYY) _____

B. Time of admission: (HH:MM) _____

C. Is this emergency/planned hospitalization event Emergency ☐ Planned ☐

D. Mandatory Past History of any chronic illness if yes (Since month/year)

- I. Diabetes _____
- ii. Heart disease _____
- iii. Osteoarthritis _____
- iv. Asthma/COPD/Bronchitis _____
- v. Cancer _____
- vi. Alcohol/Drug abuse _____
- vii. Any HIV or STD Related ailment _____
- viii. Rheumatoid Arthritis _____
- ix. Cerebrovascular Accident(Stroke) _____
- I. Liver disease _____
- xi. Kidney disease _____
- xii. Any other ailment,give details _____

E. Expected number of Days/Stay in hospital : _____ Days

F. Level / Grade of Surgery: _____

G. Days in ICU: _____ Days

H. Room Type: _____

I. Per day room rent + nursing and service charges +patients diet: _____

J. Expected cost of investigation + diagnostic: _____

K. ICU Charges: _____

L. OT Charges _____

M. Professional fees Surgeon + Anesthetist fees + consultation Charges: _____

N. Medicines + Consumable + Cost of Implants (if applicable please specify): _____

O. Other hospital expenses if any: _____

P. All-inclusive package charges if any applicable : _____

Q. Sum Total expected cost of hospitalization : _____

DECLARATION

(Please read very carefully)

A. Name of the treating doctor : _____

B. Qualification : _____

C. Registration number with state code : _____

Hospital Seal (Must include Hospital Id)	Patient/Insured Name and Sign

DECLARATION BY THE PATIENT / REPRESENTATIVE

a. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Insurer/T.P.A after the discharge. I agree to sign on the Final Bill & the Discharge Summary, before my discharge.

b. Payment to hospital is govemed by the terms and conditions of the policy. In case the Insurer / TPA is not liable to settle the hospital bill, I undertake to settle the bill as per the terms and conditions of the policy.

c. All non-medical expenses and expenses not relevant to current hospitalization and the amounts over & above the limit authorized by the Insurer/T.P.A not govemed by the terms and conditions of the policy will be paid by me.

d. I hereby declare to abide by the terms and conditions of the policy and if at any time the facts disclosed by me are found to be false or incorrect I forfeit my claim and agree to indemnify the Insurer / T.P.A

e. I agree and understand that T.P.A is in no way warranting the service of the hospital & that the Insurer / TPA is in no way guaranteeing that the services provided by the hospital will be of a particular quality or standard.

f. I hereby warrant the truth of the forgoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppression or concealment with respect to the claim, my right to claim reimbursement of the said expenses shall be absolutely forfeited.

g. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer / TPA

h. "I/We authorize Insurance Company/TPA to contact me/us through mobile/email for any update on this claim".

Authorization to Star health and allied Insurance Co. Ltd

I am admitted in your Hospital _____from _____

I hereby authorize Star health and allied Insurance Co. Ltd. and its representatives, who is my Health Insurer to seek any medical information / records from you or from the Medical Practitioners who have attended on me in connection with the above ailment and the treatment given. In case they seek any such information / records / indoor case papers, kindly oblige.

a) Patient's / Insured's Name : _____

b) Contact number : _____

c) e-mail Id : _____

d) Patient's / Insured's Signature : _____

Date : _____ Time : _____

HOSPITAL DECLARATION

a. We have no objection to any authorized TPA / Insurance Company official verifying documents pertaining to hospitalization.

b. All valid original documents duly countersigned by the insured / patient as per the checklist below will be sent to TPA / insurance Company within 7 days of the patient's discharge.

c. we agree that TPA / Insurance 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.

d. The patient declaration has been signed by the patient or by his representative in our presence

e. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications.

f. We will abide by the terms and conditions agreed in the MOU

g. We confirm that no additional amount would be collected liom the insured in excess of Agreed Package Rates except costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility choosing separate line of treatment which is not envisaged/considered in package).

h. We confirm that no recoveries would be made from the deposit amount collected from the insured except for costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility/ choosing separate line of treatment which is not envisaged/considered in package).

I. In the event of unauthorized recovery of any additional amount from the Insured in excess of Agreed Package Rates, the authorized TPA / Insurance Company reserves the right to recover the same from us (the Network Provider) and,/or take necessary action, as provided under the MOU or applicable laws.

Hospital Seal

Doctor's Signature

Date :_____Time:_____