REQUEST FOR CASHLESS HOSPITALISATION: VIDAL HEALTH
PLEASE E-MAIL TO **VHPREAUTH@VIDALHEALTH.COM**

HOSPITAL DETAILS

1. Name of Hospital:
2. Address
3. Rohini id
4. e-mail id
5. Hospital SPOC Name
6. Hospital SPOC Contact Number

PATIENT DETAILS

- Name of the Patient :
- Gender: Age: Date of Birth: _____ (DD/MM/YYYY)
- Patient Contact number:
- Contact number of attending Relative:
- VH ID number:
- Name of Corporate:
- Employee ID:
- Current Address of patient:

TO BE FILLED BY TREATING DOCTOR/HOSPITAL

- Name of the treating Doctor:
- Contact number:
- Nature of Illness / Disease with presenting complaint:
- Relevant Critical Findings:
- Duration of the present ailment: _____Days
- Date of First consultation: _____(DD/MM/YYYY)
- Past history of present ailment, if any
- Provisional diagnosis:
- ICD 10 code:
- Proposed line of treatment:

  i. Medical Management ( )
  ii. Surgical Management ( )
  ii. Intensive care ( )
  iv. Investigation ( )
  v. Non-allopathic treatment ( )

- lf surgical, name of surgery
- ICD 10 PCS code _____
- If other treatment, provide details
- ln case of accident

Is it RTA: Yes/No

Date of Injury: _____

FIR NO (If Applicable): _____

DETAILS OF PATIENT ADMITTED

- Date of admission _____(DD/MM/YYYY)
- Time of admission _____(HH:MM)
- Is this an emergency / planned hospitalization event:
- Mandatory Past History of any chronic illness: if yes (since____/_____)(month/year)

❖ Diabetes _____/_____
❖ Heart disease/Hypertension_____/_____
❖ Osteoarthritis _____/_____
❖ Asthma/COPD/Bronchitis _____/_____
❖ Cancer _____/_____
❖ Alcohol/Drug abuse _____/_____
❖ Any HIV/ or STD Related ailment _____/_____
❖ Any other ailment, give details. _____

- Expected number of Days / stay in hospital _____ Days
- Days in ICU _____ Days
- Room Type _____
- Per day Room Rent + Nursing and service charges + Patient's diet _____
- Expected cost of investigation + Diagnostic _____
- ICU charges _____
- OT charges _____
- Professional fees Surgeon + Anesthetist Fees + consultation Charges:
- Medicines + Consumables + Cost of Implants (if applicable please specify):
- Other hospital expenses if any:
- All-inclusive package charges if any applicable:
- **Total expected cost of hospitalization:**

DECLARATION

We confirm having read understood and agreed to the Declarations of this form

- Name of the treating doctor:
- Qualification:
- Registration number with State code:

Hospital Seal **Patient / Insured Name and Sign**

DECLARATION BY THE PATIENT / REPRESENTATIVE

I agree to allow the hospital to submit all original documents pertaining to hospitalization to Vidal Health after the discharge. I agree to sign on the Final Bill & the Discharge Summary before my discharge.

Payment to the hospital is governed by the terms and conditions of the the Policy. In case the Corporate is not liable to settle the hospital bill, I undertake to settle the bill as per the terms and conditions of the policy.

All non-medical expenses and expenses not relevant to current hospitalization and the amount over & above the limit, not governed by the terms and conditions of the policy will be paid by me.

I hereby declare to abide by the terms and conditions of the policy

"I/We authorize Implementing agency to contact me/us through mobile/email for any update on this claim."

Patient's / Insured's Name:

_____

Contact Number: _____email-Id (optional) _____

Patient's / Insured's Signature: _____

Date:_____**Time:** ___

HOSPITAL DECLARATION

We have no objection to any authorized official verifying documents pertaining tohospitalization.

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

We agree that Company will not be Liable to make the payment in the event of any discrepancy between the facts in thisform and discharge summary or other documents.

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

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

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

We confirm that no additional amount would be collected from 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).

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 / choosingseparate line of treatment which is not envisaged / considered in package).

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

Hospital Seal and Doctor Sign **Date----------Time--------**