

Contact us: 1800 - 103 - 6363/022 - 42492929

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PART - I (To be filled in by Claimant/Patient/Life Assured)

Mandatory Documents Attached (Please tick the relevant box)
 Photo ID Proofs: Pan Card Passport Driving License Election Card Others(Pls specify) _____

1. Name of Patient/ Life Assured: _____
 2. Policy Number: (8 Digit Number) _____
 3. Address:(Incl. state, city, pin code) _____
 4. Age: _____ 5. Gender: M F
 6. Tel / Mobile No: _____

PART - II (To be filled in by the Doctor/Hospital)

7. Clinic/Hospital Name: _____
 8. Fax No: _____
 9. Clinic/Hospital Address:(incl. State, City, Pin Code) _____
 10. Tel No & Email ID: _____
 11. Chief Complaints: _____
 12. Ailment Duration: _____
 13. Clinical Findings: _____
 14. Treatment Plan: Medical Surgical
 15. Provisional Diagnosis: _____
 16. Treatment Details: _____
 17. Name of treating Doctor: _____
 18. Doctor Mobile No: _____
 19. Any past illness relevant to present ailment: _____
 20. Doctor Sign & Date: _____ (x)

21. Expected Date & Time of Admission: | D | D | M | M | Y | Y | Y | Y | (: Hrs)
 22. Past history of any illness:
 a) Diabetes: Yes No
 b) Hypertension: Yes No
 c) Heart Disease: Yes No
 d) Br. Asthma: Yes No
 e) Osteo Arthritis: Yes No
 f) Cancer: Yes No
 g) HIV or STD: Yes No
 h) Any h/o alcohol/ substance abuse: Yes No
 i) Any other Ailment/Surgery: Yes No
 Since when: _____
 23. Emergency/ or Planned Hospitalization? Emergency Planned
 24. Expected length of stay (in days): _____
 25. Class of accommodation: _____
 26. Room Rent + Nursing Costs (per day): Rs. _____
 27. Expected Cost: (Investigation + Medicines + Consumables & Other Hospital expenses) Rs. _____
 28. Doctor Fee: (Surgeon + Asst surgeon + Anesthetist + Doctor Visit Charges) Rs. _____
 29. Package Rate (if any): Rs. _____
 30. Cost of Implants (if applicable pls specify): Rs. _____
 31. Total Expected Cost of Hospitalization: Rs. _____
 32. Maternity Details: a) Menstrual History: _____
 b) Obstetric History: _____
 c) LMP: _____ EDD: _____
 d) NORMAL / LSCS Expected: _____
 e) G: P: A: L:
 33. Accident: a) H/O Alcohol Abuse: Yes No b) Circumstances: _____
 c) MLC / FIR Copy: Yes No d) MLC/FIR No: _____
 (MLC- Medico Legal Certificate) (FIR- First Information Report)

Authorization / Declaration

The above details provided with respect to complaints and past illnesses are true, complete and correct to the best of my knowledge and belief. I understand and agree that in the event that any of the details are found to be untrue or incorrect, ICICI Prudential Life Insurance Company (Company) may refuse my preauthorization request or where the authorization has already been given, refuse payment in respect of the same. I further understand and agree that I shall be responsible and agree to bear the hospitalization expenses in any of the aforesaid event / circumstances. I hereby authorize the Company to obtain any medical records or seek additional/ related information pertaining to my claim from the Hospital/ Nursing Home.

Hospital ID: _____

 Patient/Life Assured Signature

OR

 Claimant's Signature

Name of Claimant: _____
 Relationship with Patient/Life Assured: _____

HOSPITAL STAMP

Instructions: 1. The Company will not be held liable for payment in the event of any discrepancy in information provided by the hospital at the time of admission & network settlement (in final document submission) 2. If any details provided are insufficient / incorrect, there may be a delay / denial of pre - authorization (cashless) request. All queries raised by the Company should be replied within 24 hours. 3. Denial of cashless does not mean denial of treatment. 4. Any change in the diagnosis / Treatment plan / Length of stay should be intimated to the company before discharge of the life assured. 5. Any request for authorization / enhancement made by the hospital after discharge of the life assured will not be considered