RELIANCE GENERAL INSURANCE

Tech+ ♥ = Live Smart

Claim No.: _____

PRE-AUTHORIZATION REQUEST FORM

Please use Reliance Provider Portal to communicate with us - https://provider.reliancegeneral.co.in/

PART 1 - INSURED DETAILS			
Insured Name:			
Mobile No.:		Policy No.:	
E-mail Id:			
If Group Policy, Company Name:		Employee id	
PAN No.:			
Source of Funds:	☐ Business ☐ Profession ☐ Salary ☐ Agricultural Income ☐ Savings ☐ Others		
Monthly Income:	☐ Upto ₹ 20,000 ☐ ₹ 20,001 to ₹ 50,000 ☐ ₹ 50,001 to ₹ 1,00,000 ☐ ₹ 1,00,001 and above		
Agent/Sub Agent Name:			
Agent Mobile No.:		Agent Email ID:	

PART 2 - PATIENT DETAILS					
Patient Name:					
Patient UHID:		Age:	_____Yrs	DOB:	D D / M M / Y Y Y Y
Gender:	☐ Male ☐ Female	Patient Mobile No:			
Patient Email id:					
Relation with insured:	☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Son ☐ Daughter ☐ Others_____				
Address:					
City:		Pin Code:			
Attendant Name:					
Agent Mobile No.:		Agent Email ID:			

PART 3 - SERVICE PROVIDER DETAILS			
Hospital Name:		Hospital Code:	
Hospital Address:			
City:		Pin Code:	
Contact Details (Hospital Employee)		**Treating Doctor Detail**	
Name:		Name: Dr.	
Telephone No./ Mobile No.:		Qualification:	
Fax No.:		Registration No:	
E-mail Id:		Mobile No.:	

PART 4 - CASE INFORMATION (FILLED BY TREATING DOCTOR)			
Presenting Complaint:			
Duration:		Date of first onset/Consult	D D / M M / Y Y Y Y
H/O of past illness related to present complaint:			
Relevant Clinical findings:			
Investigation findings:			
Provisional Diagnosis:			
Treatment Plan:	☐ Medical ☐ Surgical		
In case of Maternity:			
Obstetric History:	G ____ P____ L____ A ____	LMP:	EDD.:
In case to Injury/RTN Self Injury			
Under Influence of Alcohol/ Drug abuse:	☐ Yes ☐ No	Attached Copy of:	☐ MLC ☐ FIR ☐ PI
MLC/FIR Number:		Place:	

Past Medical History		Duration/Details
HTN	☐ Yes ☐ No	
IHD / CAD	☐ Yes ☐ No	
Diabetes	☐ Yes ☐ No	
Asthma / COPD / TB	☐ Yes ☐ No	
Paralysis / CVA / Epilepsy	☐ Yes ☐ No	
Arthritis	☐ Yes ☐ No	
Cancer / Tumor / Cyst	☐ Yes ☐ No	
STD / HIV	☐ Yes ☐ No	
Alcohol / Drug abuse	☐ Yes ☐ No	
Psychiatric condition	☐ Yes ☐ No	
Others	☐ Yes ☐ No	

PART 5 - BILLING DETAILS (FILLED BY HOSPITAL)			
Room Type:	☐ Single AC ☐ Single NON AC ☐ Twin Sharing AC ☐ Twin Sharing NON AC ☐ Multi-bed ☐ Others		
Hospital Room Name.:			
Type of Admission:	☐ Planned ☐ Emergency	Expected DOA:	D D / M M / Y Y Y Y
Length of Stay:	_____Days	Package Rate:	☐ Yes ☐ No
If Yes, Package Charges:			
Implant Charges:			
Remarks (if Any):			
If Package not applicable,			
Room Rent + Nursing Charges			
Surgeon / Assistant Surgeon Charges			
Anesthesia / Anesthetist Charges			
Operation theatre Charges			
Doctor's Visit Charges			

Investigation Charges	
Pharmacy Charges	
Implant Cost (if any)	
Total Cost of Hospitalization	

Please note: In case the Health Gain Policy under which the cashless claim is being lodged has been taken on installment basis then in the event of cashless claim being admissible , the company will deduct the balance installments due if any, from the claim approved amount and pay the balance due to the Policyholder. In the event of the claim assessed amount being lower than the Balance installment due then the Policyholder is liable to pay the balance premium installments due immediately by cheque or DD, failing which the said Claim would be treated as inadmissible and the Policy shall stand cancelled immediately and no liability shall be admissible under the Policy for any Claims liability in future orin period elapsed.

Consent by the Patient/Insured/Beneficiary: I/We understand that Cashless facility is not automatically guaranteed by RGICL. I/We have no objection to RGICL Health Care Officials visiting the Hospital/Nursing Home to check the details of treatment and are authorized to collect documents pertaining to my treatment from the Hospital/Nursing Home.

I/We have provided the necessary information accurately to the best of my /our knowledge. I/We agree to pay the cost of the hospitalization, if authorization given by RGICL Health Care becomes null and void, due to wrong and incorrect information.

_____ _____

Patient Signature Treating Doctor's Signature

_____

Date: _____ Stamp of Hospital

PEP DECLARATION:	
Are you a Politically Exposed Person (PEP)?	☐ Yes ☐ No
If yes, please mention the position held	
Is any of your close relation or family member a PEP?	☐ Yes ☐ No
If yes, please mention the name and relation and the position held by such close relative/family member.	

I hereby declare that in future if me, any of my close relatives or any of my family member attains a position of PEP then I shall confirm the same to Reliance General Insurance Co. Ltd as a mandate. I understand that this is a crucial information under the PMLA Rules and AML/ CFT Guidelines and shall confirm that the answers given by me is true. In case the company comes to know that this is a misrepresentation and concealment of information then the policy shall be put on hold for scrutiny by the company and I shall be solely responsible for the same.

Note :

"Politically Exposed Persons" (PEPs) shall have the meaning assigned to it under sub clause (db) of clause (1) of Rule 2 of the Prevention of Money Laundering (Maintenance of Records) Rules, 2005."

(db) "Politically Exposed Persons" (PEPs) are individuals who have been entrusted with prominent public functions by a foreign country, including the heads of States or Governments, senior politicians, senior government or judicial or military officers, senior executives of state-owned corporations and important political party officials".

AML Guidelines

1. I/We hereby confirm that all premiums have been/will be paid from bonafide sources and no premiums have been /will be paid out of proceeds of crime related to any of the offense listed in Prevention of Money Laundering Act,2002.
2. I Understand that the Company has the right to call for document to established sources of funds.
3. The Insurance Company has right to cancel the insurance contract in case I am/have been found guilty by competent court of law under any of the statutes, directly or indirectly governing the prevention of money laundering in India.

Place: _____

Date: _____

_____

Signature of Proposer

GENERAL DECLARATION:

I understand that as per the new AML/CFT Guidelines issued Reliance General Insurance Co. Ltd will be verifying my details pertaining to KYC and PAN provided at the time of proposal.

I further, do hereby agree and consent that in the case of the event of a mismatch of information provided by me in the proposal form, identification proof, and address proof at the time of issuance of the policy. I request Reliance General Insurance Company Limited to issue the policy with the details appearing as per my proposal form. I will be solely responsible for any consequences arising out of the difference in detail given by me during the verification of supporting documents provided by me at the time of issuance of the policy or otherwise.

DECLARATION

I hereby agree, affirm and declare that, the statements/information given/stated by me/us in this claim form is true, correct and complete. No material information which is relevant to the processing of the claim or which in any manner has a bearing on the claim has been with held or not disclosed. If I have given/made any false or fraudulent statement/information, or suppressed or concealed or in any manner failed to disclose material information, the policy shall be void & that I shall not be entitled to all/any rights to recover there under in respect of any or all claims, past, present or future. The receipt of this claim form/other supporting/related documents does not constitute or be deemed to constitute an agreement by the Company of the claim and the Company reserves the right to process or reject or require further/additional information in respect of the claim.

I hereby provide my consent and authorize Reliance General Insurance Company Ltd to seek any medical information from any hospital/ Medical Practitioner who has at any time attended on the insured person.

Place: _____ _____

Date: _____ (Signature of Claimant)

IMPORTANT INFORMATION FOR HOSPITALS

1. The Pre-authorisation Request Form should be filled with due care including the unique number received by the Insured/member/ beneficiary. All columns are required to be filled in block letters.
2. Completed Pre-authorization Request Form should be faxed to Health Care on 022 4890 3009 (paid), or emailed at healthcare@indusindinsurance.com by the provider hospital. It should reach us at least 4 days prior to likely date of admission. In case of emergency admission Pre-Authorisation Request Form should be sent within 4 hours of admission.
3. Authorisation may be denied if complete information is not provided or queries are not replied to.
4. Discrepancy in the information provided by the hospital records found at the time of claim may render the authorisation given null and void and the amount claimed by the hospital would have to be settled by the Insured to the hospital.
5. Any changes in Diagnosis/Treatment plan should be intimated before discharge of the patient.
6. All queries raised by us need to be replied at the earliest & maximum within 24hrs.
7. Request for authorisation/enhancement will not be entertained after discharges of the patient.
8. We shall share the authorization denial letter to the concerned hospital within 24 hours of complete and correct information being provided.
9. If clinical details provided are insufficient, there may be a delay in the authorisation or denial for cashless.
10. As per IRDAI any claimed amount above 1 lac, copy of PAN card/form 60 of the insured/Policy holder/Proposer is mandatory and for below 1 lac, Photo identity proof (For eg-Aadhar card, Driving license, Election card, Passport etc) is mandatory.

HEALTH CARE ADDRESS:

Health Care Unit: Reliance General Insurance, No.1-89/3/B/40 to 42/ks/301, 3rd floor, Krishe Block, Krishe Sapphire, Madhapur, Hyderabad - 500081. **Email: healthcare@indusindinsurance.com.**