PRE AUTHORIZATION LETTER			
PGEPHIS (Punjab)			
For Cashless Assistance: Toll Free number: 18602334400 Date:			
PART 1 - TO BE FILLED BY PATIENT / RELATIVE / ATTENDENT / HOSPITAL			
Name of Patient			
Age / Sex		MDI5-Mobile no.-	
Name of Main Member			
PART 2 - TO BE FILLED BY HOSPITAL			
Presenting Complaints with Duration-			
Clinical Findings-	(1) BP (2) Pulse (3) CVS (4) RS		
Provisional Diagnosis-			
Proposed Investigations-			
Type of Treatment (Please tick the required) - a) Surgical b) Medical Mgt. c) Maternity d) New Born e) Chemo			
Surgical Package Code -			
Surgical Package Name-			
Surgical Package Rate-			
Medical Management (Please give details of treatment)-			
Name of Implant –			
Cost of Implant –			
Total PAL Amount –			
In Case of Road Traffic Accident	FIR Yes / No	Alcohol Yes / No	Drug Intoxication Yes / No
Obsteretic History	(1) G_____ P____ L____ A___ (2) LMP (3) EDD		

PART 3 : TO BE FILLED BY HOSPITAL

Name of the hospital:	**ESTIMATED HOSPITAL EXPENSES**	
Probable Date of Admission:	Probable Date of Discharge:	
HOSPITAL DECLARATION	**PATIENTS DECLARATION**	
1. We have no objection to any authorized TPA official to verify document pertaining to insured's hospitalisation.	1. I agree to submit all original documents to TPA to enable them to process my claim at the earliest.	
2. All valid original documents countersigned as per the check list & will be dispatched within 15 days following discharge of the patients.	2. In case TPA is not liable to settle the hospital bill due to discrepancy in the documentation I take complete liability to settle the bill.	
3. All non-medical expenses & expenses not relevant to the hospital or illness which is not payable by TPA will be collected directly from the Patient.	3. All non-medical expenses and expenses incurred by me not relevant to the hospitalisation illness will be payable by me.	
4. TPA will not be liable to pay the bill on finding any discrepancy/ misrepresentation in the documentation or reports or discharge summary.	4. I hereby declare to abide by the rules and regulation of the policy and if at any time the facts disclosed by me are found to be false or incorrect I forbid my right to the claim	
5. We will submit a claim form duly filled & signed by insured alongwith all documents pertaining to the claim in orginals.	Patients Signature:	
Hospital Representative Signature:	Hospital Seal:	

ALL COLUMNS ARE TO BE MANDATORILY FILLED