Max Bupa
Health Insurance

PREAUTHORIZATION FORM

REQUEST FOR ELIGIBILITY OF TREATMENT

PATIENT'S DETAILS

Full name _____

Gender _____ Age/Date of birth _____

Corporate Name _____ Employee ID _____

Max Bupa Card number (8 digits) OR Policy Number (14 digits) | | | | | | | | | | | | | | | | | | |

Mandatory document attached (please tick in relevant box)

Valid Photo Id proof ☐ Pan Card ☐ Passport ☐ Driving license ☐ Election Card ☐ Others (please specify) _____

PROVIDER'S DETAILS

Hospital name and address _____

Hospital code _____ Telephone number _____ Fax number _____

Hospital E-mail _____

Name of treating doctor _____ Contact Number _____

MEDICAL INFORMATION

Presenting Complaints with duration _____

Vital signs: BP _____ Pulse _____ Temperature _____ Respiratory Rate _____

Important examination/investigation findings _____

When was this condition first diagnosed? (please attach first consultation papers) _____

Provisional Diagnosis _____

Proposed line of treatment _____ Mode of administration (oral/parenteral/rectal) _____

Proposed surgery/procedure (if any) _____

Is this emergency or planned hospitalization? _____

Is this a Day care procedure or requires inpatient stay for more than 24 hours? _____

Details of patient's regular medication (if any) _____

OBSTETRIC HISTORY

G _____ P _____ L _____ A _____ If pregnant, LMP _____ EDD _____

TO BE FILLED IN CASE OF ACCIDENTS/SUSPICIOUS OCCURENCES

Signs of being under the influence of alcohol at the time of hospitalization (Yes/No)

MLC filed (Yes/No) (If yes, please attach copy) MLC Number | | | | | | | | | | | | | |

FIR copy available (Yes/No)(if yes, please attach copy) FIR Number | | | | | | | | | | | | | |

Circumstances of incident _____

HOSPITALIZATION DETAILS

Proposed date of admission _____ Room category _____ Room Type ☐ Sharing ☐ Single

Proposed length of stay _____ Expected length of stay in days in a) ICU _____ b) Non ICU _____

ESTIMATED COSTS

Total Room Rent _____ Total ICU rent _____ Doctor Visiting charges _____

Pharmacy charges _____ Surgeon charges _____ OT charges _____

Anesthetist charges _____ other charges (Please provide details) _____

Any separate cost of implants (if applicable please specify) _____

Total cost of hospitalization/ all inclusive package charges (if any applicable) _____

PAST HISTORY OF ANY ILLNESS

Name of illness		(Diagnosis if applicable) with duration	Name of illness		(Diagnosis if applicable) with duration
Diabetes Mellitus	(yes/no)		Hypertension	(yes/no)	
Respiratory disease	(yes/no)		Heart Disease	(yes/no)	
Osteoarthritis	(yes/no)		Cancer	(yes/no)	
HIV	(yes/no)		STD	(yes/no)	
Epilepsy	(yes/no)		CVA	(yes/no)	

Any other condition _____

Personal Habits	please specify habit& quantity of intake	Past History	Duration
Bidi/Cigarette/paan/ Gutka/Alcohol/Narcotics			

Treating Doctor Signature _____ Registration number & Qualification of treating doctor _____

Date and Place _____ Seal of hospital

Declaration & Authorization

I hereby declare that the above information given is true and correct.
I further authorize any hospital, physician, insurance company or organizations that has any records or knowledge of me or my health to furnish such information to Max Bupa Health Insurance Company Limited ("Max Bupa") and all information with respect to any illnesses or injuries, medical history, consultation, prescriptions or treatment and copies of all hospital or medical records. A photostat copy of this authorization shall be considered as effective and valid as the original.
I understand that if I and / or the Member(s) fail to provide any information requested in this Pre-authorization form, it may result in the inability of Max Bupa to accept or process this Pre-authorization.
I understand that all Members' personal information collected or held by Max Bupa will be used for processing the claims and analysis related to insurance / reinsurance business or any association or federation of insurance company within or outside India.

Member/Relative Signature _____ Member/Relative Name _____

Relationship to member _____ Date & Place _____ Contact Number _____

INSTRUCTIONS

Please ensure this information is provided at least 72 hours prior to admission & within 48 hours of admission incase of emergencies. Failure to complete this information in full could delay our ability to provide a decision.
Any approvals granted on receipt of this form would be valid for a period of ten days from the date of approval. All treatment must commence within this period. Any delay beyond ten days would result in all approvals becoming void and requisitions would have to be submitted afresh for approvals.
Please return this document duly filled to the following fax number 180030703333.

Max Bupa Health Insurance

Max Bupa Health Insurance Company Limited
Corporate Office: D-1, 2nd Floor, Salcon Ras Vilas, District Centre, Saket, New Delhi 110017.
Registered Office: Max House, 1, Dr. Jha Marg, Okhla, New Delhi 110020
www.maxbupa.com

PLEASE FAX THIS DOCUMENT TO 1800 3070 3333