ICICI Lombard
GENERAL INSURANCE

ICICI Lombard Health Care

CASHLESS AUTHORIZATION REQUEST NOTE

Part A - To be filled in by the Insured

Policy No.		Card No.	
Corporate Name		Patient Name	
Employee's name		Age	
Employee ID		Sex	M ☐ F ☐
Mobile No. of Insured	|__|__|__|__|__|__|__|__|__|__|	Telephone No. of Insured (with STD Code)	|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|
Address of the Insured			

Consent by Patient / Insured : I hereby authorize ICICI Lombard to pay or reimburse the medical expenses as per the policy terms and conditions. This authorization shall become null and void in the event of :

- incorrect and/ or misleading information regarding the duration of ailments and/ or information regarding the health status
- any discrepancy between the facts presented at the time of hospitalization and at the time of final documents submission.

In such scenario (s) I shall be liable to pay for the hospitalization and related expenditure. I have no objection to ICICI Lombard obtaining or collecting details of my treatment. I acknowledge and agree that information provided by me/ us are true to the best of my/ our knowledge.

Signature of Insured : _____

Part B - To be filled in by the Treating Doctor

Hospital Name & Add (Including City, State, Pin code)			
Telephone No. (with STD Code)	|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|	Fax No. (with STD Code)	|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|
Treating Doctor's Name			
Doctor's Qualification		Mobile No.	|__|__|__|__|__|__|__|__|__|__|

Presenting Complaints			
Clinical Findings		Past History	
Provisional Diagnosis		Treatment Plan : Medical / Surgical	
Investigations Findings			

Particulars	Details	Particulars	Yes/No	Since When
Expected Date of Admission		Hypertension		
Expected Length of Stay (In days)		Diabetes		
Class of accommodation		Coronary Heart Disease		
Room Rent + Nursing Charges		Any other Heart Ailment		
Investigation Charges		Paralysis / Stroke		
Medicine Charges		Cancer		
Surgeon / Asst Surgeon Charges		Arthritis		
Anesthesia + OT Charges		STD / HIV		
Doctor Visit Charges		Alcohol/Drug abuse/ Intoxication		
Cost of Implants (with Name)		Maternity*		If yes details below
Package Rate (If Any)		Accident**		If yes details below
Total Expected Cost of Hospitalization		Other (If Any)		

*Maternity / Obstetric History	Menstrual History	G	P	A	L	LMP	EDD

**Accident Details	Incident History	MLC/FIR Done	MLC/FIR No.
		Yes / No	Location

Signature & Stamp of Treating Doctor _____ Rubber Stamp of Hospital & Signature _____

Mailing Address : ICICI Lombard General Insurance Company Limited, ICICI Lombard Health Care, TGV Mansion, 6th Floor, Plot No. 6-2-1012, Khairatabad, Hyderabad - 500 004.
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Email us : ihealthcare@icicilombard.com • Website : www.icicilombard.com

Insurance is the subject matter of the solicitation. IRDA Reg. No. 115.

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