



TTK HEALTHCARE SERVICES PRIVATE LIMITED

PRE-AUTHORIZATION REQUEST FORM

Form No. 7

PART – I To be filled by the Insured

Version 5 / Dec 06

Policy No		TTK ID Card No		
Pt Name		Age	Sex	Mobile No
Occupation				
Emp ID				

Address & Tel. No of Insured:

Signature of insured

PART – II To be filled by the Doctor / Hospital in Utmost Good Faith

CHIEF COMPLAINTS:		
Duration of the present illness		Any Past illness relevant to the present illness
Clinical Findings		
Provisional Diagnosis		
Plan of Treatment	Medical	*Treatment Relating to (please fill details below) a) Maternity b) Trauma c) Alternative Medicine
	Surgical	
Name and address of the HOSPITAL		Hospital Tel No.
		Hospital Fax No.
Name of TPA coordinator		Empanelment No.
Likely Date & Time of Admission		Has The Patient suffered from any of the following :
Is this an Emergency / a planned Hospitalization Event?		a) Diabetes : Yes / No If Yes, Since:
		b) Hypertension : Yes / No If Yes, Since:
Class of accommodation		c) Heart Disease : Yes / No If Yes, Since:
		d) Br. Asthma : Yes / No If Yes, Since:
Per Day Room Rent + Nursing & Service Charger + Patient's Dite		e) COPD : Yes / No If Yes, Since:
		f) Osteo Arthritis : Yes / No If Yes, Since:
Expected cost for Investigation +medicines +consumables & Other Hospital expenses if any & OT charges		g) Cancer : Yes / No If Yes, Since:
		h) Any h / o Alcohol Abuse / Intoxication:? Yes / No
Doctor's=Surgeon +asst surgeon +Anesthetist fees + visit charger		i) Any h / o a STD / Related ailments? Yes / No
All inclusive Package charges (if applicable please specify)		j) Any other ailment: Yes / No If Yes, Since:
SUM TOTAL EXPECTED COST OF HOSPITALIZATION RS:		

<p style="text-align: center;">MANDATORY IN MATERNITY</p> <p>Menstrual History:</p> <p>Obstetric History:</p> <p>G _____ P _____ A _____ L _____</p> <p>LMP: _____ EDD: _____</p> <p>NORMAL / LSCS expected</p>	<p style="text-align: center;">MANDATORY IN R.T.A.</p> <p>H/O Alcohol Abuse: YES/NO</p> <p>MLC / FIR copy: YES/NO</p> <p>CIRCUMSTANCES:</p>	<p style="text-align: center;">MANDATORY FOR ALL CASES</p> <p>Name of the Treating doctor:</p> <p>Signature:</p> <p>Mobile No:</p> <p>Hospital Stamp</p> <p style="text-align: right;">Date:</p>
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Consent by Patient/ Insured/ Beneficiary: I/We have no objection to TTK Officials visiting the hospital/Nursing Home to check details of treatment. TTK is 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 knowledge. I/We agree to pay the cost of hospitalization if authorization given by TPA becomes null & void due to wrong and incorrect information regarding the duration of ailments

PATIENT'S SIGNATURE

Toll Free Voice: 1800-425-8885

Toll Free Fax: 1800-425-2626

[Please see over leaf for instructions]

USEFUL INFORMATION FOR HOSPITALS : (This side NOT to be faxed to TTK)

1. Pre-authorization form should be filled with due care. All columns are required to be completed in block letters.
2. It should reach us at least 4 days prior to likely date of admission. In case of emergency admission within 4 hours after admission
3. Authorization could be denied if complete information is not provided or queries are not replied to
4. Discrepancy in information provided by the hospital records found at the time of claim may render the authorization given **null and void** and the amount claimed by the hospital would have to be settled by the insured to the hospital
5. Any change in Diagnosis / Treatment plan should be intimated **before discharge of the patient**
6. All queries by us need a reply at the earliest or at least **within 24 hrs.**
7. Request for authorization /enhancement will not be entertained **after discharge of the patient**
8. We promise to fax 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 authorization or denial for cashless access.

IN CASE OF ANY DIFFICULTY KINDLY CONTACT:

BRANCHES (9 AM ~ 6 PM)	TEL NO.	FAX NO. (DURING OFFICE HOURS)
Head Office (24 / 7 Coverage provided)	080 – 41155030 / 31 / 33	080 – 41155032
Bangalore	080 – 41255794 / 95 / 96	080 – 41255797
Chennai	044 – 42894444	044 – 42024343
Coimbatore	0422 – 2491335 / 2491341	0422 – 2491309
Hyderabad	040 – 23881000	040-23881015
Kochi	0484 – 2358683 / 2358805 / 3095042	0484 – 2359269
New Delhi	011 - 23715781 – 84	011 – 43586341
Pune	020 – 20245330	
Mumbai	022 – 29240700	022 – 29240880
Kolkata	033 – 22421232 / 22421225	033 – 22421232
Vizag	0891-6670197	0891-2723959