DEDICATED ADMINISTRATION SERVICES PVT. LTD.

NO. 46/1/3, NARAHENPITA ROAD,3RD FLOOR,
NAWALA 11222,SRI LANKA

REQUEST FOR PRE-AUTHORIZATION FOR CASHLESS HOSPITALIZATION

NAME OF HOSPITAL :
HOSPITAL ADDRESS :
HOSPITAL ID :

TO BE FILLED BY INSURED/PATIENT

NAME OF THE PATIENT :
GENDER : MALE / FEMALE AGE YEAR : MONTH : DATE OF BIRTH :
CONTACT NO : DAS ID CARD NO :
POLICY NO :
NAME OF CORPORATE : EMPLOYEE ID :
CURRENTLY DO YOU HAVE ANY OTHER MEDICLAIM/HEALTH INSURANCE : YES/NO
IF YES NAME OF THE INSURANCE COMPANY :
DO YOU HAVE A FAMILY PHYSICIAN : YES/NO NAME OF FAMILY PHYSICIAN :
CONTACT NO OF FAMILY PHYSICIAN :

I / WE HERE BY DECLARE THAT THESE PARTICULARS ARE TRUE & CORRECT TO THE BEST OF MY/OUR KNOWLEDGE AND BELIEF.

SIGNATURE OF INSURED PERSON/ FAMILY MEMBER

TO BE FILLED BY THE TREATING DOCTOR/HOSPITAL

NAME OF TREATING DOCTOR : CONTACT NO :
NAME OF ILLNESS/DISEASE
PRESENTING COMPLAINTS : RELEVENT CLINICAL FINDINGS :
LABORATORY FINDINGS :
DURATION OF PRESENT AILMENT : YEAR : MONTH : DAYS:
DATE OF FIRST CONSULTATION :

PAST HISTORY OF PRESENTING ILLNESS IF ANY :

PROVISIONAL/FINAL DIAGNOSIS : ICD 10 CODE :
PROPOSED LINE OF TREATMENT-CONSERVATIVE/SURGICAL

CONSERVATIVE MANAGEMENT SUMMARY WITH ROUTE OF ADMINISTRATION OF DRUGS:

NAME OF SURGERY : ANAESTHESIA TYPE :

MANDATORY PAST HISTORY

DISEASE	YES/NO	DURATION		
		YEAR	MONTH	DAYS
DIABETES				
HEART DISEASE				
HYPERTENSION				
HYPERLIPIDEMIAS				
OSTEOARTHRITIS				
ASTHMA/ COPD/ BRONCHITIS				
ANY HIV OR STD/ RELATED AILMENTS				
MALIGNANCY				
ALCOHOL OR DRUG ABUSE				

ANY OTHER AILMENT :

TO BE FILLED UP IN CASE OF ACCIDENT ONLY

1. IS IT RTA: YES/NO 2.DATE OF INJURY : 3. REPORTED TO POLICE : YES/NO 4. MLC:

5. INJURY CAUSED DUE TO SUBSTANCE ABUSE/ALCOHOL CONSUMPTION : YES/NO 6. TEST CONDUCTED TO ESTABLISH THIS: YES/NO

TO BE FILLED UP IN CASE OF MATERNITY CLAIMS		
G : P: L : A :	EXPECTED DATE OF DELIVERY :	MODE OF DELIVERY :

ADMISSION DETAILS

DATE OF ADMISSION : _____ TIME OF ADMISSION : _____

ADMISSION TYPE:

PLANNED HOSPITALISATION/ ADMISSION THROUGH EMERGENCY/ REFFERED FROM ANOTHER HOSPITAL

ROOM TYPE AT THE TIME OF ADMISSION:

ICU/ HDU/ GENERAL WARD/ SINGLE CABIN/ TRIPLE SHARING

EXPECTED LENGTH OF STAY IN HOSPITAL:_____ (NO. OF DAYS)

EXPECTED HOSPITALISATION EXPENSE WITH ITEMWISE BREAK UP	
EXPENSE TYPE	**AMOUNT**
ADMINISTRATIVE CHARGES	
ROOM RENT	
ICU/ HDU/ NICU CHARGES	
NURSING CHARGES	
PROFESSIONAL CHARGES	
OT CHARGE	
DRUGS/MEDICINES/THERAPEUTICS COST	
INVESTIGATION CHARGES	
IMPLANTS/PROSTHETICS COST	
OTHERS	
ANY PACKAGE	
TOTAL	

DECLARATION BY THE TREATING DOCTOR

I HEREBY CERTIFY THAT MR./MRS./MISS_____ IS UNDER MY TREATMENT AND ALL THE TREATMENT RELATED INFORMATION & CLINICAL HISTORY PROVIDED ABOVE ARE TRUE & CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

DATE :

_____
SIGNATURE OF TREATING DOCTOR

_____(REGD NO)

DECLARATION BY HOSPITAL

- WE HEREBY DECLARE THAT WE SHALL ABIDE BY THE TERMS AND CONDITIONS OF THE SLA SIGNED WITH DAS.
- ALL VALID ORIGINAL DOCUMENTS DULY COUNTERSIGNED BY THE INSURED/ PATIENT WILL BE SENT TO DAS WITHIN 7 DAYS OF PATIENT'S DISCHARGE

DATE :

_____
(SIGNATURE OF HOSPITAL AUTHORITY WITH STAMP)