RELIANCE
General Insurance

reliancegeneral.co.in
1800 3009

PRE-AUTHORIZATION REQUEST FORM

Part 1 Insured Details

Insured Name: _____ Claim No _____

Mobile No.: _____ Policy No.: _____

E-mail Id _____

If Group Policy, Company Name: _____ Employee id _____

PAN No. _____ UID Aadhar No. _____

Source of Funds ☐ Business ☐ Profession ☐ Salary ☐ Agricultural Income ☐ Savings ☐ Others

Monthly Income: ☐ Upto ₹ 20,000 ☐ ₹ 20,001 to ₹ 50,000 ☐ ₹ 50,001 to ₹ 1,00,000 ☐ ₹ 1,00,000 and above

Part 2 Patient Details

Patient Name: _____

Patient UHID _____ Age: _____ yrs DOB: dd/mm/yy Gender: ☐ Male ☐ Female

Patient Mobile No.: _____ Patient Email id: _____

Relation with insured: ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Son ☐ Daughter ☐ Others _____

Address: _____

City; _____ Pin Code _____

Attendant Name: _____

Attendant Mobile no.: _____ Attendant email id _____

Part 3 Service Provide Details

Hospital Name: _____ Hospital Code: _____

Hospital Address: _____

City: _____ Pin Code _____

Contact Details (Hospital Employee)	Treating Doctor's Details
Name:	Name: Dr.
Telephone no./Mobile no.	Qualification:
Fax No.:	Registration No.:
E-mail Id	Mobile No.:

Part 4 Case Information (filled by treating doctor)

Presenting Complaint _____

Duration _____ Date of first onset/Consult _____

H/O of past illness related to present complaint _____

Relevant Clinical findings _____

Investigation findings _____

Provisional Diagnosis _____

Treatment Plan : ☐ Medical ☐ Surgical

In case of Maternity

Obstetric History G____ P____ L____ A____

LMP_____ EDD._____

In case to Injury/RTA/Self Injury

Under Influence of Alcohol/Drug abuse ☐ Yes ☐ No

Attached Copy of ☐ MLC ☐ FIR ☐ PI

MLC/FIR Number: _____ Place: _____

Past Medical History		Duration/Details
HTN	☐ Y ☐ N	
IHD/CAD	☐ Y ☐ N	
Diabetes	☐ Y ☐ N	
Asthma/COPD/TB	☐ Y ☐ N	
Paralysis/CVA/Epilepsy	☐ Y ☐ N	
Arthritis	☐ Y ☐ N	
Cancer/Tumor/Cyst	☐ Y ☐ N	
STD/HIV	☐ Y ☐ N	
Alcohol/Drug abuse	☐ Y ☐ N	
Psychiatric condition	☐ Y ☐ N	
Others	☐ Y ☐ N	

R Care Health: Reliance General Insurance, No.1-89/3/B/40 to 42/ks/301, 3rd floor, Krishe Block, Krishe Sapphire, Madhapur, Hyderabad 500081.
Reliance General Insurance Company Limited.
Registered Office: 19, Reliance Centre, Walchand Hirachand Marg, Ballard Estate, Mumbai 400001.
Corporate Office: 570, Rectifier House, Naigaum Cross Road, Next to Royal Industrial Estate, Wadala (W), Mumbai 400031.
Corporate Identity Number U66603MH2000PLC128300.
An ISO 9001:2008 Certified Company

Part 5 Billing details (filled by hospital)

Room Type: ☐ Single AC ☐ Single NON AC ☐ Twin Sharing AC ☐ Twin Sharing NON AC ☐ Multi-bed ☐ Others

Hospital Room Name.: _____

Type of Admission: ☐ Planned ☐ Emergency

Expected DOA: dd/mm/yy Length of Stay: _____ Days

Package Rate: ☐ Yes ☐ No

If Yes, Package Charges _____

Implant Charges _____

Remarks (if Any) _____

If Package not applicable,

Room Rent + Nursing Charges	
Surgeon/Assistant Surgeon Charges	
Anesthesia/Anesthetist Charges	
Operation theatre Charges	
Doctor's Visit Charges	
Investigation Charges	
Pharmacy Charges	
Implant Cost(if any)	
Total Cost of Hospitalization	

Consent by the Patient/Insured/Beneficiary: I/We understand that Cashless facility is not automatically guaranteed by RGICL. I/We have no objection to RGICL RCare Health Officials visiting the Hospital/Nursing Home to check the details of treatment and are 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 /our knowledge. I/We agree to pay the cost of the hospitalization, if authorization given by RGICL RCare Health becomes null and void, due to wrong and incorrect information.

Patient Signature: _____ Treating Doctor's Signature: _____

Date & Place: d d m m y y y y Stamp of Hospital: _____

Declaration

I hereby agree, affirm and declare that, the statements/information given/stated by me/us in this claim form is true, correct and complete. No material information which is relevant to the processing of the claim or which in any manner has a bearing on the claim has been with held or not disclosed. If I have given/made any false or fraudulent statement/information, or suppressed or concealed or in any manner failed to disclose material information, the policy shall be void & that I shall not be entitled to all/any rights to recover there under in respect of any or all claims, past, present or future. The receipt of this claim form/other supporting/related documents does not constitute or be deemed to constitute an agreement by the Company of the claim and the Company reserves the right to process or reject or require further/additional information in respect of the claim.

I hereby provide my consent and authorize Reliance General Insurance Company Ltd to seek any medical information from any hospital/Medical Practitioner who has at any time attended on the insured person.

Place: _____

Date: d d m m y y y y

_____
(Signature of Claimant)

IMPORTANT INFORMATION FOR HOSPITALS:

1. The member &/or the relative must notify the claim by calling RGICL call centre on Toll Free Voice : 1800-3009 (toll free) for “Claims Intimation”.
2. The call centre would take basic information about hospitalisation and upon successful registration generate a unique “Claim No.” which would be informed to the Insured/member/beneficiary immediately followed by a confirmatory SMS sent to the registered mobile number of the Insured.
3. The Pre-authorisation Request Form should be filled with due care including the unique number received by the Insured/member/beneficiary. All columns are required to be completed in block letters.
4. Completed Pre-authorization Request Form should be faxed to RCare-Health on 1800 3010 3001, or emailed at rgicl.rcarehealth@relianceada.com by the provider hospital. It should reach us at least 4 days prior to likely date of admission. In case of emergency admission Pre-Authorisation Request Form should be sent within 4 hours of admission.
5. Authorisation may be denied if complete information is not provided or queries are not replied to.
6. Discrepancy in the information provided by the hospital records found at the time of claim may render the authorisation given null and void and the amount claimed by the hospital would have to be settled by the Insured to the hospital.
7. Any changes in Diagnosis/Treatment plan should be intimated before discharge of the patient.
8. All queries raised by us need to be replied at the earliest & maximum within 24hrs.
9. Request for authorisation/enhancement will not be entertained after discharges of the patient.
10. We promise to fax the authorisation denial letter to the concerned hospital within 24 hours of complete and correct information being provided.
11. If clinical details provided are insufficient, there may be a delay in the authorisation or denial for cashless access.

RGI/MCOM/MI-14/PRE-AUTHORIZATION REQUEST FORM /VER. 1.3/300615

Email: rgicl.rcarehealth@relianceada.com