FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

TOLL FREE PHONE: 1800 103 8889
TOLL FREE FAX: 1800 103 9998
E MAIL: fgh@futuregenerali.in

PRE-AUTHORIZATION / CLAIM FORM FOR CASHLESS FACILITY

Patient Name: _____ _____ Health Card No._____

Gender: ☐ Male ☐ Female Age: _____ years Employee ID / Company Name _____

Patient Mobile No. _____Expected Admission Date: _____Expected Length of Stay: _____days

Name of Treating Doctor: _____ Mobile No: _____

Name of Family Physician: _____ Mobile No: _____

Name of Hospital: _____ City: _____ _____

Details of presenting complaints: _____

_____

Duration of Ailment: _____ years _____ months _____ days Provisional Diagnosis: _____

Relevant Clinical Findings: _____

_____

Investigations Report (if any): _____

Proposed line of treatment during hospitalization: _____

_____

PAST HISTORY OF THE FOLLOWING WITH DURATION:

Disease / Ailment	Past History	Duration/ other details
Hypertension / Cardiovascular Diseases	◯ Yes ◯ No	
Diabetes	◯ Yes ◯ No	
Asthma	◯ Yes ◯ No	
Any Surgery / Hospitalization	◯ Yes ◯ No	
Any Other Disease / Disability	◯ Yes ◯ No	
Obstetric History	◯ Yes ◯ No	Status : G P A L LMP:
Intentional Self Injury	◯ Yes ◯ No	
Accidental injury under the influence of Alcohol or Intoxicating Drugs	◯ Yes ◯ No	

Expense Head	Amount (Rs.)	Expense Head	Amount (Rs.)
Room Rent		Investigations	
Doctor / Consultant visit charges		Medicines / Consumables	
Surgeon charges		Equipment / Monitor etc	
Operation Theatre Charges		Miscellaneous (specify)	
Package Charges		Service Tax	

Estimate of Expenses: Total Amount Rs. _____ Class of accommodation: _____

I have completed this form and will be responsible for correctness of the medical information certified by me. I agree that Future Generali shall not be liable to make payment in case of any discrepancy between the preauthorization form and discharge summary.

Signature of Doctor / Hospital Representative: _____ Stamp / Seal of Hospital _____

BENEFICIARY CONSENT / AUTHORISATION

I have 'No Objection' to Future Generali obtaining details of my treatment / collecting documents and also hereby authorize Future Generali to pay the hospital bill from the sum insured of my insurance policy. I also undertake to pay all non medical / non authorized expenses in the hospital bill directly to the hospital at the time of discharge. In case Future Generali issues "Denial of cashless facility" to the provider, I have 'No objection' in paying the hospital bill for the treatment given. All information provided above is true and I agree that if I have provided any false or untrue information, my right to claim the expenses shall be absolutely forfeited.

NAME OF INSURED_____ **SIGNATURE OF INSURED:** _____

FUTURE GENERALI Health