ICICI Lombard
GENERAL INSURANCE

iHealth Care
Healthy and Happy

# ADMISSION REQUEST NOTE

## *PART A - TO BE FILLED IN BY THE INSURED*

| | | | |
|---|---|---|---|
| Policy No. | | Card No. | |
| Corporate Name | | Patient Name | |
| Employee ID | | Age | |
| Sex | | Mobile No. of Insured | |
| Address of the Insured (Including State, City, Pincode) | | Telephone No. of Insured | |

Signature of Insured : _____

## *PART A - TO BE FILLED IN BY THE DOCTOR / HOSPITAL*

| Treating Doctor Details | | | | | |
|---|---|---|---|---|---|
| Name | | Qualification | | | |
| Telephone No. | | Mobile No. | | | |
| **Hospital Details** | | | | | |
| Name & Address (including State, City, Pincode) | | | | | |
| Telephone No. | | Fax No. | | | |
| Presenting Complaints | | | | | |
| Clinical Findings | | Past History | | | |
| Provisional Diagnosis | | Treatment Plan | | Medical | |
| Investigations Findings | | | | Surgical | |
| Particulars | Details | Particulars | | Yes/No | Since When |
| Expected Date of Admission | | Hypertension | | Yes/No | |
| Expected Length of Stay (In days) | | Diabetes | | Yes/No | |
| Class of accommodation | | Coronary Heart Disease | | Yes/No | |
| Room Rent + Nursing Charges | | Any other Heart Ailment | | Yes/No | |
| Investigation Charges | | Paralysis / Stroke | | Yes/No | |
| Medicine Charges | | Cancer | | Yes/No | |
| Surgeon / Asst Surgeon Charges | | Arthritis | | Yes/No | |
| Anesthesia + OT Charges Doctor Visit Charges | | STD / HIV Alcohol/Durg abuse/ | | Yes/No | |
| | | Intoxication | | Yes/No | |
| Cost of Implants (If Any), with Name | | Other (If Any) | | Yes/No | |
| Package Rate (If Any) | | Maternity | | Yes/No | If yes -details below* |
| Total Expected Cost of Hospitalization (Rs.) : | | Accident | | Yes/No | If yes -details below* |

| Maternity Details | Obstertric History | Menstrual History | G | P | A | I | LMP | EDD |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |

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

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

ICICI LOMBARD will not be held liable for the payment to the event of any discrepancy between the facts presented at the time of admission & in final documents submission.

I have No. Objection to ICICI LOMBARD obtaining details of my treatments/collecting documents and also hereby authorize ICICI LOMBARD to pay the hospital bill & reimburse itself/receive the amount from my claim receivable from my insurance company. If my claim is rejected, I/we (the patient) will pay for the hospital & related expenses should this authorization become null & void due to wrong and / or misleading and / or incorrect information regarding the duration of ailments and / or other historical information regarding my (patients) health status. I acknowledge and agree that information provided by me are true and up to the best of my knowledge.

Mailing Address : ICICI Lombard General Insurance Company Limited - i Health Care, TGV Manisons, 6th Floor, Plot No. 6-2-1012, Khairatabad, Hyderabad - 500 004.
Toll Free Number : 1800 209 8888 • Toll Free Fax Number : 1800-209-8880 • Fax Number : 040 - 66989160 / 61
• Email us : ihealthcare@icicilombard.com • Website : www.icicilombard.com



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