WAPMED TPA Services Co.

Phone: 2166217/8, Fax: 2166231

PREAUTHORISATION FORM/INITIAL INTIMATION LETTER

Member's Details (*compulsory fields)	**Network Hospital Details**
Patient's Name: Gender: Age:	Name of the Hospital:
*Patient UHID Number:	Location:
*Policy Number:	*Phone: *Fax:
Name of the main member:	Name of the first Dr. consulted:
*Contact No:	Admission ☐ Daycare surgery ☐ CT/MRI ☐
If Corporate, name of the corporate:	Dental ☐ Physiotherapy ☐ OPD ☐
To be filled in by the patient / family member / attendant:	
If the policy is a renewal policy year in which the policy was first taken:	
Have you ever made any claim: Yes / No. If Yes, the claim was settled / rejected (Tick the appropriate)	

INSURED CONSENT/AUTHORIZATION

I have 'No Objection' to WAPMED obtaining details of my treatment / collecting documents and I also hereby authorize WAPMED to pay the treatment bill and reimburse itself / receive the amount from my claim receivable from my Insurance company. If my claim is rejected, I here by undertake to pay Network Provider/WAPMED the expenses incurred on my treatment/consultation.

Date & Place **Signature of insured**

Note-Benefits under direct billing facility depends on the Insurance cover chosen by the member.

Kindly provide Complete details to avoid Denials.

To be filled by the treating doctor in Utmost Good Faith

Present complaint / ailments with duration:	
History of past illness relevant to present illness:	
In Case of Accident Incidence History:	
Whether present complaint / ailment is a complication of pre-existing disease / surgery: Yes / No (Please tick the appropriate)	If Yes, please specify:
Provisional / Differential diagnosis:	**Proposed line of treatment:**
Is the patient suffering from any of the following: (Tick appropriate) a. Diabetes: Yes/No If yes, since: b. Hypertension: Yes/No If yes, since: c. Heart Disease: Yes/No If yes, since: d. COPD: Yes/No If yes, since: e. Any other co-existing ailment: If yes, since: (Please specify)	**To be filled in for maternity cases:** a. Gravida: / Fertility treatment taken for the present pregnancy Yes/No (Please tick the appropriate) b. Para: c. Living : d. Abortions: e. Death: LMP: EDD:
Clinical Findings: BP: Pulse: Temp: CVS: RS: CNS: P/A: Others:	Likely date of admission: Approximate duration of stay: Class of accommodation: Approximate Expense:

Break up of Approximate Hospital Expenses:	
Room Rent (Per Day):	Professional Charges:
Medicines & Cosumables:	Investigation Charges:
Surgical Expenses:	Total Expense:
Signature of Treating Doctor: Name: Phone Number(s):	Registration Number: Rubber Stamp:

N.B: Additional information may be called for before authorising direct billing facility

IF THE SPACE IS INSUFFICIENT PLEASE ATTACH ADDITIONAL SHEETS ON HOSPITAL / CONSULTANT LETTERHEAD