Cashless Authorization

ApolloMunich HEALTH INSURANCE

www.apollomunichinsurance.com

Member's Details (* compulsory fields)
Patient's Name:
Sex: Age:
*Member ID:
*Policy Number:
Name of the main member:
If Corporate, name of the corporate:

Network Hospital Details
Name of the Hospital:
City:
Phone: Fax:
Name of the first Doctor consulted:

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 (Please tick the appropriate)	
INSURED CONSENT/AUTHORIZATION I have 'No Objection' to Apollo Munich Health obtaining details of my treatment/ collecting documents and also hereby authorize Apollo Munich Health to pay the hospital bill. If my claim is rejected, I here by undertake to pay Apollo Munich Health the amount paid by them to the hospital. The Consent is also final discharge for hospitalization part of the claim where it has affected the payment. I reserve the right to submit pre /post hospitalization to other claims separately as and when required and as per the policy terms and conditions. Date & Place Signature of insured **Please Note that hospitalization for treatment of following conditions is not payable. Convalescence, general debility, rundown condition or rest cure, congenital external disease or defects or anomalies, sterility, venereal disease, intentional self injury and use of intoxicating drugs/ alcohol. All conditions directly or indirectly caused to or associated with any syndrome or condition commonly referred to as AIDS. Admission for Investigation / Evaluation is not covered.	Address: Tel No.: Mobile No.: E-mail ID:

To be filled in by the treating doctor:

Present complaint / ailments with duration:		
History of past illness relevant to present illness:		
Whether present complaint / ailment is a complication of pre-existing disease/ surgery: Yes / No (Please tick the appropriate)		If Yes, please specify:
Personal History: (Please tick the appropriate) Alcoholism ❑ Smoking ❑ Tobacco chewing ❑ Ghutka chewing ❑ Since:		
Provisional / Differential diagnosis:		Proposed line of treatment:
Is the patient suffering from any of the following: (Please tick the appropriate)		To be filled in for maternity cases:
a. Diabetes: Yes/No	If yes, since:	a. Gravida:
b. Hypertension: Yes/No	If yes, since:	b. Para:
c. Heart Disease: Yes/No	If yes, since:	c. Living Children:
d. COPD: Yes/No	If yes, since:	d. Abortions:
e. Any other chronic ailment: Yes/No		e. Death:
If Yes (Please specify):	Since:	LMP: EDD:
Clinical Findings:		
BP:	P/R:	Likely date of admission:
Temp:	CVS:	Approximate Duration of Stay:
RS:	CNS:	Class of Accommodation:
P/A:	Others:	Approximate expenses:
In case of RTA: Is the patient under the influence of alcohol / any other narcotic substance: Yes / No (Please tick the appropriate). Please enclose the MLC copy.		

Name of Treating Doctor:

Registration Number: Signature of Treating Doctor:

Phone Number(s): Rubber Stamp:

N.B: Additional information may be called for before authorizing cashless. If space is insufficient, please attach additional sheets on hospital letterhead

We would be happy to assist you. For any help contact us at: E-mail : customerservice@apollomunichinsurance.com Toll Free : 1800-102-0333

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