

# ANNEXURE FOR PREAUTH CLAIMS

Dear Policyholder,

Please fill the following information along with the cashless form for your medical insurance policy.

Policy No.

Membership Number

Hospital Id   
(To be filled by hospital)

**DOCUMENT CHECKLIST:**

- I. Copy of Photo ID, address proof and recent photo of patient. (for Valid proof of documents kindly refer KYC documents list)  
KYC documents list includes PAN Card/Driving License/Voter Id. Card/Aadhar Card
- II. Past illness records (With duration of symptoms) if any
- III. First and subsequent consultation paper along with admission note.
- IV. Complete medical history along with supporting investigation reports.
- V. In case of accident, MLC/FIR copy (if applicable)
- VI. Claim consent letter

All documents mentioned above to be submitted along with the completed filled cashless form. Insurer may require further documents to process the request.

Name of the Proposer/insured

Contact No.

Signature

Name of the TPA coordinator

Date:

Place:

Signature

## Consent Letter

To,

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Medical Superintendent

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I, Mr./Ms \_\_\_\_\_ Age \_\_\_\_\_ Resident

of \_\_\_\_\_ State \_\_\_\_\_ Hereby

give my willful consent to Mr/ Dr \_\_\_\_\_ of Max Bupa Health

Insurance Company Limited to verify and collect necessary documents/ statements including but not limited to certified copies of medical records from your esteemed hospital for the purpose of settlement of my Insurance claim.

My other relevant details are provided below;

**Detail of Insured:-**

**DOA:-**

**DOD:-**

**MRD/ Indoor/ IP No:-**

**Policy No:-**

I request you to provide all the information/ documents as required by Max Bupa Health Insurance Company Ltd.

**Name:-**

**Signature/ Thumb Impression**

**Witness Name & Signature**

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