ERICSON INSURANCE TPA PVT. LTD.

4TH Floor, New Vijay Cinema Building, S.T. Road, Chembur, Mumbai-71
Website: www.ericsontpa.com E mail: care@ericsontpa.com
Tel. No: 022-25280280 Fax No: 022-25270200

Credit request Form

Patient details - TO BE FILLED IN BY TREATING CONSULTANT

Name: Shri/Smt/Kum: ____Age: ____yrs. Sex: _____________

Mobile no. ________________ Resi. Tel _________________

UHID. No: ____________________________ Corporate Name/ EMP Code: ____________________________________

Name of Treating Doctor/Designation: ____

Doctor's Tel No: ________________________

Name of Hospital / Nursing Home: ____

Name of Family Physician: ____ Tel No.: _______________________

Presenting Complaints: ____

History of Presenting complaints:____

Duration of presenting complaints: ____

Relevant clinical findings : ____

____

Relevant past history & treatment: ____

Investigation Reports (attach separate sheet): -____

Provisional/Final Diagnosis: ____

Proposed Treatment Plan: Diagnostic ☐ Medical management ☐ Surgical management ☐

Particulars	Details
Date of admission	
Approximate expenses	
Room Rent	
Class of accommodation with Room no.	
Approximate duration of stay	
Investigation Charges	

Particulars	Details
Doctor / Surgeon Fees/ Anesthesia	
OT Charges	
Cost of Implant/Lens	
Medicines	
Package Rate(GIPSA/Agreed package)	
Total Amount	

Particulars	Yes/ No	Since When
Hypertension		
IHD		
Osteoarthritis		
COPD/ Bronchial Asthma		
Any other Chronic Disorder		

Particulars	Yes/ No	Since When
Diabetes		
Heart Diseases (Date of First episode)		
Cancer		
Alcohol/Drug abuse		
Maternity cases: Gravida______Para_____Living _____ Abortions ______LMP_____		

In c/o Accidents:
Details of occurrence:
Influence of alcohol / any other drugs: **Yes / No**
Whether MLC/FIR done: Yes / No

Part 2-Hospital Declaration

We hereby solemnly declare that Ericson Insurance TPA will not be held liable for the payment in the event of any discrepancy between the facts presented at the time of admission & in final documents submission.

Signature & Stamp of Treating Doctor: _________________**Rubber Stamp of Hospital & Signature** ______________

Part 3- Declaration of Insured

I hereby solemnly authorize Ericson Insurance TPA to furnish all the necessary details from the hospital related to my hospitalization .Also hereby authorize 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.

Name: ____

Signature:_____________________