REQUEST FOR CASHLESS HOSPITALISATION FOR HEALTH INSURANCE POLICY PART – C (Revised)

(TO BE FILLED IN BLOCK LETTERS)

DETAILS OF THE THIRD PARTY ADMINISTRATOR/ INSURER/ HOSPITAL:

a. Name of TPA/Insurance company: _____

b. Toll free phone number: _____

c. Toll free fax: _____

d. Name of Hospital: _____

i. Address _____
ii. Rohini ID _____
iii. e-mail id _____

TO BE FILLED BY INSURED/PATIENT

A. Name of the Patient: _____

B. Gender: ☐ Male ☐ Female ☐ Third Gender

C. Age: (Years) / (Month)

D. Date of Birth: (DD/MM/YYYY)

E. Contact number: _____

F. Contact number of attending Relative: _____

G. Insured Card ID number: _____

H. Policy number/Name of Corporate: _____

I. Employee ID: _____

J. Currently do you have any other mediclaim /health insurance: ☐ Yes ☐ No

i.Company Name: _____
ii.Give Details: _____

K: Do you have a family Physician: ☐ Yes ☐ No

L: Name of the Family Physician: _____

M: Contact number, if any: _____

N: Current Address of Insured Patient: _____

O: Occupation of Insured Patient: _____

(PLEASE COMPLETE DECLARATION OF THIS FORM)

TO BE FILLED BY TREATING DOCTOR/HOSPITAL

A: Name of the treating Doctor: _____

B: Contact number: _____

C: Nature of Illness/Disease with presenting complaint: _____

D: Relevant Critical Findings: _____

E: Duration of the present ailment _____ Days

i. Date of First consultation: DD/MM/YYYY
ii. Past history of present ailment, if any _____

F: Provisional diagnosis: _____

i. ICD 10 code _____

G: Proposed line of treatment:

i. Medical Management ( )
ii. Surgical Management ( )
iii. Intensive care ( )
iv. Investigation ( )
v. Non-allopathic treatment ( )

H: If investigation and/or Medical Management, provide details _____

i. Route of Drug Administration _____

I: If surgical, name of surgery _____

i. ICD 10 PCS code _____

J: If other treatment, provide details _____

K: How did injury occur _____

L: In case of accident

i. Is it RTA: ☐ Yes ☐ No
ii. Date of Injury: (DD/MM/YYYY)
iii. Report to Police ☐ Yes ☐ No
iv. FIR NO _____
v. Injury /Disease caused due to substance abuse/alcohol consumption ☐ Yes ☐ No
vi. Test conducted to establish this (if yes, attach report) ☐ Yes ☐ No

m. In case of Maternity ☐ G ☐ P ☐ L ☐ A

i. expected date of Delivery DD/MM/YYYY

DETAILS OF PATIENT ADMITTED

A. Date of admission (DD/MM/YYYY)

B. Time of admission (HH : MM)

C. Is this an emergency/planned hospitalization event: Emergency ☐ Planned ☐

D. Mandatory Past History of any chronic illness — If yes (Since month/year)

i. Diabetes _____
ii. Heart disease _____
iii. Hypertension _____
iv. Hyperlipidemias _____
v. Osteoarthritis _____
vi. Asthma/COPD/Bronchitis _____
vii. Cancer _____
viii. Alcohol/Drug abuse _____
ix. Any HIV/ or STD Related ailment _____
x. Any other ailment, give details _____

E. Expected number of Days/stay in hospital _____ Days

F. Days in ICU _____ Days

G. Room Type

H. Per day room rent+nursing and service charges+ patients diet _____

I. Expected cost of investigation + diagnostic _____

J. ICU charges _____

K. OT charges _____

L. Professional fees Surgeon + Anesthetist Fees + consultation Charges: _____

M. Medicines + Consumables + Cost of Implants (if applicable please specify) _____

N. Other hospital expenses if any _____

O. All-inclusive package charges if any applicable _____

P. Sum Total expected cost of hospitalization _____

DECLARATION

(Please read very carefully)

We confirm having read understood and agreed to the Declarations of this form

a. Name of the treating doctor _____
b. Qualification: _____
c. Registration number with State code _____

Hospital Seal
(Must include Hospital ID)

Patient/Insured Name and Sign

DECLARATION BY THE PATIENT / REPRESENTATIVE

a. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Insurer/T.P.A after the discharge. I agree to sign on the Final Bill & the Discharge Summary, before my discharge.

b. Payment to hospital is governed by the terms and conditions of the policy. In case the Insurer / TPA is not liable to settle the hospital bill, I undertake to settle the bill as per the terms and conditions of the policy.

c. All non-medical expenses and expenses not relevant to current hospitalization and the amounts over & above the limit authorized by the Insurer/T.P.A not governed by the terms and conditions of the policy will be paid by me.

d. I hereby declare to abide by the terms and conditions of the policy and if at any time the facts disclosed by me are found to be false or incorrect I forfeit my claim and agree to indemnify the Insurer / T.P.A

e. I agree and understand that T.P.A is in no way warranting the service of the hospital & that the Insurer / TPA is in no way guaranteeing that the services provided by the hospital will be of a particular quality or standard.

f. I hereby warrant the truth of the forgoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppression or concealment with respect to the claim, my right to claim reimbursement of the said expenses shall be absolutely forfeited.

g. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer / TPA.

h. "I/We authorize Insurance Company/TPA to contact me/us through mobile/email for any update on this claim".

a) Patient's / Insured's Name: _____

b) Contact number: _____ e-mail Id (optional) _____

d) Patient's / Insured's Signature: _____

Date: _____ Time: _____

HOSPITAL DECLARATION

a. We have no objection to any authorized TPA / Insurance Company official verifying documents pertaining to hospitalization.

b. All valid original documents duly countersigned by the insured / patient as per the checklist below will be sent to TPA / Insurance Company within 7 days of the patient's discharge.

c. We agree that TPA / Insurance Company will not be liable to make the payment in the event of any discrepancy between the facts in this form and discharge summary or other documents.

d. The patient declaration has been signed by the patient or by his representative in our presence.

e. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications.

f. We will abide by the terms and conditions agreed in the MOU.

g. We confirm that no additional amount would be collected from the insured in excess of Agreed Package Rates except costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility/ choosing separate line of treatment which is not envisaged/considered in package).

h. We confirm that no recoveries would be made from the deposit amount collected from the Insured except for costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility/ choosing separate line of treatment which is not envisaged/considered in package).

i. In the event of unauthorized recovery of any additional amount from the Insured in excess of Agreed Package Rates, the authorized TPA / Insurance Company reserves the right to recover the same from us (the Network Provider) and/or take necessary action, as provided under the MoU or applicable laws.

Hospital Seal

Doctor's Signature

Date: Time:

Cashless Authorization Letter

(Part-D)

Claim Number: ..... (Please quote this number for all further correspondence) Date: DD/MM/YYYY

Authorization is valid for admission up to .....(date)

ABC Hospital Address…….. ……. …….. Rohini Id:	Name of Insurance Company : Name of TPA : Proposer Name : Patient's Member ID/TPA/Insurer Id of the Patient : Relation with Proposer :

Dear Sir /Madam ,

This has reference to the pre-authorization request submitted on ..... We hereby authorize cashless facility as per details mentioned below:

Patient Name :	Age :	Gender :
Policy Number :	Expected Date of Admission :	
Policy Period :	Expected Date of Discharge :	
Room category : Eligible Room Category as per T&C of Policy Contract:	Estimated length of stay :	
Provisional Diagnosis :	Proposed line of treatment :	

Authorization Details:-

Date & Time	Reference number	Amount	Status
dd/mm/yyyy – hh:mm			
dd/mm/yyyy – hh:mm			

Total Authorized amount:- Rs ……..(In words)

Authorization Remarks :

……..

Hospital Agreed Tariff:

I. **Package case**
Agreed Package Rate ……..

II. Non-package Case:

i. Room Rent/day .....
ii. ICU Rent/day
iii. Nursing Charges/day.....
Iv. Consultant Visit Charges/day.....
v. Surgeon's fee/OT/Anaesthetist.....
vi. Others (specify) -------

Authorization Summary:

Total Bill Amount : (INR)

*Other Deductions : (INR) (At the time of Final Authorization)

Discount : (INR) (At the time of Final Authorization)

Co-Pay : (INR)

Deductibles : (INR)

Total Authorised Amount: : (INR)

Amount to be paid by Insured : (INR)(At the time of Final Authorization)

***Other Deduction Details:**

S.no	Description	Bill Amount	Deducted Amount	Admissible Amount	Deduction Reason

Terms and Conditions of Authorization:

1. Cashless Authorization letter issued on the basis of information provided in Pre- Authorization form. In case misrepresentation/concealment of the facts, any material difference/ deviation/ discrepancy in information is observed in discharge summary/ IPD records then cashless authorization shall stand null & void. At any point of claim processing Insurer or TPA reserves right to raise queries for any other document to ascertain admissibility of claim.
2. KYC (Know your customer) details of proposer/employee/Beneficiary are mandatory for claim payout above Rs 1 lakh.
3. Network provider shall not collect any additional amount from the individual in excess of Agreed Package Rates except costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility/ choosing separate line of treatment which is not envisaged/considered in package).
4. Network Provider shall not make any recovery from the deposit amount collected from the Insured except for costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility/ choosing separate line of treatment which is not envisaged/considered in package).

5. In the event of unauthorized recovery of any additional amount from the Insured in excess of Agreed Package Rates, the authorized TPA / Insurance Company reserves the right to recover the same or get the same refunded to the policyholder from the Network Provider and/or take necessary action, as provided under the MoU.
6. Where a treatment/procedure is to be carried out by a doctor/surgeon of insured's choice (not empaneled with the hospital), Network Provider may give treatment after obtaining specific consent of policyholder.
7. Differential Costs borne by policyholder may be reimbursed by insurers subject to the terms and conditions of the policy.

DOCUMENTS TO BE PROVIDED BY THE HOSPITAL IN SUPPORT OF THE CLAIM

1. Detailed Discharge Summary and all Bills from the hospital

2. Cash Memos from the Hospitals / Chemists supported by proper prescription.

3. Diagnostic Test Reports and Receipts supported by note from the attending Medical Practitioner / Surgeon recommending such Diagnostic supported by note from the attending Medical Practitioner / Surgeon recommending such diagnostic tests.

4. Surgeon's Certificate stating nature of operation performed and Surgeon's Bill and Receipt.

5. Certificates from attending Medical Practitioner / Surgeon giving patient's condition and advice on discharge.

Name of the Product .....and UIN No .....: - Important Policy terms & conditions (sub-limits/co-pay/deductible etc)

Authorized signatory :
(Insurer/TPA)

Address: