IRDA protocols for the Hospitals

Provider Services- Cashless Facility Admission Procedure

The insured shall be provided treatment free of cost for all such ailments covered under the policy within the limits / sub-limits and the sum insured, i.e., not specifically excluded under the policy. The Provider shall be reimbursed as per the tariff agreed under the service level agreement for different treatments or procedures. The procedure to be followed for providing cashless facility shall be:

I. Pre-authorization Procedure - Planned Admissions:

1. Request for hospitalization shall be forwarded by the provider immediately after obtaining due details from the treating doctor in the pre-authorization form prescribed by the Authority i.e. "request for authorization letter" (RAL). The RAL shall be sent electronically along with all the relevant details in the electronic form to the 24-hour authorization /cashless department of the insurer or its representative TPA along with contact details of treating physician and the insured. The insurer's or its representative TPA's medical team may consult the treating physician or the insured, if necessary.
2. If the treating physician of the provider identifies any disease or ailment as pre-existing, the treating physician shall record it and also inform the insured immediately.
3. In the cases where the symptoms appear vague / no effective diagnosis is arrived at, the medical team of the insurer or its representative TPA may consult with treating physician /insured, if necessary.
4. The RAL shall reach the authorization department of insurer or its representative TPA 7 days prior to the expected date of admission, in case of planned admission.
5. If "clause 3"above is not followed, the clarification for the delay needs to be forwarded along with the request for authorization.
6. The RAL form shall be dully filled with clearly mentioning Yes or No and/or the details as required. The form shall not be sent with nil or blanks replies.
7. The guarantee o f payment shall be given only for the medically necessary treatment cost of the ailment covered and mentioned in the request for hospitalization. Non covered items i.e. non-medical items which are specifically excluded in the policy, like Telephone usage, food provided to relatives/attendants, Provider registration fees etc shall be collected directly from the insured.
8. The authorization letter by the insurer or its representative TPA shall clearly indicate the amount agreed for providing cashless facility for hospitalization.
9. In event of the cost of treatment increasing, the the provider may check the availability of further limit with the insurer or its representative TPA.
10. When the cost of treatment exceeds the authorized limit, request for enhancement of authorization limit shall be made immediately during hospitalization using the same format as for the initial pre-authorization. The request for enhancement shall be evaluated based on the availability of further limits and may require to provide valid reasons for the same. No enhancement of limit is possible after discharge of insured.
11. Further the insurer shall accept or decline such additional expenses within a maximum of 24 hours of receiving the request for enhancement. Absence of receiving the reply from the insurer within 24 hours shall be construed as denial of the additional amount.
12. In case the insured has opted for a higher accommodation / facility than the one eligible under the policy, the provider shall explain orally the effect o f such option and also take a written consent from the insured at the time of admission as regard to owing the

responsibility o f such expenses by the insured including the proportionate expenses which have a direct bearing due to up gradation o f room accommodation/facility. In all such cases the insurer shall pay for the expenses which are based on the eligibility limits o f the insured. However provider may charge any advance amount/security deposit from the insured only in such cases where the insured has opted for an upgraded facility to the extent of the amounts to be collected from the insured.
13. Insurance company guarantees payment only after receipt of RAL and the necessary medical details. The Authorization Letter (AL) shall be issued within 48hours of receiving the RAL.
14. In case the ailment is not covered or given medical data is not sufficient for the medical team of authorization department to confirm the eligibility, insurer or its representative TPA shall seek further clarification/ information immediately.
15. Authorization letter [AL] shall mention the authorization number and the amount guaranteed for the procedure.
16. In case the balance sum available is considerably less than the cost of treatment, provider shall follow their norms of deposit/running bills etc. However, provider shall only charge the balance amount over and above the amount authorized under the health insurance policy against the package or treatment from the insured.
17. Once the insured is to be discharged, the provider shall make a final request for the pre-authorization for any residual amount along with the standard discharge summary and the standard billing format. Once the provider receives final pre-authorization for a specific amount, the insured shall be allowed to get discharged by paying the difference between the pre-authorised amount and actual bill, if any. Insurer, upon receipt of the complete bills and documents, shall make payments of the guaranteed amount to the provider directly.
18. Due to any reason if the insured does not avail treatment at the Provider after the pre-authorization is released the Provider shall return the amount to the insurer immediately.
19. All the payments in respect of pre-authorised amounts shall be made electronically by the insurer to the provider as early as possible but not later than a week, provided all the necessary electronic claim documents are received by the insurer.
20. Denial of authorization (DAL) for cashless is by no means denial of treatment by the health facility. The provider shall deal with such case as per their normal rules and regulations.
21. Insurer shall not be liable for payments to the providers in case the information provided in the “request for authorization letter” and subsequent documents during the course of authorization, is found incorrect or not disclosed.
22. Provider, Insurer and its representative TPA shall ensure that the procedure specified in this Schedule is strictly complied in all respects.

II. Pre-authorization Procedure - Emergency Admissions:

1. In case of emergencies also, the procedure specified in I (1), (2) and (3) shall be followed.
2. The insurer or its representative TPA may continue to discuss with treating doctor till conclusion of eligibility of coverage is arrived at. However, any life saving, limb saving, sight saving, emergency medical attention cannot be withheld or delayed for the purpose

of waiting for pre-authorization. Provider meanwhile may consider treating him by taking a token deposit or as per their norms.
3. Once a pre-authorization is issued after ascertaining the coverage, provider shall refund the deposit amount to the insured if taken barring a token amount to take care of non covered expenses.

III. Pre-authorization Procedure - RTA / MLCs:

1. If requesting a pre-authorisation for any potential medico-legal case including Road Traffic Accidents, the Provider shall indicate the same in the relevant section of the standard form.
2. In case of a road traffic accident and or a medico legal case, if the victim was under the influence of alcohol or inebriating drugs or any other addictive substance or does intentional self injury, it is mandatory for the Provider to inform this circumstance of emergency to the insurer or its representative TPA.

IV. Authorization letter (AL):

1. Authorization letter shall mention the amount, guaranteed class of admission, eligibility, of the patient or various sub limits for rooms and board, surgical fees etc. wherever applicable, as per the benefit plan for the patient.
2. The Authorization letter will also mention validity of dates for admission and number of days allowed for hospitalization, if any. The Provider shall see that these rules are strictly followed; else the AL will be considered null and void.
3. In the event the room category, if any, is not available the same shall be informed to the insurer or its representative TPA and the insured. For such cases, if the insured is admitted to a class of accommodation higher than what he is eligible for, the provider shall collect the necessary difference, if any, in charges from the insured.
4. The AL has a limited period of validity - which is 15 days from the date of sending the authorization.
5. AL is not an unconditional guarantee of payment. It is conditional on facts presented - when the facts change the guarantee changes.

V. Reauthorization:

1. Where there is a change in the line of treatment - a fresh authorization shall be obtained from the insurer immediately - this is called a reauthorization.
2. The same pre-authorization form shall be used for the reauthorization, and the same turnaround times as specified shall apply.

VI. Discharge:

1. The following documents shall be included in the list of documents to be sent along with the claim form to the insurer or its representative TPA. These shall not be given to the insured.
a. Original pre authorization request form,
b. Original authorization letter,
c. Original investigation repots,
Schedule-I
d. All original prescription & pharmacy receipt etc
2. Where the insured requires the discharge card/reports he or she can be asked to take photocopies of the same at his or her own expenses and these have to be clearly stamped as "Duplicate & originals are submitted to insurer".
3. The discharge card/Summary shall mention the duration of ailment and duration of other disorders like hypertension or diabetes and operative notes in case of surgeries. The clinical detail shall be sufficiently and justifiably informative. In addition, the Provider shall provide all the relevant details pertaining to past treatment availed by the insured in the Provider.

4. Signature of the insured on final Provider bill shall be obtained.
5. In the event of death or incapacitation of the insured, the signature of the nominee or any of insured's of the family who represents the insured as such subject to reasonable satisfaction of Provider shall be sufficient for the insurer to consider the claim.
6. Standard Claim form duly filled in shall be presented to the insured for signing and identity of the insured shall be confirmed by the provider.

Billing:

1. The Provider shall submit original invoices directly to insurer or its representative TPA and such invoices shall contain, at the minimum, following information:
a. the insured's full name and date of birth;
b. the policy number;
c. the insured's address;
d. the admitting consultant;
e. the date of admission and discharge;
f. the procedure performed and procedure code according to ICD-10 PCS or any other code as specified by the Authority from time to time;
g. the diagnosis at the time treatment and diagnosis code according to ICD-10 or any other code as specified by the Authority from time to time;
h. whether this is an interim or final bill/account;
i. the description of each Service performed, together with associated Charges,
j. the agreed standard billing codes associated with each Service performed and dates on which items of Service were provide; and.
k. the insured's signature (in original).
2. The Provider shall submit the following documents with the final invoice:
a. copy of pre-authorization letter;
b. fully completed claim form or the relevant claim section of the pre-authorization letter, signed by the insured and the treating consultant for the treatment performed;
c. original and complete discharge summary in standard form and billing form in the standard form, including the treating Consultant's operative notes;
d. original investigation reports with corresponding prescription/request;
e. pharmacy bill with corresponding prescription/request:
f. any other statutory documentary evidence required under law or by the insured's policy; and
g. photocopy of the insured's photo identification (e.g. voter's Smart card/ ID card, passport or driving license etc).
3. The Provider shall submit the final invoice and all supporting documentation required within 2 days of the discharge date.

STANDARD DISCHARGE SUMMARY:

1. **Components of standardization:**
a. List of standard contents in the discharge summary
b. Standard guidelines for preparing a discharge summary so that the interpretation of the terms in the document and the information provided is Uniform.

2. Standard Contents of Discharge Summary Format:

a. Patient's Name*:
b. Telephone No / Mobile No*:
c. IPDNo:
d. Admission No:
e. Treating Consultant/s Name, contact numbers and Department/Specialty :
f. Date of Admission with Time :
g. Date of Discharge with Time :
h. MLC No/FIRNo*:
i. Provisional Diagnosis at the time of Admission:
j. Final Diagnosis at the time of Discharge:
k. ICD-10 code(s) or any other codes, as recommended by the Authority, for Final diagnosis*:
1. Presenting Complaints with Duration and Reason for Admission:
m. Summary of Presenting Illness:
n. Key findings, on physical examination at the time of admission:
o. History of alcoholism, tobacco or substance abuse, if any:
p. Significant Past Medical and Surgical History, if any*:
q. Family History if significant/relevant to diagnosis or treatment:
r. Summary of key investigations during Hospitalization*:
s. Course in the Hospital including complications if any*:
t. Advice on Discharge*:
u. Name & Signature of treating Consultant/ Authorized Team Doctor:
v. Name & Signature of Patient / Attendant*:
* refer to guide notes below:

3. GUIDE NOTES FOR FILLING DISCHARGE SUMMARY FORMAT:

a. The patient's name shall be the official name as appearing in the insurance policy document and the attendants should be made aware that it cannot be changed subsequently, because in some cases the attendants give the nick names which are different from documented names. As a matter of abundant precaution, all personal information should be shown to the patient/attendant and validated with their signatures.
b. The contact numbers shall be specifically those of the patient and if pertaining to attendant, the same should be mentioned.
c. Where applicable, copy of MLC/FIR needs to be attached
d. Desirable not mandatory
e. Significant past medical and surgical history shall be relevant to present ailment and shall provide the summary of treatment previously taken, reports of relevant tests conducted during that period. In case history is not given by patient, it should be specified as to who provided the same. **Schedule-III**
f. Summary of key investigations shall appear chronologically consolidated for each type of investigation. If an investigation does not seem to be a logical requirement for the main disease/line of treatment, the admitting consultant should justify the reason for carrying out such test/investigation.
g. The course in the hospital shall specify the line of treatment, medications administered, operative procedure carried out and if any complications arise during course in the hospital, the same should be specified. If opinion from another doctor from outside hospital is obtained, reason for same should be mentioned and also who decided to take opinion i.e.whether the admitting and treating consultant wanted the opinion as additional expertise or the patient relatives wanted the opinion for their reassurance.
h. Discharge medication, precautions, diet regime, follow up consultation etc should be specified. If patient suffers from any allergy, the same shall be mentioned.
i. The signatures/Thumb impression in the Discharge Summary shall be that of the patient because generally the patient is discharged after having improved. In other cases like Death summary or transfer

notes in case of terminal illness, the attendant can sign, the inability of the patient to sign should be recorded by the attending doctor.

Schedule-IV

STANDARD FORMAT FOR PROVIDER BILLS

1. Components of standardization: Standardization involves three components:

i. Bill Format
ii. Codes for billing items and nomenclature
iii. Standard guidelines for preparing the bills.

2. Format Specified: The bill is expected to be in two formats.

i. The summary bill and
ii. The detailed breakup of the bills.

3. Explanation and Guidelines - Summary Bill

i. The summary format is annexed in the Schedule-IV A
ii. The Bill shall be generated on the letter head of the provider and in A4 size to aid scanning.
iii. The summary bill shall not have any additional items (only 9)
iv. The provider has to mention the service tax number in case they charge service tax to the insurance company.
v. The payer mentioned in the bill has to be necessarily the insurance company and not the TPA.
vi. In case of package charged for any procedure/treatment, the provider is expected to mention the amount in serial no 9 only. Items beyond the package are to be mentioned in serial numbers 1 to 8.
vii. The patient/attendant signature is mandatory on the summary bill format shall be as below:

Field Name	Remarks
Provider Name	Legal entity name and not the trade name
Provider Registration Number	Registration number of the provider with local authorities. once the clinical establishments (registration and regulation) bill, 2007 is passed, then registration number under this act
Address	Address of the Facility where member is admitted. A provider can have more than one facility.
IP No	Unique number identifying the particular hospitalization of the member
Patient Name	Full name of the patient

Payer Name	Name of the Insurance company with whom the member is insured. In case of cash patient then the field is to be left blank. If the bill is raised to more than one insurer then the primary insurer who has given cashless is to be mentioned. The name of insurance company needs to be mentioned and not the TPA.
Member address	Full address of the member
Bill Number	Bill number of the provider
Bill Date	Date on which the bill is generated.
PAN Number	PAN Number – Mandatory
Service Tax Regn No	Registration number from service tax authorities. Mandatory in case service tax is charged in the bill
Date of admission	Date of admission of the member in case of IPD cases. In case of Day care procedures, this is the date of procedure
Date of discharge	Date of discharge of the member in case of IPD cases. In case of Day care procedures, this is the date of procedure(same as date of admission)
Bed Number	Bed number in which the patient is admitted. In case the member is admitted under more than one bed number, all the numbers have to be mentioned.
SL No 1 of billing Summary	All items under the primary head Rs. '100000' in the detailed bill have to be summarized into this. In case the procedure is packages, then only bills amount beyond the package needs to be mentioned here.
SL No 2 of billing Summary	All items under the primary head Rs.'200000' in the detailed bill have to be summarized into this. In case the procedure is packages, then only bills amount beyond the package needs to be

	mentioned here.
SL No 3 of billing Summary	All items under the primary head Rs. '300000' in the detailed bill have to be summarized into this. In case the procedure is packages, then only bills amount beyond the package needs to be mentioned here.
SL No 4 of billing Summary	All items under the primary head Rs.'400000' in the detailed bill have to be summarized into this. In case the procedure is packages, then only bills amount beyond the package needs to be mentioned here.
SL No 5 of billing Summary	All items under the primary head Rs.'500000' in the detailed bill have to be summarized into this. In case the procedure is packages, then only bills amount beyond the package needs to be mentioned here.
SL No 6 of billing Summary	All items under the primary head Rs.'600000' in the detailed bill have to be summarized into this. In case the procedure is packages, then only bills amount beyond the package needs to be mentioned here.
SL No 7 of billing Summary	All items under the primary head Rs.'700000' in the detailed bill have to be summarized into this. In case the procedure is packages, then only bills amount beyond the package needs to be mentioned here.
SL No 8 of billing Summary	All items under the primary head Rs.'800000' in the detailed bill have to be summarized into this. In case the procedure is packages, then only bills amount beyond the package needs to be mentioned here.
SL No 9 of billing Summary	All items under the primary head Rs.'900000' in the detailed bill have to be

	summarized into this. If more than one procedure is done, the total amount of the two procedures needs to be summarized
Total Bill amount	Sum total of all items 1 to 9 in the bill
Amount paid by the member	Amount of bill paid by the member including co-pay, deductible, non-medical items etc incl discount offered to member, if any.
Amount charged to Payer	Amount payable by Insurance company
Discount Amount	Amount offered as discount to the insurance company
Service tax	Service Tax chargeable to insurance company
Amount Payable	Total amount payable by insurance company including service tax
Amount in words	Above amount in words for the sake of clarity
Patients signature	Signature of the patient or the attendant of the patient needs to be mandatorily taken
Authorized signatory	The signature of the authorized signatory at the provider

4. Explanation and Guidelines – Detailed Breakup of the Bill

i. The summary format is annexed in Schedule-IV-B

ii. The Bill shall be generated on the letter head of the provider and in A4 size paper to aid scanning.

iii. The billing has to be done at level 2 or 3

iv. In case of medicines/consumables, the relevant level code has to be mentioned (40100, 401002) and the text should indicate the actual medicine used

v. If providers have outsourced the pharmacy to external vendors, in such cases the providers can attach the original bills separately. However, the summary of this original bill has to be mentioned in the summary bill.

vi. In case of pharmacy returns the same code originally used is to be used with a negative sign in the units.

vii. In case of cancellation of any service the same code originally used is to be used with a negative sign indicating reversal.

viii. The date on which the service is rendered is to be mentioned in the bill. This would be
   a. the date of requisition in case of investigations
   b. date of consultation for professional fees
   c. date of requisition in case of pharmacy/consumables irrespective of when they were used
   d. date of return of pharmacy items for pharmacy returns

ix. The additional guidelines to fill the summary format shall be as below, except that the first section of the bill is same as the bill summary referred in 3 above.

Field Name	**Remarks**
Date	Date on which service is rendered. For example, this is the date of investigation, date of procedure etc.
Code	Level 2 or 3 code of the billing item as per the codes(Part II[8])
Particulars	Text explanation of the item charged
Rate	Per unit price (per day room rent, per consultation charge)
Unit	No of units charged(hours, days, number as appropriate)
Amount	Rate*unit(s)

1. **Schedules:**

Schedule-IV A

SUMMARY BILL FORMAT

Provider Name	.....	Bill Number	.....
Provider registration No.		Bill Date	
Address		PAN Number	
IP No		Service Tax Regn No	
Patient Name		Date of admission	
Payer Name	XXXX Insurance Company Ltd	Date of Discharge	
Member Address		Bed Number	

Billing Summary

Sl No	Primary Code	Particulars	Amount
1	100000	Room & Nursing Charges	
2	200000	ICU Charges	
3	300000	OT Charges	
4	400000	Medicine & Consumables	
5	500000	Professional Fees'	
6	600000	Investigation Charges	
7	700000	Ambulance Charges	
8	800000	Miscellaneous Charges	
9	900000	Package Charges	

Total Bill Amount	0
Amount paid by member	0
Amount charged to Payer	0
Discount Amount	0
Service Tax	0
Amount Payable	0
Amount in Words	Rupees Zero Only

Patients Signature

Authorized Signatory

Schedule-IV B

DETAILED BREAKUP FORMAT

PART-I

Provider Name	....	Bill Number	....
Provider registration No.		Bill Date	
Address		PAN Number	
IP No		Service Tax Regn No	
Patient Name		Date of admission	
Payer Name		Date of Discharge	
Member Address		Bed Number	

Billing Details

Sl No	Date	Code	Particulars	Rate	Nos(Unit)	Amount
1		101001	General Ward Charges	500	1	500.00
2		401001	XXX medicine	50	2	100.00
3		401001	XXX Medicine – return	50	-1	-50.00

PART-II:

Level 1 Code	Level 1	Level 2 Code	Level 2	Level 3 Code	Level 3	Remarks
100000	Room & Nursing Charges					
100000	Room & Nursing Charges	101000	Room Charges			
100000	Room & Nursing Charges	101000	Room Charges	101001	General Ward charges	
100000	Room & Nursing Charges	101000	Room Charges	101002	Semi-private room charges	
100000	Room & Nursing Charges	101000	Room Charges	101003	Single Room charges	
100000	Room & Nursing Charges	101000	Room Charges	101004	Single Deluxe room charges	
100000	Room & Nursing Charges	101000	Room Charges	101005	Deluxe room charges	
100000	Room & Nursing Charges	101000	Room Charges	101006	Suite charges	
100000	Room & Nursing Charges	101000	Room Charges	101007	Electricity charges	
100000	Room & Nursing Charges	101000	Room Charges	101008	Bed sheet charges	
100000	Room & Nursing Charges	101000	Room Charges	101009	Hot water charges	
100000	Room & Nursing Charges	101000	Room Charges	101010	Establishment Charges	
100000	Room & Nursing Charges	101000	Room Charges	101011	Alpha/Water Bed Charges	
100000	Room & Nursing Charges	101000	Room Charges	101012	Attendant Bed Charges	
100000	Room & Nursing Charges	102000	Nursing charges			
100000	Room & Nursing Charges	102000	Nursing charges	102001	Nursing fees	
100000	Room & Nursing Charges	102000	Nursing charges	102002	Dressing	
100000	Room & Nursing Charges	102000	Nursing charges	102003	Nebulization	
100000	Room & Nursing Charges	102000	Nursing charges	102004	Injection charges	
100000	Room & Nursing Charges	102000	Nursing charges	102005	Infusion pump charges	
100000	Room & Nursing Charges	102000	Nursing charges	102006	Aya Charges	
100000	Room & Nursing Charges	102000	Nursing charges	102007	Blood Transfusion Charges	
100000	Room & Nursing Charges	103000	Duty Doctor fee			
100000	Room & Nursing Charges	103000	Duty Doctor fee	103001	Duty Doctor fee	
100000	Room & Nursing Charges	103000	Duty Doctor fee	103002	RMO Fees	
100000	Room & Nursing Charges	104000	Monitor charges			
100000	Room & Nursing Charges	104000	Monitor charges	104001	Pulse Oxymeter charges	If used in normal Room
200000	ICU Charges					
200000	ICU Charges	201000	ICU Charges			
200000	ICU Charges	201000	ICU Charges	201001	Burns Ward	
200000	ICU Charges	201000	ICU Charges	201002	HDU charges	
200000	ICU Charges	201000	ICU Charges	201003	ICCU charges	
200000	ICU Charges	201000	ICU Charges	201004	Isolation ward charges	
200000	ICU Charges	201000	ICU Charges	201005	Neuro ICU charges	
200000	ICU Charges	201000	ICU Charges	201006	Pediatric/neonatal ICU charges	
200000	ICU Charges	201000	ICU Charges	201007	Post Operative ICU	
200000	ICU Charges	201000	ICU Charges	201008	Recovery Room	
200000	ICU Charges	201000	ICU Charges	201009	Surgical ICU	
200000	ICU Charges	202000	ICU Nursing charges			If ICU nursing charged seperatel y

200000	ICU Charges	202000	ICU Nursing charges	202001	Nursing fees	If ICU nursing charged seperately
200000	ICU Charges	202000	ICU Nursing charges	202002	Dressing	If ICU nursing charged seperately
200000	ICU Charges	202000	ICU Nursing charges	202003	Nebulization	If ICU nursing charged seperately
200000	ICU Charges	202000	ICU Nursing charges	202004	Injection charges	If ICU nursing charged seperately
200000	ICU Charges	202000	ICU Nursing charges	202005	Infusion pump charges	
200000	ICU Charges	203000	Monitor charges			
200000	ICU Charges	203000	Monitor charges	203001	Monitor charges	
200000	ICU Charges	203000	Monitor charges	203002	Pulse Oxymeter charges	If used in ICU
200000	ICU Charges	203000	Monitor charges	203003	Cardiac Monitor charges	
200000	ICU Charges	204000	Monitor charges	203004	IABP charges	
200000	ICU Charges	204000	Monitor charges	203005	Phototherapy Charges	
200000	ICU Charges	204000	ICU Supplies & equipment			
200000	ICU Charges	204000	ICU Supplies & equipment	204001	Oxygen charges	
200000	ICU Charges	204000	ICU Supplies & equipment	204002	Ventilator charges	
200000	ICU Charges	204000	ICU Supplies & equipment	204003	Suction pump charges	
200000	ICU Charges	204000	ICU Supplies & equipment	204004	Bipap charges	
200000	ICU Charges	204000	ICU Supplies & equipment	204005	Pacing Charges	Temporary Pacemaker
200000	ICU Charges	204000	ICU Supplies & equipment	204006	Defibrillator Charges	
300000	OT Charges					
300000	OT Charges	301000	OT rent			
300000	OT Charges	301000	OT rent	301001	Major OT charge	
300000	OT Charges	301000	OT rent	301002	Minor OT Charge	
300000	OT Charges	301000	OT rent	301003	Cath Lab Charges	
300000	OT Charges	301000	OT rent	301004	Theatre charges	
300000	OT Charges	301000	OT rent	301005	Labour Room Charges	
300000	OT Charges	302000	OT Equipment charges			

300000	OT Charges	302000	OT Equipment charges	302001	C-arm charges	
300000	OT Charges	302000	OT Equipment charges	302002	Endoscopy charges	
300000	OT Charges	302000	OT Equipment charges	302003	Laproscope charges	
300000	OT Charges	302000	OT Equipment charges	302004	Equipment charges	If not specified
300000	OT Charges	302000	OT Equipment charges	302005	Monitor charges	for OT monitoring
300000	OT Charges	302000	OT Equipment charges	302006	Instrument charges	for OT instruments
300000	OT Charges	303000	OT Drugs & Consumables			
300000	OT Charges	303000	OT Drugs & Consumables	303001	OT Drugs	
300000	OT Charges	303000	OT Drugs & Consumables	303002	Implants	
300000	OT Charges	303000	OT Drugs & Consumables	303003	OT Consumables	includes guidewires, catheter etc
300000	OT Charges	303000	OT Drugs & Consumables	303004	OT Materials	
300000	OT Charges	303000	OT Drugs & Consumables	303005	OT Gases	
300000	OT Charges	303000	OT Drugs & Consumables	303006	Anaesthetic drugs	
300000	OT Charges	304000	OT Sterlization			
300000	OT Charges	304000	OT Sterlization	304001	CSSD Charges	
400000	Medicine & Consumables charges					
400000	Medicine & Consumables charges	401000	Medicine & Consumables charges			
400000	Medicine & Consumables charges	401000	Medicine & Consumables charges	401001	Ward Medicines	OT drugs under OT charges
400000	Medicine & Consumables charges	401000	Medicine & Consumables charges	401002	Ward Consumables	
400000	Medicine & Consumables charges	401000	Medicine & Consumables charges	401003	Ward disposables	
400000	Medicine & Consumables charges	401000	Medicine & Consumables charges	401004	Ward Materials	
400000	Medicine & Consumables charges	401000	Medicine & Consumables charges	401005	Vaccination drugs	
500000	Professional fees charges					
500000	Professional fees charges	501000	Visit charges			

500000	Professional fees charges	501000	Visit charges	501001	Consultation Charges	
500000	Professional fees charges	501000	Visit charges	501002	Medical Supervision Charges	
500000	Professional fees charges	501000	Visit charges	501003	Professional fees	
500000	Professional fees charges	502000	Surgery Charges			
500000	Professional fees charges	502000	Surgery Charges	502001	Surgeons Charges	
500000	Professional fees charges	502000	Surgery Charges	502002	Assisstant Surgeons Fee	Would also include Standby Surgeon
500000	Professional fees charges	503000	Anaesthetists fee			
500000	Professional fees charges	503000	Anaesthetists fee	503001	Anaesthetists fee	
500000	Professional fees charges	503000	Anaesthetists fee	503002	OT standby charges	Providers charge for standby anaesthetist
500000	Professional fees charges	504000	Intensivist Charges	504000		
500000	Professional fees charges	505000	Technician Charges	505000	OT /Cath Lab Technician	
500000	Professional fees charges	505000	Physiotherapy			
500000	Professional fees charges	504000	Procedure charges			
500000	Professional fees charges	504000	Procedure charges	504001	Bedside procedures	Catheterization, Central IV Line, Tracheostomy, Venesection
500000	Professional fees charges	504000	Procedure charges	504002	Suture charges	
600000	Investigation Charges					
600000	Investigation Charges	601000	Bio Chemistry			Serum Sodium, Ueres etc
600000	Investigation Charges	602000	Cardiology charges			for procedures like echo, ECG etc
600000	Investigation Charges	603000	Haemotology charges			cross matching etc
600000	Investigation Charges	604000	Microbiology charges			blood culture, C&S
600000	Investigation Charges	605000	Neurology			for EMG, EEG etc

600000	Investigation Charges	606000	Nuclear medicine			PET CT, Bone scan etc
600000	Investigation Charges	607000	Pathology charges			
600000	Investigation Charges	608000	Radiology services			X-ra, CT, MRI etc
600000	Investigation Charges	609000	Serology charges			
600000	Investigation Charges	610000	Medical Genetics			Chrosom al Analysis etc
600000	Investigation Charges	611000	Profiles			Profiles instead of individua l tests (Lipid profile, LFT etc)
700000	Ambulance Charges					
700000	Ambulance Charges	701000	Ambulance Charges			
800000	Miscellaneous charges					
800000	Miscellaneous charges	801000	Admission charges			
800000	Miscellaneous charges	802000	Attendant food charges			
800000	Miscellaneous charges	803000	Patient food charges			
800000	Miscellaneous charges	804000	Registration charges			
800000	Miscellaneous charges	805000	MRD Charges			
800000	Miscellaneous charges	806000	Documentation charges			
800000	Miscellaneous charges	807000	Telephone charges			
800000	Miscellaneous charges	808000	Bio Medical Waste Charges			
800000	Miscellaneous charges	809000	Taxes		Luxury Tax/Surcharge/Service Charge	Excluding VAT & Service Tax
900000	Package Charges					To be used only in case of packages
900000	Package Charges	901000	Cardiac Surgery	ICD-10-PCS	CABG	To be used only in case of packages

900000	Package Charges	902000	CardiologyPackages	ICD-10-PCS	PTCA	To be used only in case of packages
900000	Package Charges	903000	Cath Lab	ICD-10-PCS	CAG	To be used only in case of packages
900000	Package Charges	904000	Dental Procedures	ICD-10-PCS	Root Canal Treatment	To be used only in case of packages
900000	Package Charges	905000	ENT	ICD-10-PCS	FESS	To be used only in case of packages
900000	Package Charges	906000	Gastroenterology	ICD-10-PCS	Gastrectomy - Partial	To be used only in case of packages
900000	Package Charges	907000	General Surgery	ICD-10-PCS	Inguinal hernia	To be used only in case of packages
900000	Package Charges	908000	Gynaecology	ICD-10-PCS	LSCS	To be used only in case of packages
900000	Package Charges	909000	Nephrology	ICD-10-PCS	Nephrectomy	To be used only in case of packages
900000	Package Charges	910000	Neuro Surgery	ICD-10-PCS	Craniotomy	To be used only in case of packages
900000	Package Charges	911000	Oncology Procedures	ICD-10-PCS	IMRT	To be used only in case of packages
900000	Package Charges	912000	Opthalmology procedures	ICD-10-PCS	Cataract	To be used only in case of packages

900000	Package Charges	913000	Orthopaedic Surgery	ICD-10-PCS	Bilateral TKR	To be used only in case of packages
900000	Package Charges	914000	Plastic Surgery	ICD-10-PCS	Skin Grafting	To be used only in case of packages
900000	Package Charges	915000	Pulmonology Packages	ICD-10-PCS	Pleural Tapping	To be used only in case of packages
900000	Package Charges	916000	Urology	ICD-10-PCS	ERCP	To be used only in case of packages
900000	Package Charges	917000	Vascular Surgery	ICD-10-PCS	Embolectomy	To be used only in case of packages

PLEASE FAX / SCAN PAGE 1 ONLY

REQUEST FOR CASHLESS HOSPITALISATION FOR MEDICAL INSURANCE POLICY

DETAILS OF THE THIRD PARTY ADMINISTRATOR (To be filled in block letters)

a) Name of TPA / Insurance company:

b) Toll free phone number:

c) Toll free FAX:

TO BE FILLED BY THE INSURED / PATIENT

a) Name of the Patient:

b) Gender: ☐ Male ☐ Female c) Age: Years [ ][ ] Months [ ][ ] d) Date of birth: [D][D] [M][M] [Y][Y][Y][Y]

e) Contact number: f) Insured card ID number:

g) Policy number / Name of corporate: h) Employee ID:

h) Currently do you have any other Mediclaim / Health insurance: ☐ Yes ☐ No Company Name:

Give details:

i) Do you have a family physician: ☐ Yes ☐ No j) Name of the family physician:

k) Contact number, if any: (PLEASE COMPLETE DECLARATION ON THE REVERSE SIDE OF THIS FORM)

TO BE FILLED BY THE TREATING DOCTOR / HOSPITAL

a) Name of the treating doctor: b) Contact number:

c) Nature of ILLNESS / Disease with presenting complaints:

d) Relevant clinical findings:

e) Duration of the present ailment: [ ][ ][ ] Days i. Date of first consultation: [D][D] [M][M] [Y][Y] ii. Past history of present ailment if any:

f) Provisional diagnosis:

i. ICD 10 Code: [ ][ ][ ][ ][ ][ ][ ]

g) Proposed line of treatment: ☐ Medical Management ☐ Surgical Management ☐ Intensive care ☐ Investigation ☐ Non allopathic treatment

h) If Investigation & / or Medical Management provide details:

i) Route of drug administration:

j) If Surgical, name of surgery:

i. ICD 10 PCS Code: [ ][ ][ ][ ][ ][ ][ ]

j) If other treatments provide details:

k) How did injury occur:

l) In case of accident: i. Is it RTA: ☐ Yes ☐ No ii. Date of injury: [D][D] [M][M] [ ][Y] iii. Reported 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: ☐ Yes ☐ No (If Yes attach reports)

l) In case of Maternity: ☐ G ☐ P ☐ L ☐ A Date of Delivery: [D][D] [M][M] [ ][Y]

Details of the patient admitted

a) Date of admission: [D][D] [M][M] [ ][Y] b) Time: [H][H] : [M][M]

c) Is this an emergency / a planned hospitalization event?: ☐ Emergency ☐ Planned

d) Expected no. of days stay in hospital: [ ][ ][ ] Days e) Room Type:

f) Per Day Room Rent + Nursing & Service Charges + Patient's Diet: Rs. [ ][ ][ ][ ][ ][ ][ ]

g) Expected cost for investigation + diagnostics: Rs. [ ][ ][ ][ ][ ][ ][ ]

h) ICU Charges: Rs. [ ][ ][ ][ ][ ][ ][ ]

i) OT Charges: Rs. [ ][ ][ ][ ][ ][ ][ ]

j) Professional fees Surgeon + Anesthetist Fees + consultation Charges: Rs. [ ][ ][ ][ ][ ][ ][ ]

k) Medicines + Consumables + Cost of Implants (if applicable please specify) . Other hospital expenses if any: Rs. [ ][ ][ ][ ][ ][ ][ ]

l) All inclusive package charges if any applicable: Rs. [ ][ ][ ][ ][ ][ ][ ]

m) **Sum Total expected cost of hospitalization** **Rs.** [ ][ ][ ][ ][ ][ ][ ]

Mandatory: Past History of any chronic illness — **If yes, since (month / year)**

☐ Diabetes	[M][M]	[Y][Y]
☐ Heart Disease	[M][M]	[Y][Y]
☐ Hypertension	[M][M]	[Y][Y]
☐ Hyperlipidemias	[M][M]	[Y][Y]
☐ Osteoarthritis	[M][M]	[Y][Y]
☐ Asthma / COPD / Bronchitis	[M][M]	[Y][Y]
☐ Cancer	[M][M]	[Y][Y]
☐ Alcohol or drug abuse	[M][M]	[Y][Y]
☐ Any HIV or STD / Related ailments	[M][M]	[Y][Y]

Any other Ailment give details:

(PLEASE READ VERY CAREFULLY)

DECLARATION

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

a) Name of the treating doctor: [S][U][R][N][A][M][E][ ][ ][ ][F][I][R][S][T][ ][N][A][M][E][ ][ ][M][I][D][D][L][E][ ][ ][N][A][M][E][ ][ ]

b) Qualification: [ ][ ][ ][ ][ ][ ] c) Registration No. with State Code: [ ][ ][ ][ ][ ][ ][ ]

Hospital Seal (Must include Hospital ID)

Patient / Insured Name & Signature

(IMPORTANT PLEASE TURN OVER)

DECLARATION BY THE PATIENT / REPRESENTATIVE

1. 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.
2. 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.
3. 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.
4. 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.
5. 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.
6. 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.
7. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer / TPA.

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

b) **Contact number:** _____ d) **Patient's / Insured's Signature:** _____

HOSPITAL DECLARATION

1. We have no objection to any authorized TPA / Insurance Company official verifying documents pertaining to hospitalization.
2. 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.
3. All non medical expenses OR expenses not relevant to hospitalization or illness, OR expenses disallowed in the Authorization Letter of the TPA / Insurance Co, OR arising out of incorrect information in the pre-authorisation form will be collected from the patient.
4. 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.
5. The patient declaration has been signed by the patient or by his representative in our presence.
6. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications.
7. We will abide by the terms and conditions agreed in the MOU.

Hospital Seal **Doctor's Signature**

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. Receipts and Pathological Test Reports from Pathologists, supported by note from the attending Medical Practitioner / Surgeon recommending such pathological Tests.
4. Surgeon's Certificate stating nature of operation performed and Surgeon's Bill and Receipt.
5. Certificates from attending Medical Practitioner / Surgeon that the patient is fully cured.

ANNEXURE IV

List of Generally excluded in Hospitalisation Policy

SNO.	List of Expenses Generally Excluded ("Non-Medical") in Hospital Indemnity Policy -	SUGGESTIONS
	TOILETRIES/ COSMETICS/ PERSONAL COMFORT OR CONVENIENCE ITEMS	
1	HAIR REMOVAL CREAM	Not Payable
2	BABY CHARGES (UNLESS SPECIFIED/INDICATED)	Not Payable
3	BABY FOOD	Not Payable
4	BABY UTILITES CHARGES	Not Payable
5	BABY SET	Not Payable
6	BABY BOTTLES	Not Payable
7	BRUSH	Not Payable
8	COSY TOWEL	Not Payable
9	HAND WASH	Not Payable
10	MOISTURISER PASTE BRUSH	Not Payable
11	POWDER	Not Payable
12	RAZOR	Payable
13	SHOE COVER	Not Payable
14	BEAUTY SERVICES	Not Payable
15	BELTS/ BRACES	Essential and may be paid specifically for cases who have undergone surgery of thoracic or lumbar spine.
16	BUDS	Not Payable
17	BARBER CHARGES	Not Payable
18	CAPS	Not Payable
19	COLD PACK/HOT PACK	Not Payable
20	CARRY BAGS	Not Payable
21	CRADLE CHARGES	Not Payable
22	COMB	Not Payable
23	DISPOSABLES RAZORS CHARGES (for site preparations)	Payable
24	EAU-DE-COLOGNE / ROOM FRESHNERS	Not Payable
25	EYE PAD	Not Payable
26	EYE SHEILD	Not Payable
27	EMAIL / INTERNET CHARGES	Not Payable
28	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)	Not Payable
29	FOOT COVER	Not Payable
30	GOWN	Not Payable
31	LEGGINGS	Essential in bariatric and varicose vein surgery and should be considered for these conditions where surgery itself is payable.
32	LAUNDRY CHARGES	Not Payable
33	MINERAL WATER	Not Payable
34	OIL CHARGES	Not Payable
35	SANITARY PAD	Not Payable

36	SLIPPERS	Not Payable
37	TELEPHONE CHARGES	Not Payable
38	TISSUE PAPER	Not Payable
39	TOOTH PASTE	Not Payable
40	TOOTH BRUSH	Not Payable
41	GUEST SERVICES	Not Payable
42	BED PAN	Not Payable
43	BED UNDER PAD CHARGES	Not Payable
44	CAMERA COVER	Not Payable
45	CLINIPLAST	Not Payable
46	CREPE BANDAGE	Not Payable/ Payable by the patient
47	CURAPORE	Not Payable
48	DIAPER OF ANY TYPE	Not Payable
49	DVD, CD CHARGES	Not Payable (However if CD is specifically sought by Insurer/TPA then payable)
50	EYELET COLLAR	Not Payable
51	FACE MASK	Not Payable
52	FLEXI MASK	Not Payable
53	GAUSE SOFT	Not Payable
54	GAUZE	Not Payable
55	HAND HOLDER	Not Payable
56	HANSAPLAST/ ADHESIVE BANDAGES	Not Payable
57	INFANT FOOD	Not Payable
58	SLINGS	Reasonable costs for one sling in case of upper arm fractures should be considered
	ITEMS SPECIFICALLY EXCLUDED IN THE POLICIES	
59	WEIGHT CONTROL PROGRAMS/ SUPPLIES/ SERVICES	Exclusion in policy unless otherwise specified
60	COST OF SPECTACLES/ CONTACT LENSES/ HEARING AIDS ETC.,	Exclusion in policy unless otherwise specified
61	DENTAL TREATMENT EXPENSES THAT DO NOT REQUIRE HOSPITALISATION	Exclusion in policy unless otherwise specified
62	HORMONE REPLACEMENT THERAPY	Exclusion in policy unless otherwise specified
63	HOME VISIT CHARGES	Exclusion in policy unless otherwise specified
64	INFERTILITY/ SUBFERTILITY/ ASSISTED CONCEPTION PROCEDURE	Exclusion in policy unless otherwise specified
65	OBESITY (INCLUDING MORBID OBESITY) TREATMENT IF EXCLUDED IN POLICY	Exclusion in policy unless otherwise specified
66	PSYCHIATRIC & PSYCHOSOMATIC DISORDERS	Exclusion in policy unless otherwise specified
67	CORRECTIVE SURGERY FOR REFRACTIVE ERROR	Exclusion in policy unless otherwise specified
68	TREATMENT OF SEXUALLY TRANSMITTED DISEASES	Exclusion in policy unless otherwise specified

69	DONOR SCREENING CHARGES	Exclusion in policy unless otherwise specified
70	ADMISSION/REGISTRATION CHARGES	Exclusion in policy unless otherwise specified
71	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE	Exclusion in policy unless otherwise specified
72	EXPENSES FOR INVESTIGATION/ TREATMENT IRRELEVANT TO THE DISEASE FOR WHICH ADMITTED OR DIAGNOSED	Not Payable - Exclusion in policy unless otherwise specified
73	ANY EXPENSES WHEN THE PATIENT IS DIAGNOSED WITH RETRO VIRUS + OR SUFFERING FROM /HIV/ AIDS ETC IS DETECTED/ DIRECTLY OR INDIRECTLY	Not payable as per HIV/AIDS exclusion
74	STEM CELL IMPLANTATION/ SURGERY and storage	Not Payable except Bone Marrow Transplantation where covered by policy
	ITEMS WHICH FORM PART OF HOSPITAL SERVICES WHERE SEPARATE CONSUMABLES ARE NOT PAYABLE BUT THE SERVICE IS	
75	WARD AND THEATRE BOOKING CHARGES	Payable under OT Charges, not payable separately
76	ARTHROSCOPY & ENDOSCOPY INSTRUMENTS	Rental charged by the hospital payable. Purchase of Instruments not payable.
77	MICROSCOPE COVER	Payable under OT Charges, not separately
78	SURGICAL BLADES,HARMONIC SCALPEL,SHAVER	Payable under OT Charges, not separately
79	SURGICAL DRILL	Payable under OT Charges, not separately
80	EYE KIT	Payable under OT Charges, not separately
81	EYE DRAPE	Payable under OT Charges, not separately
82	X-RAY FILM	Payable under Radiology Charges, not as consumable
83	SPUTUM CUP	Payable under Investigation Charges, not as consumable
84	BOYLES APPARATUS CHARGES	Part of OT Charges, not seperately
85	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	Part of Cost of Blood, not payable
86	Antiseptic or disinfectant lotions	Not Payable-Part of Dressing Charges
87	BAND AIDS, BANDAGES, STERLILE INJECTIONS, NEEDLES, SYRINGES	Not Payable - Part of Dressing charges
88	COTTON	Not Payable-Part of Dressing Charges
89	COTTON BANDAGE	Not Payable- Part of Dressing Charges

90	MICROPORE/ SURGICAL TAPE	Not Payable-Payable by the patient when prescribed, otherwise included as Dressing Charges
91	BLADE	Not Payable
92	APRON	Not Payable -Part of Hospital Services/ Disposable linen to be part of OT/ICU chatges
93	TORNIQUET	Not Payable (service is charged by hospitals, consumables cannot be separately charged)
94	ORTHOBUNDLE, GYNAEC BUNDLE	Part of Dressing Charges
95	URINE CONTAINER	Not Payable
	ELEMENTS OF ROOM CHARGE	
96	LUXURY TAX	Actual tax levied by government is payable.Part of room charge for sub limits
97	HVAC	Part of room charge not payable separately
98	HOUSE KEEPING CHARGES	Part of room charge not payable separately
99	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	Part of room charge not payable separately
100	TELEVISION & AIR CONDITIONER CHARGES	Payable under room charges not if separately levied
101	SURCHARGES	Part of Room Charge, Not payable separately
102	ATTENDANT CHARGES	Not Payable - Part of Room Charges
103	IM IV INJECTION CHARGES	Part of nursing charges, not payable
104	CLEAN SHEET	Part of Laundry/Housekeeping not payable separately
105	EXTRA DIET OF PATIENT(OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	Patient Diet provided by hospital is payable
106	BLANKET/WARMER BLANKET	Not Payable- part of room charges
	ADMINISTRATIVE OR NON-MEDICAL CHARGES	
107	ADMISSION KIT	Not Payable
108	BIRTH CERTIFICATE	Not Payable
109	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES	Not Payable
110	CERTIFICATE CHARGES	Not Payable
111	COURIER CHARGES	Not Payable
112	CONVENYANCE CHARGES	Not Payable
113	DIABETIC CHART CHARGES	Not Payable

114	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES	Not Payable
115	DISCHARGE PROCEDURE CHARGES	Not Payable
116	DAILY CHART CHARGES	Not Payable
117	ENTRANCE PASS / VISITORS PASS CHARGES	Not Payable
118	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE	To be claimed by patient under Post Hosp where admissible
119	FILE OPENING CHARGES	Not Payable
120	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)	Not Payable
121	MEDICAL CERTIFICATE	Not Payable
122	MAINTAINANCE CHARGES	Not Payable
123	MEDICAL RECORDS	Not Payable
124	PREPARATION CHARGES	Not Payable
125	PHOTOCOPIES CHARGES	Not Payable
126	PATIENT IDENTIFICATION BAND / NAME TAG	Not Payable
127	WASHING CHARGES	Not Payable
128	MEDICINE BOX	Not Payable
129	MORTUARY CHARGES	Payable upto 24 hrs, shifting charges not payable
130	MEDICO LEGAL CASE CHARGES (MLC CHARGES)	Not Payable
	EXTERNAL DURABLE DEVICES	
131	WALKING AIDS CHARGES	Not Payable
132	BIPAP MACHINE	Not Payable
133	COMMODE	Not Payable
134	CPAP/ CAPD EQUIPMENTS	Device not payable
135	INFUSION PUMP - COST	Device not payable
136	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)	Not Payable
137	PULSEOXYMETER CHARGES	Device not payable
138	SPACER	Not Payable
139	SPIROMETRE	Device not payable
140	SPO2 PROBE	Not Payable
141	NEBULIZER KIT	Not Payable
142	STEAM INHALER	Not Payable
143	ARMSLING	Not Payable
144	THERMOMETER	Not Payable (paid by patient)
145	CERVICAL COLLAR	Not Payable
146	SPLINT	Not Payable
147	DIABETIC FOOT WEAR	Not Payable
148	KNEE BRACES (LONG/ SHORT/ HINGED)	Not Payable
149	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER	Not Payable
150	LUMBO SACRAL BELT	Essential and should be paid specifically for cases who have undergone surgery of lumbar spine.

151	NIMBUS BED OR WATER OR AIR BED CHARGES	Payable for any ICU patient requiring more than 3 days in ICU, all patients with paraplegia/quadriplegia for any reason and at reasonable cost of approximately Rs 200/ day
152	AMBULANCE COLLAR	Not Payable
153	AMBULANCE EQUIPMENT	Not Payable
154	MICROSHEILD	Not Payable
155	ABDOMINAL BINDER	Essential and should be paid in post surgery patients of major abdominal surgery including TAH, LSCS, incisional hernia repair, exploratory laparotomy for intestinal obstruction, liver transplant etc.
	ITEMS PAYABLE IF SUPPORTED BY A PRESCRIPTION	
156	BETADINE \ HYDROGEN PEROXIDE\SPIRIT\\ \ DISINFECTANTS ETC	May be payable when prescribed for patient, not payable for hospital use in OT or ward or for dressings in hospital
157	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES	Post hospitalization nursing charges not Payable
158	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES	Patient Diet provided by hospital is payable
159	SUGAR FREE Tablets	Payable -Sugar free variants of admissable medicines are not excluded
160	CREAMS POWDERS LOTIONS (Toileteries are not payable,only prescribed medical pharmaceuticals payable)	Payable when prescribed
161	Digestion gels	Payable when prescribed
162	ECG ELECTRODES	Upto 5 electrodes are required for every case visiting OT or ICU. For longer stay in ICU, may require a change and at least one set every second day must be payable.
163	GLOVES	Sterilized Gloves payable / unsterilized gloves not payable
164	HIV KIT	Payable - payable Pre operative screening
165	LISTERINE/ ANTISEPTIC MOUTHWASH	Payable when prescribed

166	LOZENGES	Payable when prescribed
167	MOUTH PAINT	Payable when prescribed
168	NEBULISATION KIT	If used during hospitalization is payable reasonably
169	NOVARAPID	Payable when prescribed
170	VOLINI GEL/ ANALGESIC GEL	Payable when prescribed
171	ZYTEE GEL	Payable when prescribed
172	VACCINATION CHARGES	Routine Vaccination not Payable / Post Bite Vaccination Payable
	PART OF HOSPITAL'S OWN COSTS AND NOT PAYABLE	
173	AHD	Not Payable - Part of Hospital's internal Cost
174	ALCOHOL SWABES	Not Payable - Part of Hospital's internal Cost
175	SCRUB SOLUTION/STERILLIUM	Not Payable - Part of Hospital's internal Cost
	OTHERS	
176	VACCINE CHARGES FOR BABY	Not Payable
177	AESTHETIC TREATMENT / SURGERY	Not Payable
178	TPA CHARGES	Not Payable
179	VISCO BELT CHARGES	Not Payable
180	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]	Not Payable
181	EXAMINATION GLOVES	Not payable
182	KIDNEY TRAY	Not Payable
183	MASK	Not Payable
184	OUNCE GLASS	Not Payable
185	OUTSTATION CONSULTANT'S/ SURGEON'S FEES	Not payable, except for telemedicine consultations where covered by policy
186	OXYGEN MASK	Not Payable
187	PAPER GLOVES	Not Payable
188	PELVIC TRACTION BELT	Should be payable in case of PIVD requiring traction as this is generally not reused
189	REFERAL DOCTOR'S FEES	Not Payable
190	ACCU CHECK (Glucometery/ Strips)	Not payable pre hospitilasation or post hospitalisation / Reports and Charts required/ Device not payable
191	PAN CAN	Not Payable
192	SOFNET	Not Payable
193	TROLLY COVER	Not Payable
194	UROMETER, URINE JUG	Not Payable
195	AMBULANCE	Payable-Ambulance from home to hospital or interhospital shifts is payable/ RTA as specific

		requirement is payable
196	TEGADERM / VASOFIX SAFETY	Payable - maximum of 3 in 48 hrs and then 1 in 24 hrs
197	URINE BAG	Payable where medicaly necessary till a reasonable cost - maximum 1 per 24 hrs
198	SOFTOVAC	Not Payable
199	STOCKINGS	Essential for ease like CABG etc. where it should be paid.

Amendment as on 04.07.2013

बीमा विनियामक और विकास प्राधिकरण
INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY

Ref: IRDA/HLT/REG/CIR/125/07/2013 3rd July, 2013

ALL LIFE AND NON-LIFE INSURANCE COMPANIES

(except AIC and ECGC) and

All TPAs

Re: Amendment to Guidelines on Standardization in Health Insurance

This is issued in terms of Section 14(2) of IRDA Act 1999 and has reference to Circular ref: IRDA/HLT/CIR/036/02/2013 dated 20/02/2013 regarding Guidelines on Standardization in Health Insurance. The following amendments may kindly be noted:-

A. Standard Definitions of terminology used in Health Insurance Policies

In terms of Regulation 5 (n) of the IRDA Health Insurance Regulations, 2013 and with reference to Para 1 of the above-mentioned circular dealing with standard defintions, the Authority hereby stipulates the following amended definitions while defining the respective terms in all health insurance policies:-

Sl No. 1. Accident

An accident is a sudden, unforeseen and involuntary event caused by external, visible and violent means.

Sl No 2. Co-payment

A co-payment is a cost-sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible claim amount. A co-payment does not reduce the Sum Insured.

Sl No 4. Deductible

Deductible is a cost-sharing requirement under a health insurance policy that provides that the insurer will not be liable for a specified rupee amount in case of

परिश्रम भवन, तीसरा तल, बशीरबाग, हैदराबाद-500 004. भारत
✆ : 91-040-2338 1100, फैक्स: 91-040-6682 3334
ई-मेल: irda@irda.gov.in वेब: www.irda.gov.in

Parisharam Bhavan, 3rd Floor, Basheer Bagh, Hyderabad-500 004. India.
Ph.: 91-040-2338 1100, Fax: 91-040-6682 3334
E-mail : irda@irda.gov.in Web.: www.irda.gov.in

indemnity policies and for a specified number of days/hours in case of hospital cash policies which will apply before any benefits are payable by the insurer. A deductible does not reduce the Sum Insured.

(Insurers to define whether the deductible is applicable per year, per life or per event and the specific deductible to be applied)

Sl No.5. Dependant child

This definition stands deleted.

Sl No. 8. Hospital

A hospital means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under:

--has qualified nursing staff under its employment round the clock;

--has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;

--has qualified medical practitioner(s) in charge round the clock;

--has a fully equipped operation theatre of its own where surgical procedures are carried out;

--maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

Sl No. 12. Medical Practitioner

A Medical Practitioner is a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of licence.'

(Insurance companies may specify additional or restrictive criteria to the above, e.g. that the registered practitioner should not be the insured or close family members)

Sl No.18. Reasonable Charges

*Term modified to '**Reasonable and Customary Charges**' and definition to read as such.*

Sl No.23a. Acute Condition

Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/illness/injury which leads to full recovery.

Sl No.23. Day Care Centre

A day care centre means any institution established for day care treatment of illness and/or injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under—

--has qualified nursing staff under its employment;

--has qualified medical practitioner/s in charge;

--has a fully equipped operation theatre of its own where surgical procedures are carried out;

--maintains daily records of patients and will make these accessible to the insurance company's authorized personnel

Sl No.28. Post Hospitalisation Medical Expenses

Medical Expenses incurred immediately after the insured person is discharged from the hospital provided that:

i. Such Medical Expenses are incurred for the same condition for which the insured person's hospitalization was required and
ii. The inpatient hospitalization claim for such hospitalization is admissible by the insurance company

Sl No. 29. Newborn baby

Newborn baby means baby born during the Policy Period and is aged between 1 day and 90 days, both days inclusive.

Sl No.30. Cumulative Bonus

Cumulative Bonus shall mean any increase in the Sum Insured granted by the insurer without an associated increase in premium.

Sl.No.31. Maternity Expenses

Maternity expenses shall include—(a). medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization).(b). expenses towards lawful medical termination of pregnancy during the policy period.

Sl No. 34a. Internal Congenital Anomaly

Congenital anomaly which is not in the visible and accessible parts of the body

Sl No. 34b. External Congenital Anomaly

Congenital anomaly which is in the visible and accessible parts of the body

Sl No.35. Unproven/Experimental treatment

Treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.

Sl No. 41. Contribution

Contribution is essentially the right of an insurer to call upon other insurers liable to the same insured to share the cost of an indemnity claim on a rateable proportion of Sum Insured.
This clause shall not apply to any Benefit offered on fixed benefit basis.

Sl No.44. Portability

Portability means transfer by an individual health insurance policyholder (including family cover) of the credit gained for pre-existing conditions and time-bound exclusions if he/she chooses to switch from one insurer to another.

Sl No.45. Room Rent

Means the amount charged by a hospital for the occupancy of a bed on per day (24 hours) basis and shall include associated medical expenses.

B. Standard Pre-authorisation and Claim form

With reference to Para 3 of the circular on Guidelines on Standardization in Health Insurance referred above, the Authority hereby makes the following amendments to the Pre-authorisation Form and the Claim Form respectively:

1. **Pre-authorisation form:**
   (a). Provision for capture of contact details of relative attending to the insured has been made.

2. **Claim form:**
   (a). The claim form is applicable for Health Insurance policies other than Personal Accident and Travel policies.
   (b). Under Part B of the form, the sub-heading should read as 'Additional details in case of non network hospital' instead of 'Details in case of non-network hospital'.

   The forms are attached.

   Insurers and Third Party Administrators are advised to make a note of the amendments and ensure necessary compliance.

(T.S. Vijayan)
Chairman

Encl: a/a.

CLAIM FORM – PART B
TO BE FILLED IN BY THE HOSPITAL

The issue of this Form is not to be taken as an admission of liability
Please include the original preauthorization request form in lieu of PART A

(To be filled in block letters)

SECTION A

DETAILS DF HOSPITAL

a) Name of the hospital:

b) Hospital ID: c) Type of Hospital: Network ☐ Non Network ☐ (If non network fill section E)

d) Name of the treating doctor:

e) Qualification: f) Registration No. with State Code: g) Phone No.

SECTION B

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient:

b) IP Registration Number: c) Gender: Male ☐ Female ☐ d) Age: Years Months e) Date of birth:

f) Date of Admission: g) Time: h) Date of Discharge: i) Time:

j) Type of Admission: Emergency ☐ Planned ☐ Day Care ☐ Maternity ☐ k) If Maternity i. Date of Delivery: ii. Gravida Status:

l) Status at time of discharge: Discharge to home ☐ Discharge to another hospital ☐ Deceased ☐ m) Total claimed amount

SECTION C

DETAILS OF AILMENT DIAGNDSED (PRIMARY)

a)	ICD 10 Codes	Description
i. Primary Diagnosis:	☐	
ii. Additional Diagnosis:		
iii. Co-morbidities:		
iv. Co-morbidities:		

b)	ICD 10 PCS	Description
i. Procedure 1:		
ii. Procedure 2:		
iii. Procedure 3:		
iv. Details of Procedure:		

d) Pre-authorization obtained: ☐ Yes ☐ No e) Pre-authorization Number:

f) If authorization by network hospital not obtained, give reason:

g) Hospitalization due to Injury: ☐ Yes ☐ No i. If Yes, give cause Self-inflicted ☐ Road Traffic Accident ☐ Substance abuse / alcohol consumption ☐

ii. If Injury due to Substance abuse / alcohol consumption, Test Conducted to establish this: ☐ Yes ☐ No (If Yes, attach reports) iii. If Medico legal: ☐ Yes ☐ No iv. Reported to Police: ☐ Yes ☐ No

v. FIR no. vi. If not reported to police give reason:

SECTION D

CLAIM DOCUMENTS SUBMITTED - CHECK LIST

- ☐ Claim Form duly signed
- ☐ Original Pre-authorization request
- ☐ Copy of the Pre-authorization approval letter
- ☐ Copy of photo ID card of patient verified by hospital
- ☐ Hospital Discharge summary
- ☐ Operation Theatre notes
- ☐ Hospital main bill
- ☐ Hospital break-up bill
- ☐ Investigation reports
- ☐ CT/MR/USG/HPE investigation reports
- ☐ Doctor's reference slip for investigation
- ☐ ECG
- ☐ Pharmacy bills
- ☐ MLC report & Police FIR
- ☐ Original death summary from hospital where applicable
- ☐ Any other, please specify

SECTION E

ADDITIONAL DETAILS IN CASE DF NDN NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)

a) Address of the Hospital:

City: State:

Pin Code: b)Phone No. c) Registration No. with State Code:

d) Hospital PAN: e) Number of Inpatient beds f) Facilities available in the hospital: i. OT : ☐ Yes ☐ No ii. ICU : ☐ Yes ☐ No

iii. Others :

SECTION F

DECLARATION BY THE HOSPITAL (PLEASE READ VERY CAREFULLY)

We hereby declare that the information furnished in this Claim Form is true & correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited.

Date:

Place: Signature and Seal of the Hospital Authority:

GUIDANCE FOR FILLING CLAIM FORM – PART B (To be filled in by the hospital)		
DATA ELEMENT	**DESCRIPTION**	**FORMAT**
SECTION A - DETAILS OF HOSPITAL		
a) Name of Hospital	Enter the name of hospital	Name of hospital in full
b) Hospital ID	Enter ID number of hospital	As allocated by the TPA
c) Type of Hospital	Indicate whether In network or non network hospital	Tick the right option
d) Name of treating doctor	Enter the name of the treating doctor	Name of doctor in full
e) Qualification	Enter the qualifications of the treating doctor	Abbreviations of educational qualifications
f) Registration No. with State Code	Enter the registration number of the doctor along with the state code	As allocated by the Medical Council of India
g) Phone No.	Enter the phone number of doctor	Include STD code with telephone number
SECTION B – DETAILS OF THE PATIENT ADMITTED		
a) Name of Patient	Enter the name of hospital	Name of hospital in full
b) IP Registration Number	Enter insurance provider registration number	As allotted by the insurance provider
c) Gender	Indicate Gender of the patient	Tick Male or Female
d) Age	Enter age of the patient	Number of years and months
e) Date of Birth	Enter date of admission	Use dd-mm-yy format
f) Date of Admission	Enter date of admission	Use dd-mm-yy format
g) Time	Enter time of admission	Use hh:mm format
h) Date of Discharge	Enter date of discharge	Use dd-mm-yy format
i) Time	Enter time of discharge	Use hh:mm format
j) Type of Admission	Indicate type of admission of patient	Tick the right option
k) If Maternity		
Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format
Gravida Status	Enter Gravida status if maternity	Use standard format
l) Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
m) Total claimed amount	Indicate the total claimed amount	In rupees (Do not enter paise values)
SECTION C – DETAILS OF AILMENT DIAGNOSED (PRIMARY)		
a) ICD 10 Code		
Primary Diagnosis	Enter the ICD 10 Code and description of the primary diagnosis	Standard Format and Open text
Additional Diagnosis	Enter the ICD 10 Code and description of the additional diagnosis	Standard Format and Open text
Co-morbidities	Enter the ICD 10 Code and description of the co-morbidities	Standard Format and Open text
b) ICD 10 PCS		
Procedure 1	Enter the ICD 10 PCS and description of the first procedure	Standard Format and Open text
Procedure 2	Enter the ICD 10 PCS and description of the second procedure	Standard Format and Open text
Procedure 3	Enter the ICD 10 PCS and description of the third procedure	Standard Format and Open text
Details of Procedure	Enter the details of the procedure	Open text
c) Pre-authorization obtained	Indicate whether pre-authorization obtained	Tick Yes or No
d) Pre-authorization Number	Enter pre-authorization number	As allotted by TPA
e) If authorization by network hospital not obtained, give reason	Enter reason for not obtaining pre-authorization number	Open text
f) Hospitalization due to injury	Indicate if hospitalization is due to injury	Tick Yes or No
Cause	Indicate cause of injury	Tick the right option
If injury due to substance abuse/alcohol consumption, test conducted to establish this	Indicate whether test conducted	Tick Yes or No
Medico Legal	Indicate whether injury is medico legal	Tick Yes or No
Reported To Police	Indicate whether police report was filed	Tick Yes or No
FIR No.	Enter first information report number	As issued by police authorities
If not reported to police, give reason	Enter reason for not reporting to police	Open Text
SECTION D – CLAIM DOCUMENTS SUBMITTED-CHECK LIST		
Indicate which supporting documents are submitted		
SECTION E – DETAILS IN CASE OF NON NETWORK HOSPITAL		
a) Address	Enter the full postal address	Include Street, City and Pin Code
b) Phone No.	Enter the phone number of hospital	Include STD code with telephone number
c) Registration No. with State Code	Enter the registration number of the doctor along with the state code	As allocated by the Medical Council of India
d) Hospital PAN	Enter the permanent account number	As allotted by the Income Tax department
e) Number of Inpatient beds	Enter the number of inpatient beds	Digits
f) Facilities available in the hospital	Indicate facilities available in the hospital	Tick the right option. If others, please specify
SECTION F - DECLARATION BY THE HOSPITAL		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign and stamp		

CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT – PART A
TO BE FILLED IN BY THE INSURED

The issue of this Form is not to be taken as an admission of liability

(To be filled in block letters)

SECTION A

DETAILS OF PRIMARY INSURED:

a) Policy No: b) Sl. No/ Certificate No:

c) Company/ TPA ID No:

d) Name :

e) Address :

City: State:

Pin Code: Phone No: Email ID :

SECTION B

DETAILS OF INSURANCE HISTORY:

a) Currently covered by any other Mediclaim / Health Insurance: Yes No b) Date of commencement of first Insurance without break:

c) If yes, company name: Policy No.

Sum Insured (Rs.) d) Have you been hospitalized in the last four years since inception of the contract? Yes No Date:

Diagnosis: e) Previously covered by any other Mediclaim / Health insurance : Yes No

f) If yes, Company Name

SECTION C

DETAILS OF INSURED PERSDN HOSPITALIZED:

a) Name:

b) Gender: Male Female c) Age: years months d) Date of Birth:

e) Relationship to Primary insured: Self Spouse Child Father Mother Other (Please Specify)

f) Occupation: Service Self Employed Homemaker Student Retired Other (Please Specify)

g) Address (if different from above):

City: State:

Pin Code: Phone No: E-mail ID:

SECTION D

DETAILS OF HOSPITALIZATION:

a) Name of Hospital where Admitted:

b) Room Category occupied: Day care Single occupancy Twin sharing 3 or more beds per room

c) Hospitalization due to: Injury Illness Maternity d) Date of Injury / Date Disease first detected /Date of Delivery:

e) Date of Admission: f) Time: : g) Date of Discharge: h) Time: :

i) If Injury give cause: Self inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption i. If Medico legal: Yes No

ii. Reported to police: Yes No iii. MLC Report & Police FIR attached: Yes No j) System of Medicine:

SECTION E

DETAILS OF CLAIM:

a) Details of the treatment expenses claimed

i. Pre-hospitalization Expenses:	Rs.	ii. Hospitalization Expenses:	Rs.
iii. Post-hospitalization Expenses:	Rs.	iv. Health-Check up Cost:	Rs.
v. Ambulance Charges:	Rs.	vi. Others (code):	Rs.
		Total	Rs.

vii. Pre-hospitalization period: days viii. Post-hospitalization period: days

b) Claim for Domiciliary Hospitalization: Yes No (If yes, provide details in annexure)

c) Details of Lump sum / cash benefit claimed:

i. Hospital Daily Cash:	Rs.	ii. Surgical Cash:	Rs.
iii. Critical Illness Benefit:	Rs.	iv. Convalescence:	Rs.
v. Pre/Post hospitalization Lump sum benefit:	Rs.	vi. Others:	Rs.
		Total	Rs.

Claim Documents Submitted- Check List:

- Claim Form Duly signed
- Copy of the claim intimation, if any
- Hospital Main Bill
- Hospital Break-up Bill
- Hospital Bill Payment Receipt
- Hospital Discharge Summary
- Pharmacy Bill
- Operation Theatre Notes
- ECG
- Doctor's request for investigation
- Investigation Reports (Including CT / MRI / USG / HPE)
- Doctor's Prescriptions
- Others

SECTION F

DETAILS OF BILLS ENCLOSED:

Sl. No	Bill No	Date	Issued by	Towards	Amount (Rs)
1.				Hospital Main Bill	
2.				Pre-hospitalization Bills: Nos	
3.				Post-hospitalization Bills: Nos	
4.				Pharmacy Bills	
5.					
6.					
7.					
8.					
9.					
10					

SECTION G

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT:

c) Bank Name and Branch:

d) Cheque/ DD Payable details: e) IFSC Code:

(IMPORTANT: PLEASE TURN OVER)

DECLARATION BY THE INSURED:

I hereby declare that the information furnished in this claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent & authorize TPA / insurance company, to seek necessary medical information / documents from any hospital / Medical Practitioner who has attended on the person against whom this claim is made. I hereby declare that I have included all the bills / receipts for the purpose of this claim & that I will not be making any supplementary claim except the pre/post-hospitalization claim, if any.

Date: D D M M Y Y Place: Signature of the Insured

SECTION H

GUIDANCE FOR FILLING CLAIM FORM – PART A (To be filled in by the insured)			
	DATA ELEMENT	DESCRIPTION	FORMAT
	SECTION A - DETAILS OF PRIMARY INSURED		
a)	Policy No.	Enter the policy number	As allotted by the insurance company
b)	SI. No/ Certificate No.	Enter the social insurance number or the certificate number of social health insurance scheme	As allotted by the organization
c)	Company TPA ID No.	Enter the TPA ID No	License number as allotted by IRDA and printed in TPA documents.
d)	Name	Enter the full name of the policyholder	Surname, First name, Middle name
e)	Address	Enter the full postal address	Include Street, City and Pin Code
	SECTION B - DETAILS OF INSURANCE HISTORY		
a)	Currently covered by any other Mediclaim / Health Insurance?	Indicate whether currently covered by another Mediclaim / Health Insurance	Tick Yes or No
b)	Date of Commencement of first Insurance without break	Enter the date of commencement of first insurance	Use dd-mm-yy format
c)	Company Name	Enter the full name of the insurance company	Name of the organization in full
	Policy No.	Enter the policy number	As allotted by the insurance company
	Sum Insured	Enter the total sum insured as per the policy	In rupees
d)	Have you been Hospitalized in the last four years since inception of the contract?	Indicate whether hospitalized in the last four years	Tick Yes or No
	Date	Enter the date of hospitalization	Use mm-yy format
	Diagnosis	Enter the diagnosis details	Open Text
e)	Previously Covered by any other Mediclaim/ Health Insurance?	Indicate whether previously covered by another Mediclaim / Health Insurance	Tick Yes or No
f)	Company Name	Enter the full name of the insurance company	Name of the organization in full
	SECTION C - DETAILS OF INSURED PERSON HOSPITALIZED		
a)	Name	Enter the full name of the patient	Surname, First name, Middle name
b)	Gender	Indicate Gender of the patient	Tick Male or Female
c)	Age	Enter age of the patient	Number of years and months
d)	Date of Birth	Enter Date of Birth of patient	Use dd-mm-yy format
e)	Relationship to primary Insured	Indicate relationship of patient with policyholder	Tick the right option. If others, please specify.
f)	Occupation	Indicate occupation of patient	Tick the right option. If others, please specify.
g)	Address	Enter the full postal address	Include Street, City and Pin Code
h)	Phone No	Enter the phone number of patient	Include STD code with telephone number
i)	E-mail ID	Enter e-mail address of patient	Complete e-mail address
	SECTION D - DETAILS OF HOSPITALIZATION		
a)	Name of Hospital where admitted	Enter the name of hospital	Name of hospital in full
b)	Room category occupied	Indicate the room category occupied	Tick the right option
c)	Hospitalization due to	Indicate reason of hospitalization	Tick the right option
d)	Date of Injury/Date Disease first detected/ Date of Delivery	Enter the relevant date	Use dd-mm-yy format
e)	Date of admission	Enter date of admission	Use dd-mm-yy format
f)	Time	Enter time of admission	Use hh:mm format
g)	Date of discharge	Enter date of discharge	Use dd-mm-yy format
h)	Time	Enter time of discharge	Use hh:mm format
i)	If Injury give cause	Indicate cause of injury	Tick the right option
	If Medico legal	Indicate whether injury is medico legal	Tick Yes or No
	Reported to Police	Indicate whether police report was filed	Tick Yes or No
	MLC Report & Police FIR attached	Indicate whether MLC report and Police FIR attached	Tick Yes or No
j)	System of Medicine	Enter the system of medicine followed in treating the patient	Open Text
	SECTION E - DETAILS OF CLAIM		
a)	Details of Treatment Expenses	Enter the amount claimed as treatment expenses	In rupees (Do not enter paise values)
b)	Claim for Domiciliary Hospitalization	Indicate whether claim is for domiciliary hospitalization	Tick Yes or No
c)	Details of Lump sum/ cash benefit claimed	Enter the amount claimed as lump sum/ cash benefit	In rupees (Do not enter paise values)
d)	Claim Documents Submitted-Check List	Indicate which supporting documents are submitted	Tick the right option
	SECTION F - DETAILS OF BILLS ENCLOSED		
	Indicate which bills are enclosed with the amounts in rupees		
	SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT		
a)	PAN	Enter the permanent account number	As allotted by the Income Tax department
b)	Account Number	Enter the bank account number	As allotted by the bank
c)	Bank Name and Branch	Enter the bank name along with the branch	Name of the Bank in full
d)	Cheque/ DD payable details	Enter the name of the beneficiary the cheque/ DD should be made out to	Name of the individual/ organization in full
e)	IFSC Code	Enter the IFSC code of the bank branch	IFSC code of the bank branch in full
	SECTION H - DECLARATION BY THE INSURED		
	Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.		

PLEASE FAX / SCAN PAGE 1 ONLY

REQUEST FOR CASHLESS HOSPITALISATION FOR MEDICAL INSURANCE POLICY

DETAILS OF THE THIRD PARTY ADMINISTRATOR

(To be filled in block letters)

a) Name of TPA / Insurance company:

b) Toll free phone number:

c) Toll free FAX:

TO BE FILLED BY THE INSURED / PATIENT

a) Name of the Patient:

b) Gender: ☐ Male ☐ Female c) Age Years ☐☐ Months ☐☐ d) Date of birth ☐☐/☐☐/☐☐☐☐

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 Company Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Give details

k) Do you have a family physician: ☐ Yes ☐ No l) Name of the family physician: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

m) Contact number, if any: ☐☐☐☐☐☐☐☐☐☐

(PLEASE COMPLETE DECLARATION ON THE REVERSE SIDE OF THIS FORM)

TO BE FILLED BY THE TREATING DOCTOR / HOSPITAL

a) Name of the treating doctor: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ b) Contact number: ☐☐☐☐☐☐☐☐☐☐

c) Nature of ILLNESS / Disease with presenting complaints

d))Relevant clinical findings:

e) Duration of the present ailment: ☐☐☐ Days f. Date of first consultation: ☐☐/☐☐/☐☐☐☐

f) Provisional diagnosis:

ii. Past history of present ailment if any:

i. ICD 10 Code: ☐☐☐☐☐☐☐

g) Proposed line of treatment: ☐ Medical Management ☐ Surgical Management ☐ Intensive care ☐ Investigation ☐ Non allopathic treatment

h) If Investigation & / or Medical Management provide details

j) Route of drug administration:

i) If Surgical, name of surgery :

i. ICD 10 PCS Code: ☐☐☐☐☐☐☐

j) If other treatments provide details:

k) How did injury occur:

l) In case of accident i. Is it RTA: ☐ Yes ☐ No ii. Date of injury: ☐☐/☐☐/☐☐☐☐ iii. Reported 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 : ☐ Yes ☐ No (If Yes attach reports)

l) In case of Maternity: ☐ G ☐ P ☐ L ☐ A Date of Delivery: ☐☐/☐☐/☐☐☐☐

Details of the patient admitted

a) Date of admission: ☐☐/☐☐/☐☐☐☐ b) Time: ☐☐ : ☐☐

c) Is this an emergency / a planned hospitalization event?: ☐ Emergency ☐ Planned

d) Expected no. of days stay in hospital: Days e) Room Type:

f) Per Day Room Rent + Nursing & Service Charges + Patient's Diet	Rs.	
g) Expected cost for investigation + diagnostics. :	Rs.	
h) ICU Charges:	Rs.	
i) OT Charges:	Rs.	
j) Professional fees Surgeon + Anesthetist Fees + consultation Charges	Rs.	
k) Medicines + Consumables + Cost of Implants (if applicable please specify) Other hospital expenses if any	Rs.	
l) All inclusive package charges if any applicable	Rs.	
m) **Sum Total expected cost of hospitalization**	**Rs.**	

Mandatory: Past History of any chronic illness **If yes, since (month / year)**

☐ Diabetes	☐☐/☐☐☐☐
☐ Heart Disease	☐☐/☐☐☐☐
☐ Hypertension	☐☐/☐☐☐☐
☐ Hyperlipidemias	☐☐/☐☐☐☐
☐ Osteoarthritis	☐☐/☐☐☐☐
☐ Asthma / COPD / Bronchitis	☐☐/☐☐☐☐
☐ Cancer	☐☐/☐☐☐☐
☐ Alcohol or drug abuse	☐☐/☐☐☐☐
☐ Any HIV or STD / Related ailments	☐☐/☐☐☐☐

Any other Ailment give details:

(PLEASE READ VERY CAREFULLY)

DECLARATION

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

a) Name of the treating doctor: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

b) Qualification: ☐☐☐☐☐☐ c) Registration No. with State Code: ☐☐☐☐☐☐☐☐☐☐

Hospital Seal (Must include Hospital ID)

Patient / Insured Name & Signature:

(IMPORTANT: PLEASE TURN OVER)

DECLARATION BY THE PATIENT / REPRESENTATIVE

1. 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.
2. 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.
3. 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.
4. 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
5. 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.
6. 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.
7. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer / TPA.

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

c) **Contact number:** _____ d) **Patient's / Insured's Signature:** _____

HOSPITAL DECLARATION

1. We have no objection to any authorized TPA / Insurance Company official verifying documents pertaining to hospitalization.
2. 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.
3. All non medical expenses , OR expenses not relevant to hospitalization or illness, OR expenses disallowed in the Authorization Letter of the TPA / Insurance Co. DR arising out of incorrect information in the pre-authorisation form will be collected from the patient.
4. 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.
5. The patient declaration has been signed by the patient or by his representative in our presence.
6. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications.
7. We will abide by the terms and conditions agreed in the MOU.

Hospital Seal **Doctor's Signature**

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. Receipts and Pathological Test Reports from Pathologists, supported by note from the attending Medical Practitioner / Surgeon recommending such pathological Tests.
4. Surgeon's Certificate stating nature of operation performed and Surgeon's Bill and Receipt
5. Certificates from attending Medical Practitioner / Surgeon that the patient is fully cured.