REQUEST FOR CASHLESS HOSPITALISATION FOR HEALTH INSURANCE
POLICY PART — C
(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 med claim /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: ☐ Yes ☐ No

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 Rs._____

I. Expected cost of investigation + diagnostic Rs._____

J. ICU charges Rs._____

K. OT charges Rs._____

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

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

N. Other hospital expenses if any Rs._____

0. All-inclusive package charges if any applicable Rs. _____

P. Sum Total expected cost of hospitalization Rs._____

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 I REPRESENTATIVE

a. 1 agrees 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: _____ c) 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 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

NETWORK HOSPITAL - DECLARATION BY PATIENT/PATIENT'S ATTENDANT

Name of the Hospital :……. Date :…….

Address :…….

PATIENT NAME (BLOCK LETTERS) :…… AGE/SEX :……

IP No :…… UHID No :…… Mobile No of Patient :……..

Date of Admission :…….. Time of Admission :……

Date of Discharge :…… Time of Discharge :……..

Address of the Patient :……

NAME OF THE ATTENDANT :…… Relationship with the Patient :……

Mobile No. of Attendant :…….. Address :……

Declaration regarding Insurance Policy (Strike off the option which is not applicable)

(i) ***Declaration when patient has no insurance policy:***

- I declare that I do not have any insurance policy.

(ii) ***Declaration when patient has insurance policy:***

- I declare that I have following Insurance Policies

Policy No/TPA card No:_____

Insurance Company:_____

2) Whether patient opted for Eligible Room Category under Policy:
Yes / No

3) In case, policyholder wishes to avail better facility:

Name of the Additional Facility/ Provision/ Procedure/ Treatment ……
…….. which costs Rs :…….
(In words: ……
……
……) only.

On my own option, I wish to avail above better facility and I hereby agree to pay on my free will, after being explained in detail by the Hospital authority in my own and understandable language about the above mentioned Additional Facility/Procedure/Treatment and associated cost of it, which is over and above the agreed tariff. Further, if I opt to go for final bill reimbursement with insurance company, respective insurance company will reimburse only as per agreed tariff rates and balance amount will be borne by myself or patient only.

I have also been explained that when room service of a category better than eligible room rent is availed by the patient, not only the difference in room rent but also an equal proportion of all other charges associated with the treatment shall be borne by me.

Signature :……
Name of the Patient/Patient's attendant:

Signature :……
Name of the Hospital Representative & Hospital Seal :

BREACH CANDY HOSPITAL TRUST

CONSENT FORM - CASHLESS CLAIM

List of Documents to be carry with the pre-authorization Form

1) Fully Filled pre-authorization form (provided by the hospital).
2) Pan card & Adhaar card of the Patient.
3) Relevant Investigation Reports.
4) Valid Insurance ID.
5) Cancelled Cheque of Patient Account.

Highlights:

- For all planned cases the pre-authorization form has to be processed a week prior to hospitalization. For emergency admissions the pre-authorization form has to be submitted to the TPA desk within 24 hours of hospitalization.
- In the absence of a valid initial authorization letter, the patient will be admitted as a Cash patient and will be required to pay the requisite deposit on admission as per the protocol.
- At the time of submission of the pre-authorization form the patient has to pay Rs. 30,000/- as a deposit towards admission. This deposit is adjustable/refundable depending upon the final bill and the final approval amount of the patient.
- If a TPA inpatient undergoes an additional procedure which is not mentioned in the Preauthorisation form then the additional documents will be processed by the TPA desk. If the approval is not received before the surgery the patient will be treated as a Cash patient & 90% of the estimated amount needs to be paid as a deposit.
- In case of an Emergency/Unplanned surgery the patient will be treated as a Cash patient & 90% of the estimated amount needs to be paid as a deposit within 24 hours of the surgery.
- On the day of discharge once all required documents are sent to the Insurance Co. / TPA, it takes up to 4 hrs. for the approval to come. Patient can be physically discharged only after final approvalis received by the hospital.
- At the time of discharge the hospital will retain 5% of the Final Approval amount as a Security deposit which will be refunded to the patient after the final settlement from the Insurance Company, the duration of which is variable (minimum is 45 days).

Consent:

I declare that I have been explained all the above mentioned points and I agree to the same.

Patient Name : _____ BH No. : _____

Name of Person Submitting Claim Documents : _____

Signature of Person Submitting Claim Documents : _____

Date : _____

For Office Use Only

Received by : _____ Date & Time : _____

BREACH CANDY HOSPITAL TRUST

IMPORTANT INFORMATION REGARDING YOUR CASHLESS CLAIM

1. For all planned cases the pre-authorization form has to be processed a week prior to hospitalization. For emergency admissions the pre-authorization form has to be submitted to the TPA desk within 24 hours of hospitalization.
2. Admission will be on the basis of the authorization letter received from the TPA/Insurance Company which is only a provisional authorization. Please show a copy of this letter on the Admission Desk at the hospital at the time of Admission.
3. In the absence of a valid initial authorization letter, the patient will be admitted as a Cash patient and will be required to pay the requisite deposit on admission as per the protocol.
4. If any query is raised before or during the hospitalization which requires to furnish additional information of the Medical condition of the patient then the clarification will be provided by the Consultant/Surgeon and may be delayed depending upon the availability of the Consultant/Surgeon.
5. If the query requires to provide any details which are non-medical in nature the TPA desk will reply to them as soon as possible which may require help from the patient relative.
6. At the time of submission of the pre-authorization form the patient has to pay Rs. 30,000/- as a deposit towards admission. This deposit is adjustable/refundable depending upon the final bill and the final approval of the patient.
7. In a single hospitalization one can avail cashless only with one TPA/Insurance Company, if the patient has more than one policy they can avail the reimbursement facility. Please contact the TPA Desk for further details.
8. For knowing the coverage of any particular (Medical/Surgical) condition under your Policy, please read the T & C of your policy document or speak to your agent.
9. For Room Eligibility of the patient please contact your agent for criterion of admission as per the policy of the patient.
10. If a TPA inpatient undergoes an additional procedure which is not mentioned in the Preauthorisation form then the additional documents will be processed by the TPA desk. If the approval is not received before the surgery the patient will be treated as a Cash patient & 90% of the estimated amount needs to be paid as a deposit.
11. In case of an Emergency/Unplanned surgery the patient will be treated as a Cash patient & 90% of the estimated amount needs to be paid as a deposit within 24 hours of the surgery.
12. On the day of discharge once we send all required documents to Insurance Co. / TPA, it takes up to 4 hrs. for approval to come . The patient can be physically discharged only after approval comes as per the policy.
13. Half day charges will be levied for patients if the discharge process is initiated between 11.00 am to 1.00 pm. All discharges processed after 1.00 pm will attract full day charges.
14. The original reports and bill will be handed over to the TPA/Insurance Company for processing of the claim. A copy of all the reports will be available at the reports counter, 7 days after the discharge.
15. A copy of the Discharge Summary will be provided to the patient at the time of discharge.
16. At the time of discharge the hospital will retain 5% of the Final Approval amount as a Security deposit which will be refunded to the patient after the final settlement from the Insurance Company, the duration of which is variable(minimum is 45 days).
17. Any deductions toward non-medical items, exclusions, class based billing etc. will have to be borne by the patient (this will not be adjusted against the security deposit).
18. Please submit a cancelled cheque to get the refund into your account directly.
19. In case of denial of the cashless claim (due to withdrawal or rejection of the claim) during the hospitalization or at the time of discharge the patient will be treated as a cash patient and will be expected to clear the entire bill of the hospital and proceed for the reimbursement process.
20. Only approval letters received on the Email or the Portal will be considered valid.
21. There may be a delay in receiving the approval on Public Holidays or Sundays.

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