

REQUEST FOR CASHLESS HOSPITALISATION FOR HEALTH INSURANCE  
POLICY PART - C

DETAILS OF THE THIRD PARTY ADMINISTRATOR/ INSURER/ HOSPITAL (All fields are mandatory and fill in CAPITALS only)

a) Name of the TPA/ Insurance Company: **HDFC ERGO General Insurance Company Limited**

b) Customer service no: 022 - 6234 6234 / 0120 - 6234 6234

c) Name of Hospital: \_\_\_\_\_  
 i. Address \_\_\_\_\_  
 ii. Rohini ID \_\_\_\_\_  
 iii. E-mail id \_\_\_\_\_

**TO BE FILLED BY INSURED/ PATIENT**

a) Name of the Patient: \_\_\_\_\_  
 (First Name) (Middle Name) (Last Name)  
 b) Gender:  Male  Female  Third Gender c) Age: Years   Months   d) Date of birth:        
 e) Contact Number: \_\_\_\_\_ f) Contact number of attending relative: \_\_\_\_\_  
 g) Insured Member ID card No: \_\_\_\_\_ h) Policy No./Name of Corporate: \_\_\_\_\_  
 i) Employee ID \_\_\_\_\_  
 j) Currently do you have any Mediclam/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 No, 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 complaints \_\_\_\_\_ d) Relevant clinical findings \_\_\_\_\_  
 e) Duration of present ailment:   Days i) Date of first consultation:       ii) Past history of present ailment, if any \_\_\_\_\_  
 f) Provisional Diagnosis \_\_\_\_\_ i) ICD Code: \_\_\_\_\_  
 g) Proposed line of treatment  i) Medical Management  ii) Surgical Management  iii) Intensive Care  iv) Investigation  v) Non allopathic treatment  
 h) If investigational &/or Medical Management provide details \_\_\_\_\_ i) Route of drug administration \_\_\_\_\_  
 j) If surgical name of surgery \_\_\_\_\_ i) ICD 10 PCS code \_\_\_\_\_  
 k) 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:       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 report)  
 m) In case of Maternity  G  P  L  A  
 i) Expected date of Delivery

**Details of patient admitted**

a) Date of admission:       b) Date of Time:  :  :    
 c) Is this a emergency/a planned hospitalisation event?: Emergency  Planned   
 e) Expected No. of days stay in hospital:   Days  
 f) Days in ICU:   Days  
 h) Per Day Room Rent + Nursing & Service Charges + Patient's Diet Rs. \_\_\_\_\_  
 i) Expected cost for investigation + diagnostics 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. \_\_\_\_\_  
 o) All inclusive package charges if any applicable Rs. \_\_\_\_\_  
 p) Sum Total expected cost of hospitalization Rs. \_\_\_\_\_

**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 or drug abuse      
 ix) Any HIV or STD / Related ailments      
 x) Any other Ailment give details: \_\_\_\_\_

**DECLARATION (Please read carefully)**

We confirm having read understood and agreed to the declarations 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

**DECLARATION BY THE PATIENT / REPRESENTATIVE**

- a. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Insurer/T.P.A after the discharge. I agree to sign on the Final Bill & the Discharge Summary, before my discharge.
- b. Payment to hospital is governed by the terms and conditions of the policy. In case the Insurer /TPA is not liable to settle the hospital bill, I undertake to settle the bill as per the terms and conditions of the policy.
- c. All non-medical expenses and expenses not relevant to current hospitalization and the amounts over & above the limit authorized by the Insurer/T.P.A not governed by the terms and conditions of the policy will be paid by me.
- d. I hereby declare to abide by the terms and conditions of the policy and if at any time the facts disclosed by me are found to be false or incorrect I forfeit my claim and agree to indemnify the Insurer / T.P.A
- e. I agree and understand that T.P.A is in no way warranting the service of the hospital & that the Insurer /TPA is in no way guaranteeing that the services provided by the hospital will be of a particular quality or standard.
- f. I hereby warrant the truth of the forgoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppression or concealment with respect to the claim, my right to claim reimbursement of the said expenses shall be absolutely forfeited.
- g. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer / TPA.
- h. "I/We authorize Insurance Company/TPA to contact me/us through mobile/email for any update on this claim".

Patient/s/ Insured's Name: \_\_\_\_\_

Contact No.: \_\_\_\_\_

E-mail Id (optional): \_\_\_\_\_

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: \_\_\_\_\_

CENTRAL KYC REGISTRY | Know Your Customer (KYC) Application Form | Individual



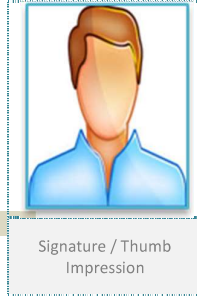
Instructions:
A) Fields marked with \*\*are mandatory fields.
B) Please Fill the form in English and in BLOCK Letters.
C) Please read guidelines / detailed instructions overleaf
D) List of Two character ISO-3166 country codes are available overleaf

Application Type : [ ] New [ ] Update
Account Type\* : [ ] Normal [ ] Small
KYC Number : [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

PERSONAL DETAILS

[ ] PHOTO

Name\* (Same as ID proof) : Prefix First Name Middle Name Last Name
Maiden Name (if any\*) : Prefix First Name Middle Name Last Name
Father / Spouse Name\* : Prefix First Name Middle Name Last Name
Mother Name\* : Prefix First Name Middle Name Last Name
Date of Birth\* : DD-MM-YYYY Gender\* : [ ] Male [ ] Female [ ] Transgender
Marital Status\* : [ ] Married [ ] Unmarried Nationality\* : [ ] Indian [ ] Others Country Name
Residential Status\* : [ ] Resident Individual [ ] Non Resident Indian [ ] Foreign National [ ] Person of Indian Origin
Occupation\* : [ ] Private Sector Service [ ] Public Sector [ ] Government Sector [ ] Business [ ] Professional
[ ] Self Employed [ ] Retired [ ] Housewife [ ] Student [ ] Other Please Specify
Tick if applicable : [ ] Residence for Tax purposes in jurisdiction(s) outside India



ADDITIONAL DETAILS REQUIRED\* (If Applicant is resident outside India for Tax purposes)

(Please read guidelines / details for 'Jurisdiction of Residence' and 'Tax Identification Number')

ISO -3166 Country Code of Jurisdiction of Residence\* :
Tax Identification Number or equivalent (If issued by jurisdiction)\* :
Place / City of Birth\* : ISO -3166 Country Code of Birth\* :

PROOF OF IDENTITY (PoI)\* (One Certified Copy of any one of the following Proof of Identity[PoI] needs to be submitted)

[ ] PAN [ ] UID (Aadhaar)
[ ] Voter ID Card [ ] NREGA Job Card
[ ] Passport Number [ ] Passport Expiry Date
[ ] Driving License [ ] Driving License Expiry Date
[ ] Others (any document notified by the central government) :

PROOF OF ADDRESS (PoA)

CURRENT / PERMANENT / OVERSEAS ADDRESS DETAILS (One Certified Copy of any one of the following Proof of Address [PoA] needs to be submitted)

Line 1\* :
Line 2 :
Line 3 : City / Town / Village :
State/U.T\* : Pin / Post code : ISO -3166 Country Code :
Proof of : [ ] Passport [ ] Driving License [ ] Aadhaar Card
Address\* : [ ] Voter Identity Card [ ] NREGA CARD [ ] Others Please Specify

CORRESPONDENCE / LOCAL ADDRESS DETAILS (In case the PoA is not the local address or address where the customer is currently residing. To be declared only and no PoA is required)

[ ] Same as Current / Permanent / Overseas Address details (In case of multiple correspondence / local addresses, Please fill 'Annexure A1')

Line 1\* :
Line 2 :
Line 3 : City / Town / Village :
State/U.T\* : Pin / Post code : ISO -3166 Country Code :

ADDRESS IN THE JURISDICTION DETAILS WHERE APPLICANT IS RESIDENT\* (If Applicant is resident outside India for Tax purposes)

[ ] Same as Current / Permanent / Overseas Address details [ ] Same as Correspondence / Local Address details

Line 1\* :
Line 2 :
Line 3 : City / Town / Village :
State/U.T\* : Pin / Post code : ISO -3166 Country Code :

CONTACT DETAILS (Communications will be done on provided Mobile no. and Email-ID)

Tel. (Off) : STD CODE Tel. (Res) : STD CODE Mobile :
FAX : STD CODE Email ID :

DETAILS OF RELATED PERSON (In case of additional related persons, Please fill 'Annexure B1' form)

[ ] Addition of Related Person [ ] Deletion of Related Person KYC Number (if available) :
Related Person Type: [ ] Guardian Of Minor [ ] Nominee [ ] Assignee [ ] Authorized Representative [ ] Beneficial Owner [ ] Beneficiary

Name\*: Prefix First Name Middle Name Last Name

PROOF OF IDENTITY (PoI)\* (Mandatory if KYC number is not available. One Certified Copy of any one of the following Proof of Identity[PoI] needs to be submitted)

[ ] PAN [ ] UID (Aadhaar)
[ ] Voter ID Card [ ] NREGA Job Card
[ ] Passport Number [ ] Passport Expiry Date
[ ] Driving License [ ] Driving License Expiry Date
[ ] Others (any document notified by the central government) :

OTHER DETAILS

Income Range : [ ] Below 1 Lac [ ] 5 Lac to 10 Lac [ ] 10 Lac to 15 Lac [ ] 15 Lac to 25 Lac [ ] 25 Lac and above
Net Worth (In INR) : As on : DD-MM-YYYY
Educational Qualification : [ ] Below SSC [ ] SSC [ ] HSC [ ] Graduate [ ] Masters [ ] Professional (CA, CS, CMA, Others)
Please Tick If Applicable : [ ] Politically Exposed Person [ ] Related to Politically Exposed Person
Any Other Information :

APPLICANT DECLARATION

I hereby declare that the details furnished above are true and correct to the best of my/our knowledge and belief and I undertake to inform you of any changes therein, immediately. In case any of the above information is found to be false or untrue or misleading or misrepresenting, I am/we are aware that I/we may be held liable for it.

I would like to share my personal / KYC details with Central KYC Registry.

[Signature / Thumb Impression]
[ ] Signature / thumb Impression of Applicant
Place :
Date :

ATTESTATION / FOR OFFICE USE ONLY

Documents Received : [ ] Self-Certified [ ] True Copies [ ] Notary
Risk Category : [ ] High [ ] Medium [ ] Low
IN PERSON VERIFICATION DETAILS
Identity Verification : [ ] Done
Date : DD-MM-YYYY
Emp. Name :
Emp. Code :
Emp. Designation :
Emp. Branch :
Signature :
INSTITUTION DETAILS
Name :
Code :
Stamp :
[Employee Signature]
[Institution Stamp]

# 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 approval is 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.

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

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- 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 approval is 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).