ICICI Lombard GENERAL INSURANCE

ICICI Lombard Health Care

CASHLESS AUTHORIZATION REQUEST NOTE

Toll Free Number: 1800 2666 • Fax Number: 1800 209 8880 / 040 6698 9160 / 61 • Email us: cashlessrequest@icicilombard.com

TO BE FILLED BY THE INSURED / PATIENT

1) Name of Patient:

2) Gender: ☐ Male ☐ Female 3) Age: ☐☐ Years 4) Date of Birth: D D M M Y Y Y Y 5) Mobile No.:

5) Insured Card ID No: 6)Email ID: _____

7) Policy No.

8) a) Corporate Policy No.: _____ b) Corporate Policy Name: _____

c) Employee ID: _____ 9) Currently do you have any other Mediclaim / Health insurance ☐ Yes ☐ No If Yes, Company Name _____

_____ Give details _____

10) a) Name of the family physician: _____ b) Contact Number:

11) ID/Age Proof Attached: ☐ Aadhar Card ☐ Passport ☐ Driving License ☐ 10 th Class Certificate ☐ Others _____

TO BE FILLED BY THE TREATING DOCTOR / HOSPITAL

1) a) Name of the treating doctor _____ b) Mobile No.:

2) a) Name of Hospital: _____ b) Contact No.:

c) NT Code: _____ d) Email ID: _____ e) Fax No. _____

3) Nature of Illness / Disease with presenting complaints: _____

4) Relevant clinical findings: _____

5) a) Past history of present ailment, if any: _____

_____ b) Duration of present ailment: ☐☐☐ Days c) Date of first consultation: D D M M Y Y Y Y

6) a) Provisional diagnosis: _____

_____ b) ICD 10 Code:

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

8) a) If Investigation & / or Medical management, provide details: _____

_____ b) Route of drug administration: _____

9) a) If Surgical, name of surgery: _____

_____ b) ICD 10 PCS Code:

10) If other treatments provide details: _____

11) In case of accident: a) Is it RTA: Y N b) Date of injury: D D M M Y Y Y Y c) Reported to Police: Y N FIR No. _____

12) a) Injury / Disease caused due to substance abuse / alcohol consumption: Y N b) Test conducted to establish this : Y N, attach report.

13) a) In case of Maternity: ☐ G ☐ P ☐ L ☐ A b) Date of Delivery: D D M M Y Y Y Y

Details of the patient admitted

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

c) Is this an emergency / 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: ₹

g) Expected cost for investigation + diagnostics: ₹

h) ICU Charges: ₹

i) OT Charges: ₹

j) Professional fees Surgeon + Anesthetist Fees + consultation Charge: ₹

k) Medicines + Consumables + Cost of Implants (if applicable Please specify). Other hospital expenses if any: ₹

l) All inclusive package charges if any applicable: ₹

Sum total expected cost of hospitalization: ₹

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
☐ Other ailments: _____	

PLEASE READ VERY CAREFULLY • THIS FORM IS TO BE FILLED IN BLOCK LETTERS

DECLARATION

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

a) Name of the treating doctor: SURNAME FIRST NAME MIDDLE NAME

b) Qualification: c) Registration No. with state code:

Signature of treating doctor | Hospital Seal (Must include Hospital NT ID) | Patient / Insured Name & Signature:

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

NOT TO BE FAXED/SCANNED

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) Address: _____

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, 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.

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) Pan card & Adhaar Card of Primary Insured.
4) Relevant Investigation Reports.
5) Vaild Insurance ID.
6) 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 am fully aware of the details mentioned in the co-morbidities/pre-existing illness/past history diseases section of my insurance claim form filled in by me. If there is any difference in the information filled in the claim form as against the past history filled in the Initial Assessment form at the time of admission then the hospital shall not be liable for any issues with regards to getting the approval from the insurance. I will not hold hospital responsible if the Insurance/TPA denies the entire claim for this reason and I shall settle the entire bill.

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

Patient Name : _____ BH No. _____ DOA : _____

Name & 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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