DEDICATED HEALTHCARE SERVICES TPA (INDIA) PRIVATE LIMITED
.... Founded on Ethics
An ISO 9001 : 2008 Certified TPA

PLEASE FAX/SCAN PAGE 1 & 2 ONLY
REQUEST FOR CASHLESS HOSPITALISATION FOR MEDICAL INSURANCE POLICY

DETAILS OF THE THIRD PARTY ADMINISTRATOR/INSURER

(To be filled in block letters)

Name of the Insurance Company

Name of TPA: DEDICATED HEALTHCARE SERVICES TPA (INDIA) PVT. LTD.

Toll free phone number: 1 8 0 0 2 0 9 0 2 0 1

Toll free FAX: 0 2 2 - 6 7 3 5 4 3 0 0

TO BE FILLED BY THE INSURED / PATIENT

a) Name of the Patient

b) Gender ☐ Male ☐ Female c) Age: Year Y Y Month M M d) Date of birth D D M M Y Y Y Y

e) Mobile Number

f) Contact number of attending relative: (Mandatory)

g)Email ID

h) Membership Card Number/ ID Number

In case group health insurance taken by Employer

i) Name of Employer

j) Employee ID

k) Work address

l) Currently do you have any other Mediclaim/Health insurance: ☐ Yes ☐ No If yes, please give policy details

m) Do you have a family physician ☐ Yes ☐ No n) Name of the family physician

o) Contact number

(PLEASE COMPLETE DECLARATION ANNEXED WITH 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 Month Year

f) Date of first consultation: D D M M Y Y Y Y

g) Past history of present ailment if any

h) Provisional diagnosis

ICD 10 Code

i) Proposed line of treatment ☐ Medical Management ☐ Surgical Management ☐ Intensive care ☐ Investigation ☐ Non-allopathic Treatment

j) If Investigation & or Medical Management provide details

k) Route of drug administration

l) If Surgical, name of surgery

ICD 10 PCS Code

m) If any other treatment, provide details

n) In case of accident
i. Is it RTA ☐ Yes ☐ No
ii. Date of injury DD MM YYYY
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
vii. If Yes, nature of test and test results__________________________

o) How did injury occur

p) In case of Maternity: ☐ G ☐ P ☐ L ☐ A Date of Delivery DD MM YYYY

Details of the patient admitted

a) Date of admission DD MM YYYY

b) Time: HH : MM

c) Is this an emergency/planned hospitalization event?

☐ Emergency ☐ Planned

d) Expected no. of days stay in hospital DD

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) Rs.

l) Other hospital expenses if any Rs.

m) All inclusive package charges if any applicable Rs.

n) Sum Total expected cost of hospitalization Rs.

Mandatory: Past History of any chronic illness	**If yes, since (month / year)**
☐ Diabetes	MM YYYY
☐ Heart Disease	MM YYYY
☐ Hypertension	MM YYYY
☐ Hyperlipidemias	MM YYYY
☐ Osteoarthritis	MM YYYY
☐ Asthma/COPD/Bronchitis	MM YYYY
☐ Cancer	MM YYYY
☐ Alcohol or drug abuse	MM YYYY
☐ Any HIV or STD/Related ailments	MM YYYY
☐ Obesity related	MM YYYY
☐ Seizure	MM YYYY
☐ Stroke/CVA	MM YYYY

Any other Ailment give details

DECLARATION **(PLEASE READ VERY CAREFULLY)**

We confirm having read understood and agreed to the Declarations attached along with this form

a) Name of the treating Doctor
SURNAME FIRST NAME MIDDLE NAME

b) Qualification

c) Registration No. with State Code

Hospital Seal
(Must include Hospital Registration No.)
and attending Physician's Signature

Patient / Insured's Signature

(IMPORTANT: PLEASE SEE ANNEXURE)

DECLARATION BY THE PATIENT / REPRESENTATIVE

1. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Insurer/TPA 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/TPA 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 / TPA
5. I agree and understand that TPA 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 foregoing 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 further declare that in respect of the above treatment no benefit is admissible under any other medical insurance scheme other than the one stated by me.

   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:______________________ c) 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. We also agree to provide copies of indoor case record and any other relevant medical record if sought by Insurer/TPA
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 (Summary bill, Itemised bill).
2. Cash Memos from the Hospitals/Chemists supported by proper prescription, receipts.
3. Pathological Test Reports from Pathologists, supported by note from the attending Medical Practitioner/Surgeon recommending such pathological Tests including X-ray and scan films.
4. Break up of package charges if any
5. KYC document obtained from insured as per AML guidelines prescribed by Government of India.
6. Patient declaration and hospital declaration statement.
7. TDS exemption details if any.

Dedicated Healthcare Services TPA (India) Pvt. Ltd.,
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42, Maharshi Karve Road, Mumbai - 400 020

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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 :…………………………………………………………………………………………

<u>Declaration regarding Insurance Policy (Strike off the option which is not applicable)</u>

(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

Cashless Consent Form – Third Party Administrator (TPA)

- I have been explained in details about the cashless facilities at Breach Candy Hospital Trust. I undertake not to hold the hospital responsible for any delay in getting approval or extensions from TPA.

- I have understood that such approvals are my responsibility and the hospital renders this service as a value addition only.

- I will be admitted on the basis of authorization letter received from the insurance Co / TPA which is only a provisional authorization.

- In the absence of an authorization letter, I would be admitted as a "Cash" patient. I would be required to pay the requisite deposit on admission & subsequently clear all hospital bills.

- In case of emergency admission, if the authorization is not received from the insurance Co. / TPA, then I would undertake to clear the bills of the hospital.

- I would have to clear all bills related to exclusions as stated by the Insurance Co. / TPA

- I am aware that subsequent to the pre-authorization and admission a request for confirmation of claim payable is sent to TPA. Only on confirmation from TPA, I will be treated as TPA (Cashless Facility)

- In case I undergo treatment for which the Insurance Co / TPA withdraws authorization or rejects the claim, then I would clear all hospital bills of the hospital.

- I would be required to pay security deposit 48 hrs before the admission. The same will be refunded on settlement from the Insurance Co/ TPA.

- The hospital is not responsible for refusal on part of TPA for reimbursement of my claims.

- I am aware that the original reports and original discharge card are handed over to the Insurance Co/ TPA.

- I am aware that I have to show the copy of the pre-authorization form at the reception on the day of admission to get the cashless benefit.

- I am aware that in planned admission I have to submit the pre-authorization form one week prior to admission and in emergency within 24 hrs. of admission.

- I agree to pay the over and above bill of the approval amount and that I will not seek reimbursement for the same.

Signature of the Patient ________________ Signature of the Relative ________________

Name of the Patient ___________________ Name the of Relative ___________________