HDFC ERGO General Insurance Company Limited



REQUEST FOR CASHLESS HOSPITALISATION FOR HEALTH INSURANCE POLICY PART - $\ensuremath{\text{C}}$

	DMINISTRATOR/ INSURER/ HOSPITAL (All fields are mandatory and fill in CAPITALS only)
	pany: HDFC ERGO General Insurance Company Limited
b) Customer service no: 022 - 6234 c) Name of Hospital:	6234 / 0120 - 6234 6234
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 Y Y Months M M d) Date of birth: D D M M Y Y Y Y
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 Medicli	am/Health Insurance: Yes No
i) Company Name:	
ii) Give details:	
k) Do you have a family physician:	Yes No I) 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)
a) Name of the Treating Doctor:	TO BE FILLED BY TREATING DOCTOR/HOSPITAL b) Contact Number:
c) Nature of illness/ Disease with presenting complaints	d) Relevant dinical findings
e) Duration of present ailment:	Days i) Date of first consultation: D D M M Past history of present allment, 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
I) If surgical name of surgery	i) ICD 10 PCS code
j) If other treatment provide details	k) How did injury occur
I) In case of Accident:	i, Is it RTA: Yes No ii. Date of injury: D D M M Y Y Y Y iii. Reported to police: Yes No iv. FIR No.:
v) Injury/Disease caused due to sub m) In case of Maternity G i) Expected date of Delivery	stance abuse/alcohol consumption: Yes No vi) Test conducted to establish this: Yes No (If yes, attach report) P L A
Details of patient admitted	
a) Date of admission:	M Y Y Y Y B) Date of Time: H H : M M d) Mandatory Past history of any chronic illness
c) Is this a emergency/a planned hos	i) Diabetes
e) Expected No. of days stay in hosp f) Days in ICU: Days	g) Room Type
h) Per Day Room Rent + Nursing &	iii) Hypertension
Expected cost for investigation + d	iagnostics Rs.
j) ICU Charges	Rs. v) Osteoarthrits
k) OT Charges	Rs. vi) Asthma/ COPD/ Bronchitis
I) Professional fees Surgeon + Anes	thetist Fees + consultation Charges Rs.
m) Medicines + Consumables + Cos	t of Implants (if applicable please specify).
n) Other hospital expenses if any	Rs. x) Any other Ailment give details:
o) All inclusive package charges if a	ny applicable Rs.
p) Sum Total expected cost of hospit	alization Rs.

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 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 s 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 & aborgoverned 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 for 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 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 mak concealment with respect to the claim, my right to claim reimbursement of the said expenses shall be absolutely for I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurent's Insurerd's Name: Patient's Insured's Name: 	settle the hospital bill, I undertake to settle the bill ve the limit authorized by the Insurer/T.P.A not ound to be false or incorrect I forfeit my claim and o way guaranteeing that the services provided by see any false or untrue statement, suppression or registed.						
Contact No.: E-mail Id (optional):							
Potterille Harrison die Office harri							
Patient's/Insured's Signature:							
Date: Time:							
<u> </u>							
HOSPITAL DECLARATION							
 a. We have no objection to any authorized TPA/Insurance Company official verifying documents pertaining to hospit b. All valid original documents duly countersigned by the insured/patient as per the checklist below will be sent to 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 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 respons 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 (including additional charges due to opting higher room rent than eligibility/choosing separate line of treatment whh. We confirm that no recoveries would be made from the deposit amount collected from the Insured except for conditional charges due to opting higher room rent than eligibility/choosing separate line of treatment which is note. l. In the event of unauthorized recovery of any additional amount from the Insured in excess of Agreed Package Reserves the right to recover the same from us (the Network Provider) and/or take necessary action, as provided under the patient of the patient of	o TPA / Insurance Company within 7 days of the nand discharge summary or other documents sibility for any delay in offering clarifications except costs towards non-admissible amounts lich is not envisaged/considered in package), sets towards non-admissible amounts (including invasged/considered in package). Rates, the authorized TPA / Insurance Company						
Hospital Seal	Doctor's Signature						

Time: _

CENTRAL KYC REGISTRY Know Your Customer (KYC) Applic	ation Form Individual	A TOTAL STATE OF THE PARTY OF T
Instructions: A) Fields marked with '*'are mandatory fields.	Application Type : ☐ New ☐ Update Account Type* : ☐ Normal ☐ Small	
B) Please Fill the form in English and in BLOCK Letters. C) Please read guidelines / detailed instructions overleaf	KYC Number : Sinding	CERSAI
D) List of Two character ISO-3166 country codes are available overleaf		Apple Saca
□ PERSONAL DETAILS		□ РНОТО
Name* (Same as ID proof) : Prefix First Name Maiden Name (If any*) : Prefix First Name	Middle Name Last Name Middle Name Last Name	, pp. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.
Father / Spouse Name* : Prefix First Name	Middle Name Last Name	
Mother Name* : Frefix First Name	Middle Name Last Name	
Date of Birth* : DD - MM - YYYY	Gender* : ☐ Male ☐ Female ☐ Transgender	()
Marital Status* : ☐ Married ☐ Unmarrie Residential Status* : ☐ Resident Individual ☐ Nor	d Nationality* : Indian Others Country Name a Resident Indian Foreign National Person of Indian Origin	
	blic Sector Government Sector Business Professional	
·	Housewife ☐ Student☐ Other Please Specify	
Tick if applicable : Residence for Tax purposes in ju		
ADDITIONAL DETAILS REQUIRED* (If Applicant is resident outs (Please read guidelines / details for 'Jurisdiction of Residence' and 'Tax		Signature / Thumb
ISO -3166 Country Code of Jurisdiction of Residence*:		Impression
Tax Identification Number or equivalent (If issued by jurisdict	ion)* :	
Place / City of Birth* : ISO -3166 C PROOF OF IDENTITY (Pol)* (One Certified Copy of any one of	,	
□ PAN :	☐ UID (Aadhaar) :	
□ Voter ID Card :	□ NREGA Job Card	
☐ Passport Number : ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	Passport Expiry Date : DD - MM - Y Y Y Y Driving License Expiry Date : DD - MM - Y Y Y Y	
Others (any document notified by the central government)		
☐ PROOF OF ADDRESS (PoA)		
CURRENT / PERMANENT / OVERSEAS ADDRESS DETAILS (One Line 1*	Certified Copy of any one of the following Proof of Address [PoA] needs to be su	ibmitted)
Line 2		
Line 3 :	City / Town / Village :	
State/U.T* : Pin / Post of	•	
Proof of : ☐ Passport Address* ☐ Voter Identity Card	☐ Driving License ☐ Aadhaar Card ☐ NREGA CARD ☐ Others ☐ Please Specify ☐ Driving License ☐ Driving L	
,	t the local address or address where the customer is currently residing. To be declared only and no PoA is n	required)
 Same as Current / Permanent / Overseas Address details 		
Line 1*		
Line 2 : Line 3 :	City / Town / Village :	
State/U.T* : Pin / Post of		
ADDRESS IN THE JURISDICTION DETAILS WHERE APPLICANT IS I	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 of		
CONTACT DETAILS (Communications will be done on provide		
Tel. (Off) : STD CODE Tel. (ReFAX : STD CODE Email II		
☐ DETAILS OF RELATED PERSON (In case of additional related		
☐ Addition of Related Person ☐ Deletion of Related Perso		
Name*: Prefix First Name Middle Name	signee	
	rble. One Certified Copy of any one of the following Proof of Identity[PoI] needs to be subm	itted)
□ PAN :	☐ UID (Aadhaar) :	
☐ Voter ID Card : ☐ Passport Number : ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	NREGA Job Card : Passport Expiry Date : DD - MM - Y Y Y Y	
☐ Driving License :	Driving License Expiry Date : DD - MM - Y Y Y Y	
Others (any document notified by the central government		
OTHER DETAILS		
Income Range : Below 1 Lac 5 La Net Worth (In INR) :	c to 10 Lac	
	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
	n □Related to Politically Exposed Person	
AnyOther Information : APPLICANT DECLARATION	ATTESTATION / FOR OFFICE USE ONLY	
I hereby declare that the details furnished above are true and correct	Documents Received : □Self-Certified □True Copies □Notary	
to the best of my/our knowledge and belief and I undertake to	Risk Category : □High □Medium □Low IN PERSON VERIFICATON DETAILS INSTITUTIO	N DETAILS
inform you of any changes therein, immediately. In case any of the above information is found to be false or untrue or misleading or	IN PERSON VERIFICATION DETAILS INSTITUTIO	IN DETAILS
misrepresenting, I am/we are aware that I/we may be held liable for	Date : D D - M M - Y Y Y Y Code :	
it. I would like to share my personal / KYC details with Central KYC	Emp. Name : Stamp : Emp. Code	
Registry.	Emp. Designation :	
[Cignotius / Thumb long	Emp. Branch : Signature :	
[Signature / Thumb Impression]		
☐ Signature / thumb Impression of Applicant	[Institutio [Employee Signature]	n Stamp]
Place :	[Employee signature]	
Date :		

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:

Received by:_

- 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 4hrs. for the approval to come. Patientcan 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	e co-morbidities/pre-existing	illness/past history diseases se	ection			
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 ent	tire 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 Doo						
Date :						
For Office Use Only						

BCHT/TPA/CON/3/01-23

Date & Time :_

BREACH CANDY HOSPITAL TRUST

IMPORTANT INFORMATION REGARDING YOUR CASHLESS CLAIM

- 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.
- 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.
- 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.
- 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. Acopy 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.

BCHT/TPA/INFO/3/01-23

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- For all planned cases the pre-authorization form has to be processed a week prior to hospitalization.
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