Exposure Draft

To

All CEOS of

Life Insurers, Non-Life Insurers, Standalone Health Insurers and TPAs

Re: Standardization in Health Insurance

Health insurance addresses a major area of public concern. Although it is rapidly growing, access to health insurance still remains limited and add to it complaints especially due to variable interpretations of key policy terms are enormous. In order to address the expectation of public more effectively, the Authority propose to stipulate the following in respect of all health insurance policies issued by life and general insurers in the country.

1. **Standard Definition for 46 commonly used terms in health insurance policies:**

Standard terms would reduce ambiguity, enable all stakeholders to provide better services and enable customers to interact more effectively with insurers, TPAs and providers. All insurers should adhere to the stipulated definitions, annexed at **Annexure I**, while defining these 46 core terms in all health insurance policies.

2. Standard Nomenclature and Procedures for Critical Illnesses:

In view of resolving the differences in the definitions of terms on Critical Illnesses adopted by the different insurers which are creating confusion in the minds of consumers and the industry especially at the time when insurers and re-insurers have to arrive at a point where lump sum payment is made, 11 Critical Illness terms have been standardized to be adopted uniformly across industry. All Policies offering critical illness coverage should ensure that definitions of the stated 11 terms are in line with the stipulated definitions annexed at **Annexure II**.

3. Standard Pre-authorization and Claim form:

A common industry wide pre-authorization and claim form will significantly streamline processes at all stages. This will enhance the ability of providers to obtain a timely prior authorization. By implementing it in an optical character recognition (OCR) format, the ability to transfer data from a handwritten paper based form to IT systems has been enhanced thus reducing the data entry issues for TPAs and insurers. Every company shall attach set of claim forms to the customer along with policy terms and conditions. The forms are attached at **Annexure III**.

4. Standard List of Excluded Expenses in Hospitalization Indemnity policies:

Hospitalization indemnity products are the commonest products in the Indian market and account for most of the health insurance sold in the country. The standard listing of 203 excluded items, an area which has otherwise been fairly variable in its interpretation and implementation, has been finalized. The same is annexed at **Annexure IV**. However, Insurers may include these exclusions, if the product design allows for, or if the insurer wants to include these as part of hospitalization expenses.

5. Standard File and Use Application Form, Database Sheet and Customer Information Sheet:

The existing F&U form used by the non-life insurers is designed keeping in view largely the characteristics of Non Life products other than Health. With this, the essential information like the sum insured, the minimum and maximum age, term of the product etc that gets captured in the F&U form is very minimal. In order to capture the relevant product design information, the modified File and Use Application form along with the Database sheet and Customer information sheet as annexed in the **Annexure: V, VI and VII** respectively shall be submitted under File and Use procedure by the insurers.

6. **Standard agreement between TPA & Insurer and Provider (Hospital) & Insurer**:

The insurers enter into agreements with the TPAs health services under health insurance contracts and with the Providers (Hospitals) for health care services under health insurance contracts. A standard agreement with all the basic details is annexed in **Annexure: VIII and IX**, which shall necessarily be included in the above service level agreements, wherever relevant.

Standard Definitions of terminology used in Health Insurance Policies

1. **Accident**
   An accident is a sudden, unforeseen and involuntary event caused by external and visible means.
   [Insurance companies can define the term accidental injury in the context of the term 'accident'].

2. **Co-Payment**
   A co-payment is a cost-sharing requirement under a health insurance policy that provides that the insured will bear a specified percentage of the admissible costs. A co-payment does not reduce the sum insured.

3. **Day Care Treatment**
   Day care treatment refers to medical treatment, and/or *surgical procedure* which is:
   - undertaken under General or Local Anesthesia in a *hospital/day care centre* in less than 24 hrs because of technological advancement, and
   - which would have otherwise required a hospitalization of more than 24 hours.

   Treatment normally taken on an out-patient basis is not included in the scope of this definition.
   [Insurers can, in addition, restrict coverage to a specified list].

4. **Deductible**
   A deductible is a cost-sharing requirement under a health insurance policy that provides that the Insurer will not be liable for a specified rupee amount of the covered expenses, which will apply before any benefits are payable by the insurer. A deductible does not reduce the sum insured.
   [Insurers to define whether the deductible is applicable per year, per life or whether per event and specific deductible limits would be applied].

5. **Dependent Child**
   A dependent child refers to a child (natural or legally adopted), who is financially dependent on the primary insured or proposer and does not have his / her independent sources of income.

   [Insurers can add additional criteria relating to age, marital status, education and disablement].

6. **Domiciliary Hospitalisation**
   Domiciliary hospitalization means medical treatment for a period exceeding 3 days, for an illness/disease/injury which in the normal course would require care and

treatment at a *hospital* but is actually taken while confined at home under any of the following circumstances:

- the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
- the patient takes treatment at home on account of non availability of room in a hospital.

7. Emergency Care

Emergency care means management for a severe illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a *medical practitioner* to prevent death or serious long term impairment of the insured person's health.

8. Grace Period

Grace period means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of *pre-existing diseases.* Coverage is not available for the period for which no premium is received.

9. Hospital

A hospital means any institution established for *in- patient care* and *day care treatment* of sickness and / or injuries and which has been registered as a hospital with the local authorities, wherever applicable, and is under the supervision of a registered and qualified *medical practitioner* AND must comply with all minimum criteria as under:

- has at least 10 inpatient beds, in those towns having a population of less than 10,00,000 and 15 inpatient beds in all other places;
- has qualified nursing staff under its employment round the clock;
- has qualified medical practitioner (s) in charge round the clock;
- has a fully equipped operation theatre of its own where surgical procedures are carried out
- maintains daily records of patients and will make these accessible to the Insurance company's authorized personnel.

10. Intensive Care Unit

Intensive care unit means an identified section, ward or wing of a *hospital* which is under the constant supervision of a dedicated *medical practitioner(s)*, and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

11. Inpatient Care

Inpatient care means treatment for which the insured person has to stay in a *hospital* for more than 24 hours for a covered event.

12. Medical Practitioner

A Medical practitioner is a person who holds a valid registration from the medical council of any state of India and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his license.

[Insurance companies can specify additional or restrictive criteria to the above, e.g. that the registered practitioner should not be the insured or close family members].

13. Medically Necessary

Medically necessary treatment is defined as any treatment, tests, medication, or stay in *hospital* or part of a stay in *hospital* which

- is required for the medical management of the illness or injury suffered by the insured;
- must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
- must have been prescribed by a *medical practitioner*;
- must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

14. Network

All such hospitals, day care centers or other providers that the insurance company/TPA have mutually agreed with, to provide services like cashless access to policyholders. The list is available with the insurer/TPA and subject to amendment from time to time.

15. Non- Network

Any *hospital*, day care centre or other provider that is not part of the *network.*

16. Pre-Existing Disease

Any condition, ailment or injury or related condition(s) for which you had signs or symptoms, and / or were diagnosed, and / or received medical advice / treatment within 48 months to prior to the first policy issued by the insurer.

[Life Insurers can define norms for applicability at reinstatement].

17. Qualified Nurse

Qualified nurse is a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

18. Reasonable Charges

Reasonable charges means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness / injury involved .

19. Surgery

Surgery or Surgical Procedure means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed in a hospital or day care centre by a *medical practitioner*

20. OPD treatment

OPD treatment is one in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

21. Hospitalisation

Means admission in a Hospital for a minimum period of 24 In patient Care consecutive hours except for specified procedures/ treatments, where such admission could be for a period of less than 24consecutive hours.

22. Illness

Illness means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment.

23a Acute condition - Acute condition is a medical condition that can be cured by Treatment

23b. Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:—it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests—it needs ongoing or long-term control or relief of symptoms— it requires your rehabilitation or for you to be specially trained to cope with it—it continues indefinitely—it comes back or is likely to come back.

23. Day care centre

A day care centre means any institution established for day care treatment of sickness and / or injuries or a medical set –up within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under:- has qualified nursing staff under its employment ;- has qualified medical practitioner (s) in charge ;- has a fully equipped operation theatre of its own

where surgical procedures are carried out- maintains daily records of patients and will make these accessible to the Insurance company's authorized personnel.

24. Injury

Injury means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a Medical Practitioner.

25. Medical Advise

Any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.

26. Medical expenses

Medical Expenses means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

27. Pre hospitalisation "Pre-hospitalization Medical Expenses

Means Medical Expenses incurred immediately before the Insured Person is Hospitalised, provided that :i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

28. Post hospitalization "Post-hospitalization Medical Expenses

Means Medical Expenses incurred immediately after the Insured Person is Hospitalised, provided that :i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

29. New Born Baby

Newborn Baby means those babies born to you and your spouse during the Policy Period Aged between 1 day and 90 days.

30. Cumulative Bonus

Cumulative Bonus shall mean any increase in the sum assured / Mallus granted by the insurer without an associated increase in premium.

31. Maternity expense/

Maternity expense / treatment shall include the following Medical treatment Expenses: a) Medical Expenses for a delivery (including complicated deliveries and caesarean sections) incurred during Hospitalization b) the lawful medical termination of pregnancy during the Policy Period limited to 2 deliveries or terminations or either during the lifetime of the Insured Person, c) Pre-natal and post-natal Medical Expenses for delivery or termination.

32. Dental Treatment

Dental treatment is treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery excluding any form of cosmetic surgery/implants.

33. Any one illness

Any one illness means continuous Period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment may have been taken.

34. Congenital Anomaly

Congenital Anomaly refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

35a. Internal Congenital Anomaly

which is not in the visible and accessible parts of the body is called Internal Congenital Anomaly

35b. External Congenital Anomaly

which is in the visible and accessible parts of the body is called External Congenital Anomaly.

35. Unproven/Experimental treatment

Unproven/Experimental treatment is treatment, including drug Experimental therapy, which is based on established medical practice in India, is treatment experimental or unproven.

36. Condition Precedent

Condition Precedent shall mean a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

37. Notification of Claim

Notification of claim is the process of notifying a claim to the insurer or TPA by specifying the timelines as well as the address / telephone number to which it should be notified.

38. Disclosure to information norm

The Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

39. Cashless service / definition

Cashless facility means the TPA / Insurer may authorize upon the definition insured's request for the direct settlement of admissible claim as per agreed charges between Network hospitals and the TPA / Insurer. In such cases, the TPA/ Insurer will directly settle all eligible amounts with the Network Hospitals and the Insured person may not have to pay any bills after the end of the treatment at hospital to the extent the claim is covered under the Policy.

40. Subrogation

Subrogation shall mean the right of the insurer to assume the rights of the insured person to recover expenses paid out under the policy that may be recovered from any other source.

41. Contribution

Contribution is essentially the right of an insurer to call upon other insurers, liable to the same insured, to share the cost of an indemnity claim on a ratable proportion.

42. Cancellation

Cancellation defines the terms on which the policy contract can be terminated either by the insurer or the insured by giving sufficient notice to other which is not lower than a period of fifteen days. The terms of cancellation may differ from insurer to insurer.

43. Renewal

Renewal defines the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of all waiting periods.

44. Portability

Portability means the right accorded to an individual health insurance policy holder (including family cover) to transfer the credit gained by the insured for pre-existing conditions and time bound exclusions if the policyholder chooses to switch from one insurer to another insurer or from one plan to another plan of the same insurer, provided the previous policy has been maintained without any break.

45. Room rent

Room Rent shall mean the amount charged by a hospital for the deductibles occupying of a bed and associated medical expenses. Deductible is a cost sharing

requirement that provides that We will not be liable for the amount of covered Medical Expenses, as specifically mentioned in the Policy Schedule, which has to be borne by You for each and every Claim during the Policy Period, before it becomes payable by Us under the Policy. This is to clarify that a deductible does not reduce the sum insured.

46. Alternative treatments

Alternative treatments are forms of treatments other than treatment "Allopathy" or "modern medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context

Annexure - II

1. CANCER OF SPECIFIED SEVERITY

A malignant tumour characterised by the uncontrolled growth & spread of malignant cells with invasion & destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy & confirmed by a pathologist. The term cancer includes leukemia, lymphoma and sarcoma.

The following are excluded –

(1) Tumours showing the malignant changes of carcinoma in situ & tumours which are histologically described as premalignant or non invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 & CIN-3.
(2) Any skin cancer other than invasive malignant melanoma
(3) All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0.....
(4) Papillary micro - carcinoma of the thyroid less than 1 cm in diameter
(5) Chronic lymphocyctic leukaemia less than RAI stage 3
(6) Microcarcinoma of the bladder
(7) All tumours in the presence of HIV infection.

2. FIRST HEART ATTACK – OF SPECIFIED SEVERITY

The first occurrence of myocardial infarction which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for this will be evidenced by all of the following criteria:

a) a history of typical clinical symptoms consistent with the
diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain)
b) new characteristic electrocardiogram changes
c) elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

The following are excluded:

(1).Non-ST-segment elevation myocardial infarction (NSTEMI) with elevation of Troponin I or T;
(2).Other acute Coronary Syndromes (3).Any type of angina pectoris.

3. OPEN CHEST CABG

The actual undergoing of open chest surgery for the correction of one or more coronary arteries, which is/are narrowed or blocked, by coronary artery bypass graft (CABG). The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a specialist medical practitioner.

Excluded are:

(1) Angioplasty and/or any other intra-arterial procedures

(2) any key-hole or laser surgery.

4. OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES

The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease-affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner. Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty are excluded.

5. COMA OF SPECIFIED SEVERITY

A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:

Ø no response to external stimuli continuously for at least 96 hours;
Ø life support measures are necessary to sustain life; and
Ø permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

6. KIDNEY FAILURE REQUIRING REGULAR DIALYSIS

End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (hemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

7. STROKE RESULTING IN PERMANENT SYMPTOMS

Any cerebrovascular incident producing permanent neurological sequelae.This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan
or MRI of the brain. Evidence of permanent neurological deficit lasting for atleast 3 months has to be produced.

The following are excluded:

Ø Transient ischemic attacks (TIA)
Ø Traumatic injury of the brain
Ø Vascular disease affecting only the eye or optic nerve or vestibular functions.

Annexure - II

8. MAJOR ORGAN /BONE MARROW TRANSPLANT

The actual undergoing of a transplant of:

Ø One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
Ø Human bone marrow using haematopoietic stem cells The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

The following are excluded:

• Other stem-cell transplants
• Where only islets of langerhans are transplanted

9. PERMANENT PARALYSIS OF LIMBS

Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.

10. MOTOR NEURONE DISEASE WITH PERMANENT SYMPTOMS

Motor neurone disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

11. MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

The definite occurrence of multiple sclerosis. The diagnosis must be supported by all of the following:
• investigations including typical MRI and CSF findings, which unequivocally confirm the diagnosis to be multiple sclerosis;
• there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months, and
• well documented clinical history of exacerbations and remissions of said symptoms or neurological deficits with atleast two clinically documented episodes atleast one month apart.

Other causes of neurological damage such as SLE and HIV are excluded.

CLAIM FORM – PART A
TO BE FILLED IN BY THE INSURED
The issue of this Form is not to be taken as an admission of liability

(To be filled in block letters)

SECTION A | SECTION B | SECTION C | SECTION D | SECTION E | SECTION F | SECTION G

DETAILS OF PRIMARY INSURED:

a) Policy No: b) Sl. No/ Certificate No:

c) Company/ TPA ID No:

d) Name : SURNAME FIRST NAME MIDDLE NAME

e) Address :

City: State:

Pin Code: Phone No: Email ID :

DETAILS OF INSURANCE HISTORY:

a) Currently covered by any other Mediclaim / Health Insurance: Yes No b) Date of commencement of first Insurance without break: D D M M Y Y (Copies of Policies to be attached)

c) If yes, company name: Policy No.

Sum Insured (Rs.) d) Have you been hospitalized in the last 4 years? Yes No Date: M M Y Y Diagnosis:

e) Previously covered by any other Mediclaim / Health insurance : Yes No f) If yes, Company Name

DETAILS OF INSURED PERSON HOSPITALIZED:

a) Name: SURNAME FIRST NAME MIDDLE NAME

b) Gender: Male Female c) Age: years Y Y months M M d) Date of Birth: D D M M Y Y

e) Relationship to Primary insured: Self Spouse Child Father Mother Other (Please Specify)

f) Occupation: Service Self Employed Homemaker Student Retired Other (Please Specify)

g) Address (if different from above):

City: State:

Pin Code: Phone No: E-mail ID:

DETAILS OF HOSPITALIZATION:

a) Name of Hospital where Admitted:

b) Room Category occupied: Day care Single occupancy Twin sharing 3 or more beds per room

c) Hospitalization due to: Injury Illness Maternity d) Date of Injury / Date Disease first detected /Date of Delivery: D D M M Y Y

e) Date of Admission: D D M M Y Y f) Time: H H : M M g) Date of Discharge: D D M M Y Y h) Time: H H : M M

i) If Injury give cause: Self inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption i. If Medico legal: Yes No

ii. Reported to police: Yes No iii. MLC Report & Police FIR attached: Yes No j) System of Medicine:

DETAILS OF CLAIM:

a) Details of the treatment expenses claimed

i. Pre-hospitalization Expenses: Rs. ii. Hospitalization Expenses: Rs.

iii. Post-hospitalization Expenses: Rs. iv. Health-Check up Cost: Rs.

v. Ambulance Charges: Rs. vi. Others (code): Rs.

Total **Rs.**

vii. Pre-hospitalization period: days viii. Post-hospitalization period: days

b) Claim for Domiciliary Hospitalization: Yes No (If yes, provide details in annexure)

c) Details of Lump sum / cash benefit claimed:

i. Hospital Daily Cash: Rs. ii. Surgical Cash: Rs.

iii. Critical Illness Benefit: Rs. iv. Convalescence: Rs.

v. Pre/Post hospitalization Lump sum benefit: Rs. vi. Others: Rs.

Total **Rs.**

Claim Documents Submitted- Check List:

- Claim Form Duly signed
- Copy of the claim intimation
- Hospital Main Bill
- Hospital Break-up Bill
- Hospital Bill Payment Receipt
- Hospital Discharge Summary
- Pharmacy Bill
- Operation Theatre Notes
- ECG
- Doctor's request for investigation
- Investigation Reports (Including CT / MRI / USG / HPE)
- Doctor's Prescriptions
- Others

DETAILS OF BILLS ENCLOSED:

Sl. No	Bill No	Date	Issued by	Towards	Amount (Rs)
1.		D D M M Y Y		Hospital Main Bill	
2.		D D M M Y Y		Pre-hospitalization Bills:___Nos	
3.		D D M M Y Y		Post-hospitalization Bills:___Nos	
4.		D D M M Y Y		Pharmacy Bills	
5.		D D M M Y Y			
6.		D D M M Y Y			
7.		D D M M Y Y			
8.		D D M M Y Y			
9.		D D M M Y Y			
10		D D M M Y Y			

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT:

a) PAN: b) Account Number:

c) Bank Name and Branch:

d) Cheque/ DD Payable details: e) IFSC Code:

(IMPORTANT: PLEASE TURN OVER)

DECLARATION BY THE INSURED:

I hereby declare that the information furnished in this claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact, my right to claim reimbursement shall be forfeited. I also consent & authorize TPA / insurance company, to seek necessary medical information / documents from any hospital / Medical Practitioner who has attended on the person against whom this claim is made. I hereby declare that I have included all the bills / receipts for the purpose of this claim & that I will not be making any supplementary claim except the pre/post-hospitalization claim, if any.

SECTION H

Date: D D M M Y Y Place: Signature of the Insured

GUIDANCE FOR FILLING CLAIM FORM – PART A (To be filled in by the insured)		
DATA ELEMENT	**DESCRIPTION**	**FORMAT**
SECTION A - DETAILS OF PRIMARY INSURED		
a) Policy No.	Enter the policy number	As allotted by the insurance company
b) SI. No/ Certificate No.	Enter the social insurance number or the certificate number of social health insurance scheme	As allotted by the organization
c) Company TPA ID No.	Enter the TPA ID No	License number as allotted by IRDA and printed in TPA documents.
d) Name	Enter the full name of the policyholder	Surname, First name, Middle name
e) Address	Enter the full postal address	Include Street, City and Pin Code
SECTION B - DETAILS OF INSURANCE HISTORY		
a) Currently covered by any other Mediclaim / Health Insurance?	Indicate whether currently covered by another Mediclaim / Health Insurance	Tick Yes or No
b) Date of Commencement of first Insurance without break	Enter the date of commencement of first insurance	Use dd-mm-yy format
c) Company Name	Enter the full name of the insurance company	Name of the organization in full
Policy No.	Enter the policy number	As allotted by the insurance company
Sum Insured	Enter the total sum insured as per the policy	In rupees
d) Have you been Hospitalized in the last 4 years	Indicate whether hospitalized in the last 4 years	Tick Yes or No
Date	Enter the date of hospitalization	Use mm-yy format
Diagnosis	Enter the diagnosis details	Open Text
e) Previously Covered by any other Mediclaim/ Health Insurance?	Indicate whether previously covered by another Mediclaim / Health Insurance	Tick Yes or No
f) Company Name	Enter the full name of the insurance company	Name of the organization in full
SECTION C - DETAILS OF INSURED PERSON HOSPITALIZED		
a) Name	Enter the full name of the patient	Surname, First name, Middle name
b) Gender	Indicate Gender of the patient	Tick Male or Female
c) Age	Enter age of the patient	Number of years and months
d) Date of Birth	Enter Date of Birth of patient	Use dd-mm-yy format
e) Relationship to primary Insured	Indicate relationship of patient with policyholder	Tick the right option. If others, please specify.
f) Occupation	Indicate occupation of patient	Tick the right option. If others, please specify.
g) Address	Enter the full postal address	Include Street, City and Pin Code
h) Phone No	Enter the phone number of patient	Include STD code with telephone number
i) E-mail ID	Enter e-mail address of patient	Complete e-mail address
SECTION D - DETAILS OF HOSPITALIZATION		
a) Name of Hospital where admitted	Enter the name of hospital	Name of hospital in full
b) Room category occupied	Indicate the room category occupied	Tick the right option
c) Hospitalization due to	Indicate reason of hospitalization	Tick the right option
d) Date of Injury/Date Disease first detected/ Date of Delivery	Enter the relevant date	Use dd-mm-yy format
e) Date of admission	Enter date of admission	Use dd-mm-yy format
f) Time	Enter time of admission	Use hh:mm format
g) Date of discharge	Enter date of discharge	Use dd-mm-yy format
h) Time	Enter time of discharge	Use hh:mm format
i) If Injury give cause	Indicate cause of injury	Tick the right option
If Medico legal	Indicate whether injury is medico legal	Tick Yes or No
Reported to Police	Indicate whether police report was filed	Tick Yes or No
MLC Report & Police FIR attached	Indicate whether MLC report and Police FIR attached	Tick Yes or No
j) System of Medicine	Enter the system of medicine followed in treating the patient	Open Text
SECTION E - DETAILS OF CLAIM		
a) Details of Treatment Expenses	Enter the amount claimed as treatment expenses	In rupees (Do not enter paise values)
b) Claim for Domiciliary Hospitalization	Indicate whether claim is for domiciliary hospitalization	Tick Yes or No
c) Details of Lump sum/ cash benefit claimed	Enter the amount claimed as lump sum/ cash benefit	In rupees (Do not enter paise values)
d) Claim Documents Submitted-Check List	Indicate which supporting documents are submitted	Tick the right option
SECTION F - DETAILS OF BILLS ENCLOSED		
Indicate which bills are enclosed with the amounts in rupees		
SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT		
a) PAN	Enter the permanent account number	As allotted by the Income Tax department
b) Account Number	Enter the bank account number	As allotted by the bank
c) Bank Name and Branch	Enter the bank name along with the branch	Name of the Bank in full
d) Cheque/ DD payable details	Enter the name of the beneficiary the cheque/ DD should be made out to	Name of the individual/ organization in full
e) IFSC Code	Enter the IFSC code of the bank branch	IFSC code of the bank branch in full
SECTION H - DECLARATION BY THE INSURED		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.		

CLAIM FORM – PART B
TO BE FILLED IN BY THE HOSPITAL
The issue of this Form is not to be taken as an admission of liability
Please include the original preauthorization request form in lieu of PART A

(To be filled in block letters)

SECTION A

DETAILS OF HOSPITAL

a) Name of the hospital:

b) Hospital ID: c) Type of Hospital: Network ☐ Non Network ☐ (If non network fill section E)

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

e) Qualification: f) Registration No. with State Code: g) Phone No.

SECTION B

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient: SURNAME FIRST NAME MIDDLE NAME

b) IP Registration Number: c) Gender: Male ☐ Female ☐ d) Age: Years YY Months MM e) Date of birth: DD MM YY

f) Date of Admission: DD MM YY g) Time: HH : MM h) Date of Discharge: DD MM YY i) Time: HH : MM

j) Type of Admission: Emergency ☐ Planned ☐ Day Care ☐ Maternity ☐ k) If Maternity i. Date of Delivery: DD MM YY ii. Gravida Status:

l) Status at time of discharge: Discharge to home ☐ Discharge to another hospital ☐ Deceased ☐

SECTION C

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a)	ICD 10 Codes	Description	b)	ICD 10 PCS	Description
i. Primary Diagnosis:			i. Procedure 1:		
ii. Additional Diagnosis:			ii. Procedure 2:		
iii. Co-morbidities:			iii. Procedure 3:		
iv. Co-morbidities:			iv. Details of Procedure:		

c) Present ailment is a complication of PED? ☐ Yes ☐ No (If Yes, specify details)

d) Pre-authorization obtained: ☐ Yes ☐ No e) Pre-authorization Number:

f) If authorization by network hospital not obtained, give reason:

g) Hospitalization due to Injury: ☐ Yes ☐ No i. If Yes, give cause Self-inflicted ☐ Road Traffic Accident ☐ Substance abuse / alcohol consumption ☐

ii. If Injury due to Substance abuse / alcohol consumption, Test Conducted to establish this: ☐ Yes ☐ No (If Yes, attach reports) iii. If Medico legal: ☐ Yes ☐ No iv. Reported to Police: ☐ Yes ☐ No

v. FIR no. vi. If not reported to police give reason:

SECTION D

CLAIM DOCUMENTS SUBMITTED - CHECK LIST

- ☐ Claim Form duly signed
- ☐ Original Pre-authorization request
- ☐ Copy of the Pre-authorization approval letter
- ☐ Copy of photo ID card of patient verified by hospital
- ☐ Hospital Discharge summary
- ☐ Operation Theatre notes
- ☐ Hospital main bill
- ☐ Hospital break-up bill
- ☐ Investigation reports
- ☐ CT/MR/USG/HPE investigation reports
- ☐ Doctor's reference slip for investigation
- ☐ ECG
- ☐ Pharmacy bills
- ☐ MLC report & Police FIR
- ☐ Original death summary from hospital where applicable
- ☐ Any other, please specify

SECTION E

DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)

a) Address of the Hospital:

City: State:

Pin Code: b)Phone No. c) Registration No.:

d) PAN: e) Number of Inpatient beds f) Facilities available in the hospital: i. OT : ☐ Yes ☐ No ii. ICU : ☐ Yes ☐ No

iii. Others :

SECTION F

DECLARATION BY THE INSURED **(PLEASE READ VERY CAREFULLY)**

I hereby declare that the information furnished in this claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact, my right to claim reimbursement shall be forfeited.I also consent & authorize TPA / insurance company, to seek necessary medical information / documents from any hospital / Medical Practitioner who has attended on the person against whom this claim is made.I hereby declare that I have included all the bills / receipts for the purpose of this claim & that I will not be making any supplementary claim except the pre/post hospitalization claim, if any.

Date: DD MM YY Place: Signature of the Insured:

SECTION G

DECLARATION BY THE HOSPITAL **(PLEASE READ VERY CAREFULLY)**

We hereby declare that the information furnished in this Claim Form is true & correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited. The signature of the insured is taken on this form after Claim Form B is fully filled up by us.

Date: DD MM YY

Place: Signature and Seal of the Hospital Authority:

GUIDANCE FOR FILLING CLAIM FORM – PART B (To be filled in by the hospital)			
	DATA ELEMENT	**DESCRIPTION**	**FORMAT**
	SECTION A - DETAILS OF HOSPITAL		
a)	Name of Hospital	Enter the name of hospital	Name of hospital in full
b)	Hospital ID	Enter ID number of hospital	As allocated by the TPA
c)	Type of Hospital	Indicate whether In network or non network nospital	Tick the right option
d)	Name of treating doctor	Enter the name of the treating doctor	Name of doctor in full
e)	Qualification	Enter the qualifications of the treating doctor	Abbreviations of educational qualifications
f)	Registration No. with State Code	Enter the registration number of the doctor along with the state code	As allocated by the Medical Council of India
g)	Phone No.	Enter the phone number of doctor	Include STD code with telephone number
	SECTION B – DETAILS OF THE PATIENT ADMITTED		
a)	Name of Patient	Enter the name of hospital	Name of hospital in full
b)	IP Registration Number	Enter insurance provider registration number	As allotted by the insurance provider
c)	Gender	Indicate Gender of the patient	Tick Male or Female
d)	Age	Enter age of the patient	Number of years and months
e)	Date of Admission	Enter date of admission	Use dd-mm-yy format
f)	Time	Enter time of admission	Use hh:mm format
g)	Date of Discharge	Enter date of discharge	Use dd-mm-yy format
h)	Time	Enter time of discharge	Use hh:mm format
i)	Type of Admission	Indicate type of admission of patient	Tick the right option
j)	If Maternity		
	Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format
	Gravida Status	Enter Gravida status if maternity	Use standard format
k)	Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
	SECTION C – DETAILS OF AILMENT DIAGNOSED (PRIMARY)		
a)	ICD 10 Code		
	Primary Diagnosis	Enter the ICD 10 Code and description of the primary diagnosis	Standard Format and Open text
	Additional Diagnosis	Enter the ICD 10 Code and description of the additional diagnosis	Standard Format and Open text
	Co-morbidities	Enter the ICD 10 Code and description of the co-morbidities	Standard Format and Open text
b)	ICD 10 PCS		
	Procedure 1	Enter the ICD 10 PCS and description of the first procedure	Standard Format and Open text
	Procedure 2	Enter the ICD 10 PCS and description of the second procedure	Standard Format and Open text
	Procedure 3	Enter the ICD 10 PCS and description of the third procedure	Standard Format and Open text
	Details of Procedure	Enter the details of the procedure	Open text
c)	Present Ailment is a Complication of PED	Indicate whether present ailment is a complication of some pre-existing disease	Tick Yes or No
d)	Pre-authorization obtained	Indicate whether pre-authorization obtained	Tick Yes or No
e)	Pre-authorization Number	Enter pre-authorization number	As allotted by TPA
f)	If authorization by network hospital not obtained, give reason	Enter reason for not obtaining pre-authorization number	Open text
g)	Hospitalization due to injury	Indicate if hospitalization is due to injury	Tick Yes or No
	Cause	Indicate cause of injury	Tick the right option
	If injury due to substance abuse/alcohol consumption, test conducted to establish this	Indicate whether test conducted	Tick Yes or No
	Medico Legal	Indicate whether injury is medico legal	Tick Yes or No
	Reported To Police	Indicate whether police report was filed	Tick Yes or No
	FIR No.	Enter first information report number	As issued by police authorities
	If not reported to police, give reason	Enter reason for not reporting to police	Open Text
	SECTION D – CLAIM DOCUMENTS SUBMITTED-CHECK LIST		
Indicate which supporting documents are submitted			
	SECTION E – DETAILS IN CASE OF NON NETWORK HOSPITAL		
a)	Address	Enter the full postal address	Include Street, City and Pin Code
b)	Phone No.	Enter the phone number of hospital	Include STD code with telephone number
c)	Registration No.	Enter the registration number of patient	As allocated by the Hospital
d)	PAN	Enter the permanent account number	As allotted by the Income Tax department
e)	Number of Inpatient Beds	Enter the number of inpatient beds	Digits
f)	Facilities available in the hospital	Indicate facilities available in the hospital	Tick the right option. If others, please specify
	SECTION F - DECLARATION BY THE INSURED		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.			
	SECTION G - DECLARATION BY THE HOSPITAL		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign and stamp			

PLEASE FAX / SCAN PAGE 1 ONLY

REQUEST FOR CASHLESS HOSPITALISATION FOR MEDICAL INSURANCE POLICY

DETAILS OF THE THIRD PARTY ADMINISTRATOR

(To be filled in block letters)

a) Name of TPA / Insurance company:

b) Toll free phone number:

c) Toll free FAX:

TO BE FILLED BY THE INSURED / PATIENT

a) Name of the Patient:

b) Gender: ☐ Male ☐ Female c) Age: Years [Y][Y] Months [M][M] d) Contact number:

e) Insured card ID number: f) Policy number / Corporate:

g) Employee ID: h) Currently do you have any other Mediclaim / Health insurance: ☐ Yes ☐ No

i. Company Name ii. Give details:

iii. Policy No. iv. Sum Insured

i) Name of the family physician: j) Contact number:

(PLEASE COMPLETE DECLARATION ON THE REVERSE SIDE OF 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 l) Date of first consultation: [D][D] [M][M] [Y][Y] II) Past history of present ailment if any:

f) Provisional diagnosis:

l) ICD 10 Code:

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

h) If Investigation & / or Medical Management provide details

i) Route of drug administration:

i) If Surgical, name of surgery :

l) ICD 10 PCS Code:

j) If other treatments provide details:

k) How did injury occur:

l) In case of accident: II) Is it RTA: ☐ Yes ☐ No III) Date of injury: [D][D] [M][M] [Y][Y] iv) Reported to Police: ☐ Yes ☐ No 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 reports)

l) In case of Maternity: ☐ G ☐ P ☐ L ☐ A LMP [D][D] [M][M] [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 / a 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: 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) . Other hospital expenses if any: Rs.

l) All inclusive package charges if any applicable Rs.

m) **Sum Total expected cost of hospitalization** **Rs.**

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]

Any other Ailment give details:

(PLEASE READ VERY CAREFULLY)

DECLARATION

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

a) Name of the treating doctor: [S][U][R][N][A][M][E] [F][I][R][S][T] [N][A][M][E] [M][I][D][D][L][E] [N][A][M][E]

b) Qualification: c) Registration No. with State Code:

Signature of treating doctor

Hospital Seal (Must include Hospital ID)

Patient / Insured Name & Signature:

(IMPORTANT: PLEASE TURN OVER)

PAGE 2: 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. In case any clarification is needed on admissibility of a particular item I shall contact T.P.A at the Toll Free Number on the reverse of this form.
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, my right to claim reimbursement of the said expenses shall be absolutely forfeited. I further declare that, in respect of the above treatment, no benefits are admissible under any other Medical Scheme or Insurance
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) **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.

Annexure - IV

List of Expenses Generally excluded in Hospitalisation Policy

S NO.	List of Expenses Generally Excluded ("Non-Medical") in Hospital Indemnity Policy -	SUGGESTIONS
	TOILETRIES/ COSMETICS/ PERSONAL COMFORT OR CONVENIENCE ITEMS	
1	ANNE FRENCH CHARGES	**Not Payable**
2	BABY CHARGES (UNLESS SPECIFIED/INDICATED)	**Not Payable**
3	BABY FOOD	**Not Payable**
4	BABY UTILITES CHARGES	**Not Payable**
5	BABY SET	**Not Payable**
6	BABY BOTTLES	**Not Payable**
7	BOTTLE	**Not Payable**
8	BRUSH	**Not Payable**
9	COSY TOWEL	**Not Payable**
10	HAND WASH	**Not Payable**
11	MOISTURISER PASTE BRUSH	**Not Payable**
12	POWDER	**Not Payable**
13	RAZOR	**Payable**
14	TOWEL	**Not Payable**
15	SHOE COVER	**Not Payable**
16	BEAUTY SERVICES	**Not Payable**
17	BELTS/ BRACES	**Essential and should be paid at least specifically for cases who have undergone surgery of thoracic or lumbar spine.**
18	BUDS	**Not Payable**
19	BARBER CHARGES	**Not Payable**
20	CAPS	**Not Payable**
21	COLD PACK/HOT PACK	**Not Payable**
22	CARRY BAGS	**Not Payable**
23	CRADLE CHARGES	**Not Payable**
24	COMB	**Not Payable**
25	DISPOSABLES RAZORS CHARGES (for site preparations)	**Payable**
26	EAU-DE-COLOGNE / ROOM FRESHNERS	**Not Payable**
27	EYE PAD	**Not Payable**
28	EYE SHEILD	**Not Payable**
29	EMAIL / INTERNET CHARGES	**Not Payable**
30	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)	**Not Payable**
31	FOOT COVER	**Not Payable**
32	GOWN	**Not Payable**
33	LEGGINGS	**Essential in bariatric and varicose vein surgery and may be considered for at least these conditions where surgery itself is payable.**
34	LAUNDRY CHARGES	**Not Payable**
35	MINERAL WATER	**Not Payable**

36	OIL CHARGES	**Not Payable**
37	SANITARY PAD	**Not Payable**
38	SLIPPERS	**Not Payable**
39	TELEPHONE CHARGES	**Not Payable**
40	TISSUE PAPER	**Not Payable**
41	TOOTH PASTE	**Not Payable**
42	TOOTH BRUSH	**Not Payable**
43	GUEST SERVICES	**Not Payable**
44	BED PAN	**Not Payable**
45	BED UNDER PAD CHARGES	**Not Payable**
46	CAMERA COVER	**Not Payable**
47	CARE FREE	**Not Payable**
48	CLINIPLAST	**Not Payable**
49	CREPE BANDAGE	**Not Payable/ Payable by the patient**
50	CURAPORE	**Not Payable**
51	DIAPER OF ANY TYPE	**Not Payable**
52	DVD, CD CHARGES	**Not Payable (However if CD is specifically sought by Insurer/TPA then payable)**
53	EYELET COLLAR	**Not Payable**
54	FACE MASK	**Not Payable**
55	FLEXI MASK	**Not Payable**
56	GAUSE SOFT	**Not Payable**
57	GAUZE	**Not Payable**
58	HAND HOLDER	**Not Payable**
59	HANSAPLAST/ ADHESIVE BANDAGES	**Not Payable**
60	LACTOGEN/ INFANT FOOD	**Not Payable**
61	SLINGS	**Reasonable costs for one sling in case of upper arm fractures may be considered**
	ITEMS SPECIFICALLY EXCLUDED IN THE POLICIES	
62	WEIGHT CONTROL PROGRAMS/ SUPPLIES/ SERVICES	**Exclusion in policy unless otherwise specified**
63	COST OF SPECTACLES/ CONTACT LENSES/ HEARING AIDS ETC.,	**Exclusion in policy unless otherwise specified**
64	DENTAL TREATMENT EXPENSES THAT DO NOT REQUIRE HOSPITALISATION	**Exclusion in policy unless otherwise specified**
65	HORMONE REPLACEMENT THERAPY	**Exclusion in policy unless otherwise specified**
66	HOME VISIT CHARGES	**Exclusion in policy unless otherwise specified**
67	INFERTILITY/ SUBFERTILITY/ ASSISTED CONCEPTION PROCEDURE	**Exclusion in policy unless otherwise specified**
68	OBESITY (INCLUDING MORBID OBESITY) TREATMENT	**Exclusion in policy unless otherwise specified**
69	PSYCHIATRIC & PSYCHOSOMATIC DISORDERS	**Exclusion in policy unless otherwise specified**
70	CORRECTIVE SURGERY FOR REFRACTIVE ERROR	**Exclusion in policy unless otherwise specified**

71	TREATMENT OF SEXUALLY TRANSMITTED DISEASES	**Exclusion in policy unless otherwise specified**
72	DONOR SCREENING CHARGES	**Exclusion in policy unless otherwise specified**
73	ADMISSION/REGISTRATION CHARGES	**Exclusion in policy unless otherwise specified**
74	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE	**Exclusion in policy unless otherwise specified**
75	EXPENSES FOR INVESTIGATION/ TREATMENT IRRELEVANT TO THE DISEASE FOR WHICH ADMITTED OR DIAGNOSED	**Not Payable - Exclusion in policy unless otherwise specified**
76	ANY EXPENSES WHEN THE PATIENT IS DIAGNOSED WITH RETRO VIRUS + OR SUFFERING FROM /HIV/ AIDS ETC IS DETECTED/ DIRECTLY OR INDIRECTLY	**Not payable as per HIV/AIDS exclusion**
77	STEM CELL IMPLANTATION/ SURGERY	**Not Payable except Bone Marrow Transplantation where covered by policy**
	ITEMS WHICH FORM PART OF HOSPITAL SERVICES WHERE SEPARATE CONSUMABLES ARE NOT PAYABLE BUT THE SERVICE IS	
78	WARD AND THEATRE BOOKING CHARGES	**Payable under OT Charges, not payable separately**
79	ARTHROSCOPY & ENDOSCOPY INSTRUMENTS	**Rental charged by the hospital payable. Purchase of Instruments not payable.**
80	MICROSCOPE COVER	**Payable under OT Charges, not separately**
81	SURGICAL BLADES,HARMONIC SCALPEL,SHAVER	**Payable under OT Charges, not separately**
82	SURGICAL DRILL	**Payable under OT Charges, not separately**
83	EYE KIT	**Payable under OT Charges, not separately**
84	EYE DRAPE	**Payable under OT Charges, not separately**
85	X-RAY FILM	**Payable under Radiology Charges, not as consumable**
86	SPUTUM CUP	**Payable under Investigation Charges, not as consumable**
87	BOYLES APPARATUS CHARGES	**Part of OT Charges, not seperately**
88	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	**Part of Cost of Blood, not payable**
89	SAVLON	**Not Payable-Part of Dressing Charges**
90	BAND AIDS, BANDAGES, STERLILE INJECTIONS, NEEDLES, SYRINGES	**Not Payable - Part of Dressing charges**
91	COTTON	**Not Payable-Part of Dressing Charges**
92	COTTON BANDAGE	**Not Payable- Part of**

		Dressing Charges
93	MICROPORE/ SURGICAL TAPE	**Not Payable-Payable by the patient when prescribed, otherwise included as Dressing Charges**
94	BLADE	**Not Payable**
95	APRON	**Not Payable -Part of Hospital Services/ Disposable linen to be part of OT/ICU chatges**
96	TORNIQUET	**Not Payable (service is charged by hospitals, consumables cannot be separately charged)**
97	ORTHOBUNDLE, GYNAEC BUNDLE	**Part of Dressing Charges**
98	URINE CONTAINER	**Not Payable**
	ELEMENTS OF ROOM CHARGE	
99	LUXURY TAX	**Actual tax levied by government is payable.Part of room charge for sub limits**
100	HVAC	**Part of room charge not payable separately**
101	HOUSE KEEPING CHARGES	**Part of room charge not payable separately**
102	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	**Part of room charge not payable separately**
103	TELEVISION & AIR CONDITIONER CHARGES	**Payable under room charges not if separately levied**
104	SURCHARGES	**Part of Room Charge, Not payable separately**
105	ATTENDANT CHARGES	**Not Payable - Part of Room Charges**
106	IM IV INJECTION CHARGES	**Part of nursing charges, not payable**
107	CLEAN SHEET	**Part of Laundry/Housekeeping not payable separately**
108	EXTRA DIET OF PATIENT(OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	**Patient Diet provided by hospital is payable**
109	BLANKET/WARMER BLANKET	**Not Payable- part of room charges**
	ADMINISTRATIVE OR NON-MEDICAL CHARGES	
110	ADMISSION KIT	**Not Payable**
111	BIRTH CERTIFICATE	**Not Payable**
112	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES	**Not Payable**

113	CERTIFICATE CHARGES	**Not Payable**
114	COURIER CHARGES	**Not Payable**
115	CONVENYANCE CHARGES	**Not Payable**
116	DIABETIC CHART CHARGES	**Not Payable**
117	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES	**Not Payable**
118	DISCHARGE PROCEDURE CHARGES	**Not Payable**
119	DAILY CHART CHARGES	**Not Payable**
120	ENTRANCE PASS / VISITORS PASS CHARGES	**Not Payable**
121	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE	**To be claimed by patient under Post Hosp where admissible**
122	FILE OPENING CHARGES	**Not Payable**
123	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)	**Not Payable**
124	MEDICAL CERTIFICATE	**Not Payable**
125	MAINTAINANCE CHARGES	**Not Payable**
126	MEDICAL RECORDS	**Not Payable**
127	PREPARATION CHARGES	**Not Payable**
128	PHOTOCOPIES CHARGES	**Not Payable**
129	PATIENT IDENTIFICATION BAND / NAME TAG	**Not Payable**
130	WASHING CHARGES	**Not Payable**
131	MEDICINE BOX	**Not Payable**
132	MORTUARY CHARGES	**Payable upto 24 hrs, shifting charges not payable**
133	MEDICO LEGAL CASE CHARGES (MLC CHARGES)	**Not Payable**
	EXTERNAL DURABLE DEVICES	
134	WALKING AIDS CHARGES	**Not Payable**
135	BIPAP MACHINE	**Not Payable**
136	COMMODE	**Not Payable**
137	CPAP/ CAPD EQUIPMENTS	**Device not payable**

138	INFUSION PUMP - COST	**Device not payable**
139	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)	**Not Payable**
140	PULSEOXYMETER CHARGES	**Device not payable**
141	SPACER	**Not Payable**
142	SPIROMETRE	**Device not payable**
143	SPO2 PROBE	**Not Payable**
144	NEBULIZER KIT	**Not Payable**
145	STEAM INHALER	**Not Payable**
146	ARMSLING	**Not Payable**
147	THERMOMETER	**Not Payable (paid by patient)**
148	CERVICAL COLLAR	**Not Payable**
149	SPLINT	**Not Payable**
150	DIABETIC FOOT WEAR	**Not Payable**
151	KNEE BRACES (LONG/ SHORT/ HINGED)	**Not Payable**
152	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER	**Not Payable**
153	LUMBO SACRAL BELT	**Essential and should be paid at least specifically for cases who have undergone surgery of lumbar spine.**
154	NIMBUS BED OR WATER OR AIR BED CHARGES	**Payable for any ICU patient requiring more than 3 days in ICU, all patients with paraplegia/quadriplegia for any reason and at reasonable cost of approximately Rs 200/ day**
155	AMBULANCE COLLAR	**Not Payable**
156	AMBULANCE EQUIPMENT	**Not Payable**
157	MICROSHEILD	**Not Payable**

158	ABDOMINAL BINDER	**Essential and should be paid at least in post surgery patients of major abdominal surgery including TAH, LSCS, incisional hernia repair, exploratory laparotomy for intestinal obstruction, liver transplant etc.**
	ITEMS PAYABLE IF SUPPORTED BY A PRESCRIPTION	
159	BETADINE \ HYDROGEN PEROXIDE\SPIRIT\\DETTOL \SAVLON\ DISINFECTANTS ETC	**May be payable when prescribed for patient, not payable for hospital use in OT or ward or for dressings in hospital**
160	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES	**Post hospitalization nursing charges not Payable**
161	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES-DIET CHARGES	**Patient Diet provided by hospital is payable**
162	ALEX SUGAR FREE	**Payable -Sugar free variants of admissable medicines are not excluded**
163	CREAMS POWDERS LOTIONS (Toileteries are not payable,only prescribed medical pharmaceuticals payable)	**Payable when prescribed**
164	DIGENE GEL/ ANTACID GEL	**Payable when prescribed**
165	ECG ELECTRODES	**Upto 5 electrodes are required for every case visiting OT or ICU. For longer stay in ICU, may require a change and at least one set every second day must be payable.**
166	GLOVES	**Sterilized Gloves payable / unsterilized gloves not payable**
167	HIV KIT	**Payable - payable Pre operative screening**
168	LISTERINE/ ANTISEPTIC MOUTHWASH	**Payable when prescribed**
169	LOZENGES	**Payable when prescribed**
170	MOUTH PAINT	**Payable when prescribed**
171	NEBULISATION KIT	**If used during hospitalization is payable reasonably**
172	NEOSPRIN	**Payable when prescribed**
173	NOVARAPID	**Payable when prescribed**
17	VOLINI GEL/ ANALGESIC GEL	**Payable when prescribed**

4		
175	ZYTEE GEL	**Payable when prescribed**
176	VACCINATION CHARGES	**Routine Vaccination not Payable / Post Bite Vaccination Payable**
	PART OF HOSPITAL'S OWN COSTS AND NOT PAYABLE	
177	AHD	**Not Payable - Part of Hospital's internal Cost**
178	ALCOHOL SWABES	**Not Payable - Part of Hospital's internal Cost**
179	SCRUB SOLUTION/STERILLIUM	**Not Payable - Part of Hospital's internal Cost**
	OTHERS	
180	VACCINE CHARGES FOR BABY	**Not Payable**
181	AESTHETIC TREATMENT / SURGERY	**Not Payable**
182	TPA CHARGES	**Not Payable**
183	VISCO BELT CHARGES	**Not Payable**
184	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]	**Not Payable**
185	EXAMINATION GLOVES	**Not payable**
186	KIDNEY TRAY	**Not Payable**
187	MASK	**Not Payable**
188	OUNCE GLASS	**Not Payable**
189	OUTSTATION CONSULTANT'S/ SURGEON'S FEES	**Not payable, except for telemedicine consultations where covered by policy**
190	OXYGEN MASK	**Not Payable**
191	PAPER GLOVES	**Not Payable**
192	PELVIC TRACTION BELT	**Should be payable in case of PIVD requiring traction as this is generally not reused**
193	REFERAL DOCTOR'S FEES	**Not Payable**
194	ACCU CHECK (Glucometery/ Strips)	**Not payable pre hospitilasation or post hospitalisation / Reports and Charts required/ Device not payable**
195	PAN CAN	**Not Payable**

196	SOFNET	**Not Payable**
197	TROLLY COVER	**Not Payable**
198	UROMETER, URINE JUG	**Not Payable**
199	AMBULANCE	**Payable-Ambulance from home to hospital or interhospital shifts is payable/ RTA as specific requirement is payable**
200	TEGADERM / VASOFIX SAFETY	**Payable - maximum of 3 in 48 hrs and then 1 in 24 hrs**
201	URINE BAG	**Payable where medicaly necessary till a reasonable cost - maximum 1 per 24 hrs**
202	SOFTOVAC	**Not Payable**
203	STOCKINGS	**Essential for case like CABG etc. where it should be paid.**

Annexure - V

FORM: IRDA-HEALTH PRODUCTS

File and Use Application form for 'health products':

S No	Item	Particulars (to be filled in by insurer)
1	Name of Non-Life Insurer	
1.1	Registration No.alloted by IRDA	
2	Name of Appointed Actuary [Please note that his appointment should be in force as on the date of this application]	
3	Brand Name [Give the name of the product which will be printed in Sales Literature and known in the market. This name should not be altered/modified in any form after launching in the market. This name shall appear in all returns etc. which would be submitted to IRDA.]	
3.1	Unique ID no. (allotted by IRDA, if this application is for modification of an exisitng product)	
4	Date of introduction of the product (proposed in case of new products; actual date in case of existing products): [In case of new products being launched for the first time in the market, give the proposed date (However the date cannot be within 30 days from date of this application) from which Insurer wants to market. In case of existing products, the actual date from which product was launched in the product.]	
5	Date of modificiation/withdrawal (proposed in case of existing products, but not applicable for new products): [(a)This must be filled as "Not Applicable" for all the new products. (b) Proposed date of modification of the features of the product, where such product is already in use in the market. (c) In case the Insurer wishes to withdraw the existing product from the market, the date of withdrawal must be furnished under this item.]	
6	General Terms and Conditions [All the items should be filled in properly and carefully. No item must be left blank.]	

6.1	Whether the health product is offered to/through: [Answer YES/NO]			
	6.1.1	Individuals		**YES / NO**
	6.1.2	Family Floater		**YES / NO**
	6.1.3	Groups		**YES / NO**
	6.1.4	Specify geographic locations in India [if YES, specify the locations.]		**YES / NO**
	6.1.5	All geographic locations in India		**YES / NO**
	6.1.6	Rural population		**YES / NO**
	6.1.7	Micro Insurance		**YES / NO**
	6.1.8	Government Schemes		**YES / NO**
	6.1.9	Indemnity basis		**YES / NO**
	6.1.10	Benefit basis		**YES / NO**
6.2	Specify the following:			
	6.2.1	Target population [This section should discuss the target market for which the product is designed. Also please enclose separately the details of any market research conducted for this purpose.]		
	6.2.2	Grace period allowed for renewal—specify the number of days allowed for renewal of the contract.		
	6.2.3	Grace period allowed for payment of premiums in installments—specify the number of days allowed for payment of premium when premiums are not paid on stiuplated dates.		
	6.2.4	Minimum Group Size (state the minimum membership of the group)		
	6.2.5	Basic Sum Insured (for groups, per member details to be furnished):		
		6.2.5.1	Minimum offered	
		6.2.5.2	Maximum offered	
		6.2.5.3	Sum insured rebates /discounts offered, if any (please provide objective and transparent criteria to offer rebates and financial justifications)	

	6.2.6	Policy Period:		
		6.2.6.1	Minimum Policy period offered	
		6.2.6.2	Maximum Policy period offered	
		6.2.6.3	Premium paying terms, if different from policy term	
	6.2.7	Modes of Premium Payment Offered:		
		6.2.7.1	State the modes of premium payment allowed- (Single premium /annual/ halfy-yearly, etc.)	
		6.2.7.2	Rebates/charges for different modes offered, with justifications:	
	6.2.8	Annualised Premium (for group give the details per member)		
		6.2.8.1	Minimum:	
		6.2.8.2	Maximum:	
		6.2.8.3	Premium rebates /discounts offered, if any (please provide objective and transparent criteria to offer rebates and financial justifications)	
	6.2.9	Entry Age:		
		6.2.9.1	Minimum:	
		6.2.9.2	Maximum:	
	6.2.10	Maximum renewal Age, for age specific products		
	6.2.11	Restrictions on travel outside India (If YES, specify the conditions]		**YES/NO**
	6.2.12	Any other restrictions [If there is restriction proposed, the same should be furnished, e.g. future occupation]		**YES/NO**
	6.2.13	Deductibles allowed		
	6.2.14	Co-pay allowed		
	6.2.15	Staff rebates or any other Rebates offered—(please provide objective and		

		transparent criteria to offer rebates and financial justifications)				
	6.2.16	Any other discounts offered—(please provide objective and transparent criteria to offer rebates and financial justifications)				
	6.2.17	Any loadings proposed—(please provide objective and transparent criteria for loadings and financial justifications)				
	6.2.18	Subrogation				
6.3	**Product details:**					
	6.3.1	Is the Product filed for the first time?	Yes/No			
		6.3..1.1	If no, furnish the date of first filing of the product. If yes, please go to item no 7 directly.			
		6.3.1.2	Please give the proposed modifications in tabular form			
		S.no	Existing Features / assumptions/premiums rates –which are proposed to modify	Proposed modifications	Justification for such modification	Any supporting data for such modification
	6.3.2	Whether the product features/assumptions/premium rates have been modified from the date of clearance?	Yes/No			
		6.3.2.1	If Yes, Please give the information of all the modifications carried out till date in tabular form:-**History of modifications carried out till date:**			
			S No	Date of modification filed with the Authority	Exisitng Features/Assumpitons/ premium rates as on date of clearance of the product i.e. before the modification	Features/Assumptions/premium rates modified from the first/subsequent filing i.e. after the clearance of the modification	Date of clearance of the modification from the Authority and the unique identification number allotted
7	Benefit Structure of the Product. [This section should describe the various contingencies under which the benfits would be payable and how these would be determined-please do not refer to any other document which is enclosed along with this]					
	Event:		Benefit Amount:			
7.1	On Hospitalization					
7.2	On events other than (7.1) – (please furnish the complete details)					

7.3	On cancellation by the insured:					
7.4	On cenaellation by the insurer					
7.5	Specify Non-forfeiture conditions [When the contract would be not null and void]					
7.6	Specify options available under the product. (e.g. to increase or decrease benefits, plan changes, etc.) [This section should specify the various options available under the product.The charges , if any, towards the cost of the option shall also be specified.]					
7.7	Procedure for renewal along with the proposed loadings, if any					
7.8	Riders / ADD-ons					
	7.8.1	Riders / Add-ons attached to the product	S.No	Rider/Add-on Name	UIN alloted by IRDA	Date of clearance
	7.8.2	Any other features that may be relevant for the product.				
8	Underwriting –Selection of Risks [This section should discuss how the different segments of the population will be dealt with for the purpose of underwriting (to the extent they are relevant and a brief detail of procedure adopted for assessment of various risk classes may be given.)					
8.1	Specify Non-medical Limit [No medical examination asked for]					
8.2	Specify when and what classes of lives would be subject to medical examination					
8.3	Specify the minimum participation of membership for groups.					
8.4	Retention Limits [Specify what limits have been proposed for the purposes of reinsurance]					
8.5	Exclusions: please specify what exclusions have been proposed for payment of benefits					
9	**Other Terms:**					
9.1	Nomination					
9.2	Conditions for revival of the contract, in case of installment premiums:					
10	**Distribution Channels & NB Strain.**					
10.1	Distribution channels:					
	10.1.1	Specify the various distribution channels to be used for distributing the product- [reply shall be specific and can not refer to the replies like “as approved by IRDA]				
	10.1.2	Commission scales to distribution channels—specify the rates which are to be paid- [reply shall be specific and can not refer to the replies like “as				

		per the ACT]						
10.2	Expected proportions of business to be procured by each channel shall be indicated for the next 5 years.		Distribution Channel	Year 1	Year 2	Year 3	Year 4	Year 5
			1.Individual Agents					
			2. Corporate Agents					
			3. Brokers					
			4. Others-specify					
			5. Total					
10.3	New Business Strain, if any		Year 1	Year 2	Year 3	Year 4	Year 5	
11	**Reinsurance arrangements:**							
11.1	Retention limit							
11..2	Name of the reinsurer (s)							
11.3	Terms of reinsurance(type of reinsurance, commissions, etc.).							
11.4	Any recapture provisions shall be described.							
11.5	Reinsurance rates provided							
11.6	Whether a copy of the reinsurance program and a copy of the Treaty is sumbitted to the Authority.		Yes/NO					
	11.6.1	Whether reinsuracne program and a copy of the treaty enclosed (required only if these are not filed with the Authority previously)	Yes/No					
12	**Pricing:** The pricing assumptions and the methodology may vary depending on the nature of product. Give details of the following							
12.1	Give the actuarial formulae, if any, used; if not, state how premiums are arrived at giving briefly the methodology and details):							
12.2	Source of data (internal/industry/ reinsurance)							
12.3	Rate of morbidity [The tables whereever relevant shall be the prescribed one.]							
12.4	Rates of policy terminations. [The rates used must be in accordance with insurer's experience, if such experience is not available, this can be from the industry/reinsurer's experience .]							
12.5	Rate of interest, if any. [The rate or rates must be consistent with the							

	investment policy of the insurer.]						
12.6	Commission scales [Give rates of commission. These are explicit items.]						
12.7	Expenses: Split into:- [Expense assumptions must be company specific. If such experience is not available, the Appointed Actuary might consider industry experience or make reasonable assumptions.]						
	12.7.1	First year expenses by : sum assured related, premium related, per policy related					
	12.7.2	Renewal expenses (including overhead expenses) by : sum assured related, premium related, per policy related					
	12.7.3	Claim expenses					
	12.7.4	Future inflationary increases, if any					
12.8	Allowance for transfers to shareholder, if any: [Please see section 49 of the Insurance Act, 1938]						
12.9	Taxation. [Please see the relevant sections of the Income Tax Act, 1961]						
12.10	Any other parameter relevant to pricing of product –please specify						
12.11	Reserving assumptions (please specify all the relevant details)						
12.12	Base rate (risk premium)-furnish the rate table, if any						
12.13	Gross premium- furnish the rate table, if any						
12.14	Expected loss ratio (for the product) -to be furnished for each plan separately						
12.15	Age-wise loss ratio- to be furnished for each plan separately	S.No	Age	Loss ratio			
12.16	Sum insured-wise- loss ratio to be furnished for each plan separately	S.No	SA	Loss ratio			
12.17	Age and sum insured wise loss ratio - to be furnished for each plan separately	Table given below (SI band and age bands shall be increased depending on the minimum and maximum SI offered)					

	S.NO	SI/Age bands	25000	50000	100000	150000	200000
	1	>=0<=2					
	2	>=3<=15					
	3	>=16<=25					
	4	>=26<=30					
	5	>=31<=35					
	6	>=36<=40					
	7	>=41<=45					
	8	>=46<=50					
	9	>=51<=55					
	10	>=56<=60					

	11	>=61<=65					
	12	>=66					
12.18	Expected combined ratio (for the product) -to be furnished for each plan separately						
12.19	Age-wise combined ratio- to be furnished for each plan separately						
12.20	Sum insured-wise- combined ratio to be furnished for each plan separately						
12.21	Age and sum insured wise combined ratio - to be furnished for each plan separately	Table given below (SI band and age bands shall be increased depending on the minimum and maximum SI offered)					
	S.NO	SI/Age bands	25000	50000	100000	150000	200000
	1	>=0<=2					
	2	>=3<=15					
	3	>=16<=25					
	4	>=26<=30					
	5	>=31<=35					
	6	>=36<=40					
	7	>=41<=45					
	8	>=46<=50					
	9	>=51<=55					
	10	>=56<=60					
	11	>=61<=65					
	12	>=66					
12.22	Expected cross-subsidy between age/sum insured/ plans etc						
12.23	Experience of similar products, if any						

	S.No	Exposure	Premium –Rs.	Number of claims	Incurred claims-Rs.	Claim frequency	Average cost per claim	Burning cost-Rs.	Loss ratio	Combined ratio
	2008-09									
	2007-08									
	2006-07									
	2005-06									
	2004-05									

1. Exposure: earned life year (no of life earned during a particular financial year);
2. Premium: premium earned during the financial year;
3.Number of claims: claims occurred during the financial year;
4. Incurred claims: Incurred amount as of today for claims mentioned in “3”;
5. Claim frequency: No. of claims/ Exposure;
6. Average cost per claim: Incurred claims / No. of claims;
7. Burning cost: Claims frequency* Average cost per claim;
8. Loss ratio: Incurred claims/ Premium;
9. Combined ratio: Loss ratio + Expense ratio;

13	Revision in pricing for existing products	
13.1	Justification for change/ modification in	

	premium			
13.2	Experience of the product across plans / sum insured / age bands	In addition to the experience of similar products in Item 12.14 t o12.23, these tables to be furnished for the product for which revision in pricing is requested		
13.3	How the pricing differs between sum insured options			
14	**Results of Financial Projections/Sensitivity Analysis:** [The profit margins should be shown for various model points for base,optimistic and pessimistic scenarios in a tabular format below. The definition of profit margin should be taken as the present value of net profits to the p.v of premiums. Please specify assumptions made in each scenario. For terms less than or equal t oone year loss ratio may be used and for terms more than one year, profit margin may be used.]			
14.1	Risk discount rate used in the profit margin			
14.2	Average Sum Insured Assumed			
14.3	Assumptions made under pessimistic scenario			
14.4	Assumptions made under optimistic scenario			
14.4	Age [PM: Profit Margin/Loss Ratio]	*PM (base scenario)*	*PM (pessimistic scenario)*	*PM (optimistic scenario)*
	>=0<=2			
	>=3<=15			
	>=16<=25			
	>=26<=30			
	>=31<=35			
	>=36<=40			
	>=41<=45			
	>=46<=50			
	>=51<=55			
	>=56<=60			
	>=61<=65			
	>=66			
15	The following specimen documents should be enclosed:			
15.1	Proposal Form**:**			
15.2	Sales Literature /Prospectus – the pamphlets made available to members of the public at the time of sale. This is the literature which is to be used by the various distribution channels for selling the produc in the market. This shall enumerate all the salient features of the product alongwith the exclusions applicable for the basic benefits and shall be incomplaince with the relevant circulars issued by the Authority at all times).			
15.3	Policy Document			
15.4	Underwriting Manual			
15.5	Claims Manual			
15.6	Premium Table			

15. Certification. The Insurer shall enclose a certificate from the Appointed Actuary, countersigned by the

principal officer of the insurer, as per specimen given below: (The language of this should not be altered at all)

" I, (**name of the appointed actuary**), the appointed actuary, hereby solemnly declare that the information furnished above is true. I also certify that, in my opinion, the premium rates, advantages, terms and conditions of the above product are workable and sound, the assumptions are reasonable and premium rates are fair."

Place Signature of the Appointed Actuary.
Date:

Name and Counter Signature of the principal officer along with name, and Company's seal.

INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY
DATABASE FORMAT
(DETAILS FOR FILE AND USE APPROVAL OF HEALTH INSURANCE PRODUCTS)

A. PRODUCT INDEX

Insurer Code:

Product Category (3-tier codes at annexure): | | | |

(The logic of Categorization is provided at Appendix 1. Accordingly, insurers have to provide the Categorization in the order of priority and the pricing impact)

Additional Category 1: | | | |

Additional Category 2: | | | |

Additional Category 3: | | | |

Number of Plans/ Variants within the product: . . . . . .

Nomenclature used for Plans/ Variants: . . . . . .

Product Commercial Name:

New or Revision: New (V00) / Revised Version (V01/V02/V03): . . . . . .

If Revision, give application/ approval dates of earlier version: . . . . . .

Unique ID no: . . . . . .
(Automatically generated field after product approval by Authority)

B. PROCESSING HISTORY (FOR INTERNAL USE ONLY)

IRDA Inward date:
IRDA Inward Number:
Nodal Officer processing the product:
IRDA File number:
Product Category: HEALTH
Last clarification received date (DDMMYY):
Approval communicated on (DDMMYY):
Text of any Major Policy Stand/ Observation by Chairman/Member on this product file:
. . . . . .
. . . . . .

C. PRODUCT DETAILS

C.a. Hospitalization : Contingencies covered:

Contingency	Covered (Y/N)	Sub-Limits in % of SI, if applicable	Sub limits in fixed rupee terms, if applicable
Room charges			
Boarding charges for patient			
Nursing charges for patient			
ICU charges			
Medical Practitioners Fees			
Operation Theatre charges			
Surgical Consumables			
Prescribed drugs			
Diagnostic tests			
Cost of blood			
Cost of transplantation			
Hospitalization expenses of donor			
Cost of artificial limbs			
Cost of pacemakers			
Parenteral Chemotherapy			
Radiotherapy			
Haemodialysis			
Domiciliary Hospitalization			
Ambulance charges			
Maternity expenses			
Neonatal expenses			
Funeral expenses			
Pre-hospitalization expenses			
Post-hospitalization expenses			
Cost of periodic health check-up for policies without claims			
Cost of periodic health check-up for policies with claims			
Day Care procedures covered			
Dental Procedures			
Hearing Aids			
Spectacles/ contact lens			
Any other contingency covered			

Whether any waiver of sub-limits is available in different plans or at different terms: Y/N
If yes, details of sub-limits which can be waived and terms for the same:

If any other contingency is covered, details of sub-limits which can be waived and terms for the same.

C.b. Waiting periods and sub limits for specified diseases:

Type of waiting period	Period in months (Mention '0' if no waiting period)	Any sub-limits in rupee terms	Any sub-limits in % of S.I. terms
General waiting period for new covers (except accidents)			
Pre-existing diseases			
Cataract			
Hernia or Hydrocele			
Benign Prostate Hypertrophy			
Hysterectomy (non-malignant)			
Fistula in Anus, Anal Fissure, Piles			
Sinusitis			
Gall Bladder Stones			
Joint replacement			
Gastric or Duodenal ulcer			
Tonsilitis or Adenoids			
Breast lumps			
Cysts, nodules or polyps			
Intervertebral disc prolapse			
Arthritis			
Varicose veins/ varicose ulcers			
Spondylosis/ Spondylitis			
Maternity cover			
Renal Failure (old product)			
Heart Disease (old product)			
Cancer (old product)			
Hypertension (old product)			
Diabetes (old product)			
Any other waiting period/ sub-limit.			

If any other waiting period/ sub-limits are applicable, details of the same.

C.c. Exclusions:

Type of exclusion	Applicable (Y/N)	Special conditions, if any
Pre-existing disease for non-indemnity or non-domestic policies		
War, invasion, war like operation		
Circumcision unless medically necessary		

Vaccination/inoculation except post-bite		
Venereal diseases and HIV/AIDS		
Pregnancy/ Maternity except ectopic pregnancy		
Voluntary termination of pregnancy		
Fertility or assisted conception		
Treatment of obesity		
Cosmetic or aesthetic procedures except for burns/ injuries etc.		
Change of life/ sex-change		
Spectacles or contact lens		
Hearing Aids		
Dental treatment except requiring hospitalization		
Convalescence/ debility		
Intentional self-injury/ suicide attempt		
Influence of intoxicating drugs or alcohol		
Expenses unlinked to active treatment in hospital		
Nuclear weapons/material		
OPD expenses except pre and post-hospitalization as covered under Scope		
Naturopathy or Yoga		
Ayurvedic Medicine		
Homeopathic Medicine		
Unani Medicine		
Unrecognized systems of medicine		
Speed contest, racing, adventure sports		
Durable or external medical equipment required post-operatively		
Personal comfort and convenience items		
Hormone replacement therapy		
Mental Illness		
Any other		

If any other exclusion applies, details of the same.

C.d. Age Limits

Minimum Age at Entry –Adult (Years)	
Maximum Age at Entry –Adult (Years)	
Maximum Age till which renewal is available –Adult (Years)	
Minimum Age at Entry –Child (Months)	
Maximum age up to which dependent children who are unmarried and unemployed can be covered (Years)	

C.e. Cost sharing:

Cost Sharing Details	Applicable (Y/N)	Details
Does the policy have compulsory deductibles		
Does the policy have voluntary deductibles		

Cost Sharing Details	Applicable (Y/N)	Percentage
Does the policy require any compulsory co-pay in network hospitals		
Does the policy have option for voluntary co-pay in network hospitals		
Does the policy require any compulsory co-pay in non-network hospitals		
Does the policy require any compulsory co-pay in hospitals outside a specified geographical area?		
Does the policy require any compulsory co-pay for pre-existing diseases?		
Does the policy require any compulsory co-pay for 'packaged' charges by hospitals?		
Any other sub-limits?		

If any other cost sharing applies, details of the same.

C.f. Loyalty Benefits

	Offered (Y/N)	At first renewal	At second renewal (cumulative)	Maximum
Cumulative No Claim Bonus				
Cumulative Loyalty Bonus (regardless of Claim history)				
Health Check up for claim-free policies				
Health check up regardless of claim history				
No Claim Discount				
Loyalty Discount (regardless of claim)				
Any Other				

If any other loyalty benefit applies, details of the same.

C.g. Other Terms and Conditions

Terms/Conditions	Applicable (Y/N)	Details as applicable
Whether the policy is only available to a restricted group (e.g. customers of a bank)		
Whether the policy is only intended for claims arising in a specified and limited network of medical providers?		
Whether change in risk is to be intimated on renewal		
Whether TPA being used for the product		
Whether there is a Premium Installment option		
Whether increase in sum insured permissible at renewal		
Whether change of options/plans within same product permissible at renewal		
Whether inward migration allowed from other products of same insurer		
Whether inward migration allowed from other/ similar products of any insurer		
Whether there are any restrictions on renewal of specific sections/ components before the maximum renewal age for the product		
Whether parents are covered under the policy?		
Whether cancellation at option of insurer is on pro-rata basis?		
Whether cancellation at option of insurer for fraudulent cases is on 'no refunds' basis		
Whether Free Look period option is provided under the policy?		
Others		

C.h. Sum Insured and Rate Structure for Primary Member:

Chart given below applicable for primary member alone: Y/N

If No, Chart applicable for: _____

Different Sums Insured (in Rs)	Sum Insured (Rs)	Premiums applicable at different ages (Rs. per annum)						
		For 25 years	For 30 years	For 40 years	For 50 years	For 60 years	For 65 years	For 70 years
Minimum sum insured available								
Premium charged for Rs. 2 lakhs sum insured where applicable	200,000							
Premium charged	300,000							

for Rs. 3 lakhs sum insured where applicable								
Maximum sum insured available								

C.i. Reinsurance Details:

Reinsurance Details	Y/N	Details
Any reinsurance other than obligatory cession		
If yes, whether pricing is linked to reinsurance rates		

C.j. Critical Illness Coverage:

C.j.1. Critical Illness	Covered (Y/N)	If yes, details thereof
If Critical Illness is an additional component of a wider health cover, whether sum insured for Critical Illness is different from that for the primary component		

C.j.2. Critical Illness	Covered (Y/N)	If yes, survival period required in number of days
Survival Period required		

C.j.3. Critical Illness	Covered (Y/N)	Period	If modified from Standard Definitions, details
Stroke resulting in permanent symptoms			
Cancer of specified severity			
Kidney Failure requiring regular dialysis			
Open Chest Coronary Artery Bypass Graft			
Major Organ/ Bone Marrow Transplant			
Coma of specified severity			
Multiple Sclerosis with persisting symptoms			
First Heart Attack of specified severity			
Open Heart repair or replacement of heart valves			
Motor Neuron Disease with permanent symptoms			
Permanent Paralysis of Limbs			
Major Injuries			
Major Burns			
Others			

If any other critical illness cover is applicable, details of the same.

C.k. Hospital Cash Coverage:

C.k.1. Hospital Cash	Covered (Y/N)	If yes, details thereof
If Hospital Cash is an additional component of a wider health cover, whether the amount of hospital cash cover is linked to sum insured		

C.k.2. Hospital Cash	Minimum Stay required (days)	Deductible if any (days)	Maximum Period Covered (days)	Minimum Daily Payout option (Rs)	Maximum Daily Payout option (Rs)
Room					
ICU					
Accidental					
Any other					

C.l. High Deductible Coverage:

High Deductible Coverage	Amount (Rs.)
Minimum Deductible Option	
Minimum Sum Insured above the minimum deductible	
Maximum Deductible Option	
Maximum Sum Insured above the maximum deductible	

C.m. Outpatient Coverage:

C.m.1. Outpatient Coverage	Y/N	If yes, Fixed Premium (Rs.)
Is the policy modeled as fixed total premium and variable OPD sum insured?		

C.m.2. Outpatient Coverage	Y/N	Period (MM/YY)
Is there any restriction on period?		
If yes, the period till which IRDA approval was given for this component		

C.m.3. Outpatient Coverage	Sum Insured (Rs)	OPD Premiums applicable for different ages (Rs. per annum)						
		For 25 years	For 30 years	For 40 years	For 50 years	For 60 years	For 65 years	For 70 years
Minimum OPD Cover offered								
Maximum OPD cover offered								

C.n. Travel Coverage:

C.n.1. Travel Coverage	Applicable (Y/N)	If yes, days	Conditions/ Details
Minimum duration of travel specified			
Maximum duration of travel specified			
Coverage for emergency evacuation-ground			
Coverage for emergency evacuation-air ambulance			
Coverage for emergency hospitalization			
Coverage for emergency OPD expenses			
Coverage for emergency repatriation			
Coverage for repatriation of mortal remains			
Coverage for attendant travel			
Coverage for loss of baggage			
Coverage for loss of passport			
Coverage for emergency stabilization in case of pre-existing diseases			
Coverage beyond emergency stabilization in cases with pre-existing diseases			
TPA used for servicing policies			
Any Other Coverage			

C.n.2. Travel Coverage	Applicable (Y/N)	If yes, Code	Details
Geographical zones where policy covers travel (Refer Travel Code Master for codes)			
If any other zone is applicable, give details of the zone.			

C.o. Pricing and Underwriting Details:

C.o.1. Pricing Criteria	Applicable (Y/N)	Rank by Priority/ Weightage
Age		
Sum Insured		
Gender		
Size of Group		
Geographical location of insured		
Deductible or Co-pay opted		
Occupation		
Policy period		
Discount for number of sections/ components covered		
Extension or reduction in geographical jurisdiction of coverage		
Any other pricing criteria		

C.o.2. Expected Claim Ratio	Percentage
Expected incurred claim ratio in first completed year	
Expected incurred claim ratio in second completed year	
Expected incurred claim ratio in third completed year	

C.o.3. Underwriting Details	Applicable (Y/N)	If yes, Age after which required
Whether entirely pre-underwritten		
Pre Insurance Medical Examination requirement		
Whether required at an earlier age based on proposal form details		

C.o.4. Underwriting Details	Applicable (Y/N)	Criteria filed with IRDA (Y/N)	Maximum loading/ discount (%)
Health-status based loading applicable on new policies			
Health status based loading applicable on renewals			
Claim history based loading applicable on renewals			
Maximum loading for all variables taken together			
Maximum discount for all variables taken together.			
Any other underwriting criteria			

If any other underwriting criteria are applicable, details of the same.

Addl. Comments/ Remarks/ Notes:

INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY

DETAILS FOR FILE AND USE APPROVAL OF HEALTH INSURANCE PRODUCTS

1	**A & B. PRODUCT INDEX & PROCESSING HISTORY**
2	**C. PRODUCT DETAILS** **C.a. Hospitalization : Contingencies covered**
3	**C.b. Waiting periods and sub limits for specified diseases**
4	**C.c. Exclusions**
5	**C.d. Age Limits & C.e. Cost sharing**
6	**C.f. Loyalty Benefits & C.g. Other Terms and Conditions**
7	**C.h. Sum Insured and Rate Structure for Primary Member & C.i. Reinsurance Details**
8	**C.j. Critical Illness Coverage & C.k. Hospital Cash Coverage**
9	**C.l. High Deductible Coverage & C.m. Outpatient Coverage**
10	**C.n. Travel Coverage**
11	**C.o. Pricing Criteria, Expected Claim Ratio & Underwriting Details**

Customer Information Sheet

Description is illustrative and not exhaustive

S. NO	TITLE	DESCRIPTION	REFER TO POLICY CLAUSE NUMBER
1	**Product Name**	• Approved Brand Name	
2	**What am I covered for:**	• Hospital admission longer than xx hrs • Related medical expenses incurred xx days prior to hospitalisation / amounting to x% of claim • Related medical expenses incurred within xx days from date of discharge / amounting to x% of claim • Specified / Listed procedures requiring less than 24 hours hospitalisation (day care) • Cover for xx critical illnesses on undergoing specified procedure or on diagnosis of an illness of specified severity • Hospital daily cash benefit of Rs__ per day • OPD / Dental / Maternity coverage • Emergency or Travel Medical Assistance etc	
3	**What are the major exclusions in the policy:**	• Any hospital admission primarily for investigation / diagnostic purpose • Pregnancy, infertility, congenital/genetic conditions, • Non-allopathic medicine, • Domiciliary treatment, treatment outside India. • Circumcision, sex change surgery ,cosmetic surgery & plastic surgery, • refractive error correction, hearing impairment correction, corrective & cosmetic dental surgeries, • Organ donor expenses, • Substance abuse, self-inflicted injuries, STDs and HIV / AIDS, • Hazardous sports, war, terrorism, civil war or breach of law, • Any kind of service charge, surcharge, admission fees, registration fees levied by the hospital. (Note: the above is a partial listing of the policy exclusions. Please refer to the policy clauses for the full listing).	
4	**Waiting period**	• **Initial waiting period:** 30 days for all illnesses (not applicable on renewal or for accidents) • **Specific waiting periods :** o 12 months for xx diseases (clauses aa to bb) o 24 months for yy diseases (clauses cc to dd) o 36 months for zz diseases (clauses ee to ff) o 48 months for xx diseases (clauses gg to hh) • **Pre-existing diseases:** Covered after __ months/ Not covered	
5	**Payout basis**	• Reimbursement of covered expenses up to specified limits AND / OR • Fixed amount on the occurrence of a covered event	
6	**Cost sharing**	• In case of a claim, this policy requires you to share the following costs: o Expenses exceeding the following **Sub-limits** ▪ Room / ICU charges beyond _____ ▪ For the following specified diseases: ▪ _____ ▪ _____ o **Deductible** of Rs XXX per claim / per year / both o xx% of each claim as **Co-payment** (yy % in a non-network hospital)	
7	**Renewal Conditions**	• Your policy is ordinarily renewable (OR Guaranteed) up to age x (OR for x years) • After you attain the age of x years, the following features of your policy change: o ---------- o ---------- • Other terms and conditions of renewal	

(LEGAL DISCLAIMER) NOTE: The information must be read in conjunction with the product brochure and policy document. In case of any conflict between the KFD and the policy document the terms and conditions mentioned in the policy document shall prevail.

S. NO	TITLE	DESCRIPTION	REFER TO POLICY CLAUSE NUMBER
8.	**Renewal Benefits:**	• x% increase in your annual limit for every claim free year (or) x% discount on renewal premium, subject to a maximum of x%. • In case a claim is made during a policy year, the bonus proportion (or) discount would reduce by x% in the following year. • For every block of x claim free policy years, free health check up for the insured persons subject to maximum x% of sum insured.	
9.	**Cancellation**	• This policy would be cancelled, and no claim or refund would be due to you if: o you have not correctly disclosed details about your current and past health status OR o have otherwise encouraged or participated in any fraudulent claims under the policy.	

(LEGAL DISCLAIMER) NOTE: The information must be read in conjunction with the product brochure and policy document. In case of any conflict between the KFD and the policy document the terms and conditions mentioned in the policy document shall prevail.

SERVICE LEVEL AGREEMENT

This agreement made and entered into on this ----- day of ------20XX at, _____, India between:-

"_____" an insurance company having its Registered Office at _____ and its Corporate Office at _____, (hereinafter referred to as the "**Insurer",** which expression shall unless repugnant to the context or meaning thereof be deemed to mean and include its successors and permitted assigns) of the First Part.

AND

"_____" licensed by the Insurance Regulatory and Development Authority under the IRDA (Third Party Administrators - Health Services), Regulation 2001, under License no _____ and having its Registered Office at (_____) (hereinafter referred to as the "**TPA**", which expression shall unless repugnant to the context or meaning thereof be deemed to mean and include its successors and permitted assigns) of the Second Part.

("**The Insurer"** and the "**TPA"** are individually referred to as a **"party"** and collectively as **"parties"**)

WHEREAS

1 The Insurer has been registered under Section 3 of the Insurance Act 1938 (Act 4 of 1938) and is, *inter-alia*, engaged in the business of providing health insurance in India.

2 The TPA has obtained a license as a Third Party Administrator under the IRDA (Third Party Administrator - Health Services) Regulation, 2001 (hereinafter referred to as "**the Regulation")** framed under Sections 14 and 26 of the Insurance Regulatory and Development Authority Act, 1999 (Act 4 of 1999) read with Section 114 A of the Insurance Act, 1938 (Act 4 of 1938) and is engaged in making available health services with regard to Health Insurance business conducted by the insurer.

3 The parties have agreed that the TPA shall provide the insured person of the Insurer, health services for a fee and on terms and conditions more particularly described in this Agreement.

4 Whereas the parties are desirous of recording in this Agreement, the terms and conditions under which the TPA will render the aforesaid services to the insured person of the Insurer.

NOW THEREFORE IT IS AGREED as follows: -

1 DEFINITIONS & INTERPRETATION

1.1 The following terms and expressions shall have the following meanings for purposes of this Agreement.

1.1.1 **"Agreement"** shall mean this agreement and all schedules supplements, appendices, appendages, annexure and modifications thereof made in accordance with the terms of this agreement and shall be deemed to be the Agreement as defined in Section 2(a) of the Regulation.

1.1.2 **"Emergency"** shall mean a serious medical condition or symptom resulting from injury or sickness which arises suddenly and requires immediate care and treatment, generally received within 24 hours of onset to avoid jeopardy to life or serious damage to the health of Insured Person, until stabilization at which time this medical condition or symptom is not considered an Emergency anymore.

1.1.3 **"Force Majeure Event"** shall have the meaning ascribed to it in clause 20 below.

1.1.4 **"Fees"** shall mean the agreed fees payable by the Insurer to the TPA for health services rendered by it as detailed in clause 3 of the Agreement hereto.

1.1.5 "Health Services by TPA" means the services to be rendered by a TPA under an agreement with an insurance company in connection with "health insurance business" or 'health cover' as defined above but does not include the business of an insurance company or the soliciting either directly or through an insurance intermediary including an insurance agent, of health insurance business or claim settlements of health insurance policies or claim rejections of health insurance policies.

1.1.6 **"IRDA"** shall mean the Insurance Regulatory and Development Authority established under the Insurance Regulatory and Development Authority Act 1999.

1.1.7 **"I.D. Card or smart card"** shall mean the identity card provided by the insurer or its representative TPA on behalf of the insurer to the Insured Persons and bearing the details listed in clause 3.1.4 of Annexure A below

1.1.8 "Network Provider" means hospitals or health care providers which have a valid agreement with the insurer to settle claims through cashless facility.

1.1.9 **"Service Area"** shall mean the area within which the Insurer has authorized the TPA to provide services.

1.1.10 **"TPA Regional Office"** shall mean the offices of the TPA located at various regional locations throughout India and agreed with the Insurer to be known as TPA Regional Office.

1.1.11 **"Underwriting Offices"** shall mean the offices of the Insurer located at various locations throughout India.

1.2 Any grammatical form of a defined term herein shall have the same meaning as that of such term.

1.4 Any reference to an Agreement, Memorandum of Understanding, Instrument or other Document (Including a reference to this agreement) herein shall be to such Agreement, Instrument or other Document, as amended, supplemented or notated pursuant to the terms thereof.

1.5 Terms and expressions denoting the singular shall include the plural and vice versa.

1.6 The term “including” shall always mean “including, without limitation,” for purposes of this Agreement.

1.7 The terms “herein”, “hereinafter”, “hereto”, “hereunder” and words of similar import refer to this agreement as a whole.

1.8 Headings are used for convenience only and shall not affect the interpretation of this Agreement.

2 THE SERVICES

The TPA hereby agrees to provide the health services, by itself, in due compliance of the terms and conditions and in the manner more particularly set out in Annexure A to this Agreement.

3 SERVICE FEES

Subject to the TPA rendering the health services, the Insurer shall pay to the TPA the Fee as detailed below

Rate of Service Charge

Type of service	Rate of service

4 CLAIMS PROCESSING AND PAYMENT (CPP) SERVICES

The procedure of processing of the claims shall be handled by the TPA Regional Offices. Any intimation of claim and receipt of claim papers by the respective Underwriting office of the Insurer shall be forwarded to the Regional Processing Office of the TPA. This service provided by the TPA along with the responsibilities of the TPA as detailed in Annexure C to this agreement is collectively referred to as the “CPP Service”.

5 CLAIMS HANDLING

The TPA shall only process the claim to facilitate the insurer to take decision on claim settlement or claims rejection, as applicable. Only the insurer shall have the right to settle or repudiate a claim. The TPA may convey the repudiation of a claim to the insured, on advice by the insurer. Where the TPA sends the intimation about the repudiation to the claimant, it shall be clearly indicated in the repudiation letter that “the claim has been repudiated as advised by the insurer” and the specific reasons thereof for repudiation. Further, the repudiation letter shall also clearly mention that

the insured may approach the grievance cell of the insurer if he/ she is not satisfied by the settlement. The contact details of grievance cell shall be provided in the letter.

6 GRIEVANCE RAISED BY INSURED AND REOPENING OF CLAIM

The Insured Person may approach the grievance cell of the Insurer against the decision of the Insurer. This right of approaching the grievance cell of the Insurer will be mentioned by the TPA in every repudiation/settlement advice as mentioned in Clause 5 above. The insurer may advise the TPA to re-open the claim and process suitably if proper and relevant documents as required for the claim settlement are submitted.

7 PROCESSING OF CLAIMS AND TURN AROUND TIME

The TPA will process all the claims applications to the extent possible within 2 working days after receipt of the complete set of claim documents,

8 MANAGEMENT INFORMATION SYSTEMS (MIS) SERVICE

The TPA shall provide management information system reports whereby the Insurer will be provided information regarding the enrolment, pre authorization/reauthorization, claims processed and such other information regarding the services as required by the Insurer. The reports will be submitted by the TPA to the Insurer on a regular basis as agreed between the Parties. The Management Information system reports provided by the TPA to the Insurer are referred to as the “MIS Service” and are detailed in Annexure D to this agreement.

9 AUTHORITY OF TPA

The TPA has declared that it has full capacity and authority to execute deliver and perform this Agreement and it has taken all necessary action(s) (corporate, statutory or to otherwise) to execute, deliver, perform and authorize the execution, delivery and performance of this Agreement and that it is fully empowered to enter into and execute this Agreement, as well as perform all its obligations hereunder.

10 TPA REPRESENTATIONS WARRANTIES AND RESPONSIBILITES

The TPA representations, warranties and responsibilities are detailed in Annexure E to this agreement

11 COMPLAINTS BEFORE JUDICIAL AND QUASI-JUDICIAL BODIES

Any complaint filed before any judicial or quasi-judicial body against the TPA for claim repudiation by insurer, would be jointly defended by the Insurer and the TPA (through an advocate in case of judicial bodies). Where an advocate has been engaged for the purpose, the professional fee will be paid by the Insurer.

Where the case is due to deficiency of health service by the TPA and is not related to policy terms and conditions, the complaint would be defended by the TPA alone and all costs to defend the complaint would be borne by the TPA.

12 AUTHORITY OF THE INSURER

The Insurer has full capacity and authority to execute deliver and perform this Agreement and it has taken all necessary action (corporate, statutory or otherwise) to execute delivery, perform and authorize the execution delivery and performance of this Agreement and that it is fully empowered to enter into and execute this Agreement as well as perform all its obligations hereunder.

13 INSURER REPRESENTATIONS WARRANTIES AND RESPONSIBILITIES

The Insurer representations, warranties and responsibilities are detailed in Annexure F to this agreement.

14 CONFIDENTIAITY

Maintenance and Confidentiality of information

(i) TPA shall abide by its obligations mentioned under IRDA (Third Party Administrators - Health Services) Regulations, 2001 with respect to data maintenance and confidentiality.

(ii) TPA shall, in maintaining the records in terms of Regulation (22) (1), follow strictly the professional confidentiality between the parties as required.

(iii) If the licence granted to the TPA is either revoked or cancelled in terms of these regulations, the data collected by the TPA and all the books, records or documents, etc., relating to the business carried on by it with regard to an insurance company, shall be handed over to that insurer by the TPA forthwith, complete in all respects.

(iv) TPA shall maintain the data under this agreement by taking all reasonable care and precautions including but not limited to:

(a) The Data must be maintained and updated using information technology.

(b) The TPA shall have systems, fireballs and all paraphernalia to avoid jeopardizing the data.

(c) The TPA shall have a Business Continuity Plan ready, in order to face any contingency that may arise.

(d) The TPA shall make adequate arrangements for data backup. Data backup shall be done in electronic data Storage (e.g. Magnetic tape, used for tertiary and off-line storage) and the data backup shall be preserved for three years

(e) The entire data related shall be sole proprietary of Insurer

The expression Confidential Information shall, without limitation, include confidential or proprietary information received by the other party whether directly from the other party or otherwise. Confidential Information includes without limitation inventions, innovations, works or intellectual property and any idea, trade secret, know-how or data of any nature concerning the development, use, formulation, manufacture or performance of either party or its products or prospective products or services, and any research and development activities, process, techniques, inventions, specifications, algorithms, prototypes, designs, drawings or test data thereof, software programs, computer programs or documentation, specifications, source code, object code of such software and computer programs, inventions, processes, engineering products, services, the Insurer's markets or the business of either party or that of their respective clients. Information shall be deemed to be confidential whether the same comes to the knowledge of the other party orally or is contained in tangible or fungible form and whether contained in a floppy disc, computer system, brochure, booklet or otherwise. Unless otherwise specified, all information received by the either party and pertaining to the other party shall be deemed to be Confidential Information. The terms of this Agreement are confidential and shall only be disclosed on a need to know basis.

The TPA shall keep the Insurer informed of any breach of the confidentiality obligations and shall provide necessary assistance and co-operation to the Insurer as the Insurer may require in this regard.

Notwithstanding anything contained herein, the restriction on use and disclosure set out above shall not apply to any Confidential Information which is required to be disclosed by way of an action, subpoena or order of a court of competent jurisdiction or of any requirement of legal process, law or governmental order, decree, regulation or rule;

15 INDEMNIFICATION

15.1 TPA shall hereby indemnify and keep the Insurer indemnified from and against all and any costs, damages or losses (whether consequential, business or otherwise) arising out of the breach of any representation warrant and or covenant made by it in this Agreement, breach of the Agreement generally or for non-fulfillment of its obligations under law or to any third party/parties.

15.2 TPA shall be solely liable for and will indemnify defend and hold harmless the other party from and against any and all claims, liability damages and/or costs (including but not limited to legal fees) arising from out of or in connection with:

15.2.1 The breach of any warranty, representation, covenant or term of this agreement;

15.2.2 The non-fulfillment of its obligations under law or to any third party / parties;

15.2.3 The gross negligence and / or willful misconduct by it and/or its Officers, Directors, Employees, Agents or Affiliates;

15.2.4 The infringement or violation of any third party's copyright patent, trade, secret, trademark, intellectual property, intellectual property right in relation to the services.

16. TERM & TERMINATION

16.1 This Agreement shall take effect on the date of execution hereof by both Parties, and shall remain in force for an initial period of 1 year subject to quarterly review at the discretion of the Insurer and also subject to a right to the Insurer to terminate the Agreement after review of the performance of the TPA by the Insurer on a monthly basis. The Insurer will review the performance of the TPA based on factors including but not limited to:-

16.1.1 The facilities set up including quality and reliability of software other infrastructure based on the volume of business serviced and arrangement made by the TPA towards servicing the Policy Holders of the TPA.

16.1.2 The quality of service provided;

16.1.3 The customers satisfaction reports received and

16.1.4 Such other factors as the Insurer deems fit and specifies

16.2 This Agreement may be terminated;

16.2.1 By both Parties by mutual consent; or

16.2.2 By the non- defaulting Party in the event of a change in the management or a change in the controlling interest of the other party without the prior written consent of the non defaulting Party; or

16.2.3 By the non-defaulting Party in the event that the other Party fails a maintain any license certification or accreditation required to conduct or perform the business contemplated by such party under this agreement; or

16.2.4 By the Insurer in the event of breach by the TPA of

(i) This agreement or

(ii) Its representations and warranties in this Agreement; or

(iii) Its covenants, agreements or obligations contained herein;

16.2.5 By the Insurer after a period of three months in pursuance of clause 16.1 above.

16.3 The TPA shall apply in writing for renewal of this agreement at least 15 days before expiry of one year from the date of execution (if not already cancelled in terms of clause 16.1). The Insurer may consider continuance of the services of the TPA and may require them to enter into a fresh agreement. Continuance of services is not mandatory but it is at the discretion of the Insurer and the decision of the Insurer shall be binding final in this regard.

16.4 This Agreement may be terminated forthwith by either Party if the other Party is prevented from performing any of its obligations hereunder due to a Force Majeure Event and such Force Majeure Event continues for a period of 4 weeks without interruption.

16.5 On termination of this agreement for any reason whatsoever.

16.5.1 The Insurer shall be liable to the TPA for all costs and charges for services performed in accordance with the terms of this agreement until the date of termination.

16.5.2 The TPA shall comply with the provisions of IRDA (Health Insurance) Regulations 2013 in case of terminations of this agreement.

16.5.3 The TPA shall not deny access to Insurer for any records, documents, evidence, books of all transactions or any related information for a period of five years from the date of termination of agreement and shall comply with the extant rules on this.

17 COSTS

Except as provided to the contrary in this Agreement, each party shall bear their own costs in relation to complying with the terms and conditions of and performing their respective obligations under this agreement including without limitation legal fees, advisory fees and other expenses required for the preparation and execution of this agreement.

18 FORCE MAJEURE

18.1 Neither Party shall be in breach of any of its obligations under this agreement to the extent that its performance is prevented, physically hindered or delayed by an act, event or circumstance (whether of the kind described herein or otherwise) which is not reasonable within the control of such.

Force Majeure shall include the following:

(a) Fire, flood, atmospheric disturbance, lighting, storm, typhoon, tornado, earthquake, washout, or other acts of God;

(b) War, riot, blockage, insurrection, acts of public enemies, civil disturbances, terrorism and sabotage and threats of such actions;

(c) Strikes lock-outs, or other industrial disturbances or labors disputes;

(d) Changes of any applicable Rule, Regulation or Law.

18.2 In the event that any Force Majeure Event continues for a period of 4 (four) weeks without interruption, the party not affected by such Force Majeure Event shall be entitled to terminate this Agreement by giving notice to the other Party pursuant to and in accordance with the provisions of clause 16.4 of this Agreement.

19 ASSIGNMENT

19.1 Neither Party shall be entitled to assign its rights and/or obligations under this agreement.

19.2 Subject to the foregoing this agreement shall be fully binding to the benefit of and be enforceable by the Parties hereto and their respective successors and permitted assigns.

20 GENERAL

20.1 The Insurer shall have the discretion in entrusting/ allocating the servicing of its policyholders to the TPA.

20.2 The Insurer may allow the TPA to continue to service the existing clients irrespective of the service area allocated to the TPA.

20.3 The Insurer shall have discretion at all times, in modifying, adding, deleting or canceling the areas and / or offices entrusted with the TPA at its sole discretion.

20.4 The Insurer shall have discretion at all time to induct new TPAs to provide services to the Policyholders at any place or region or service area.

20.5 The Insurer shall have discretion at all times to inspect the TPAs infrastructure and activities.

21 ENTIRE AGREEMENT

This Agreement entered into between the Insurer and the TPA represents the entire agreement between the Parties and shall supersede any previous agreement or understanding between the Parties in relation to matters covered hereby.

22 RELATIONSHIP

22.1 The parties to this Agreement are independent contractors. Neither Party is an agent, representative or partner of the other Party. Neither Party shall have any right, power or authority to enter into any agreement or memorandum of understanding for or on behalf of or incur any obligation or liability of or to otherwise bind the other party. This Agreement shall not be interpreted or construed to create an association, agency, joint venture collaboration or partnership between the Parties or to impose any liability attributable to such relationship upon either Party.

22.2 It is clarified that neither the TPA nor any of its employees shall be deemed to be the employees of the Insurer for any purpose whatsoever.

23 VARIATION

No variation of this Agreement shall be binding on either Party unless, and to the extent that such variation is recorded in written document executed by both Parties. Where any such document is executed by both Parties, neither Party shall allege that such document is not binding by virtue of an absence of consideration.

24 SEVERABILITY

If any provision of this Agreement is invalid, unenforceable or prohibited by Law, this Agreement shall be considered divisible as to such provision and such provision shall be inoperative and the remainder of this Agreement shall be valid, binding and do the like effect as though such provision was not included herein.

25 NOTICES

Any notice given under or in connection with this Agreement shall be in writing and in the English language. Notices may be given by being delivered to the address of the addressee as set out below (in which case the notice shall be deemed to be served at the time of delivery) by courier services or by fax or by email or by any other method agreed by the parties(in which case the original shall be sent by courier services).

_____ :
Address :
Tel :
Fax :
Email :

Name of the TPA : _____
Address of the TPA : _____,
_____ - _____
Tel : _____
Fax : _____
Email:_____

26 DISPUTE RESOLUTION

26.1 If any dispute arises between the Parties hereto during the subsistence of this agreement or thereafter in connection with the validity, interpretation, implementation or alleged breach of any provision of this agreement, the Parties will refer such dispute to their respective Head Offices for resolution. If the dispute is not resolved within 30 days of such reference, either party may refer the dispute for resolution to a sole arbitrator who shall be jointly appointed by both parties. Where the parties do not agree upon a sole arbitrator within 30 days from receipt of a request by one party from the other party, parties would appoint one arbitrator each, who shall in turn appoint the presiding arbitrator.

26.2 The law governing the arbitration shall be the Arbitration and Conciliation Act, 1996 as amended or re-enacted from time to time.

26.3 The proceedings of arbitration shall be conducted in English language.

26.4 The arbitration shall be held in XXXX, India.

27 GOVERNING LAW AND JURISDICTIONAL COURTS:

This agreement shall be governed and construed by the laws of India without regard to the conflict of laws, principles and any dispute in relation to this AGREEMENT. Disputes not resolved between the parties shall be subject to the exclusive jurisdiction of the courts at XXXX India

IN WITNESS WHEREOF the Parties have caused this agreement to be executed by their duly authorized representative in as of the date first hereinabove written.

SIGNED, SEALED AND DELIVERED
BY The Within Named
By

Authorized signatory
For _____

In the presence of

1.

2.

SIGNED SEALED AND DELIVERED
By the within named
By ……., Director
For (_____).

In the presence of
1.

2.

Annexure A

1. HEALTH SERVICE BY TPA UNDER HEALTH INSURANCE CONTRACTS

1.1 TPA to provide list of Network Service Providers.

The TPA shall make available the list of Network Service Providers affiliated by the insurer to the Insured Person in the Guidebook issued to the Insured People.

1.2 Non-Network Service Providers

The TPA shall also process claims of such Insured who have not opted for Cashless Service and also Claims of Insured who avail treatment from non-Network Service Providers.

2. CALL CENTER SERVICES

2.1 The TPA shall provide telephone services for the guidance and benefit of the Insured Persons whereby the Insured Persons shall receive guidance about various issues by dialing a national Toll free number. These services provided by the TPA subject to its responsibilities and subject to responsibilities of the Insurer as detailed in this clause 2.2, are collectively referred to as the Call Centre Service.

2.1.1 Call Centre Information

The TPA shall operate a call center for the benefit of all Insured Persons. The call center shall function for 24 hours a day 7 days a week around the year. As part of the call Centre Service the TPA shall provide the following:-

1) Provide instant accessibility to the clients for all information required about network providers.
2) Provide complete list of network hospitals at all locations of client operations.
3) Provide Fax confirmation (received, and sending).
4) Provide Claim status (Cashless, Reimbursement, and Payments).
5) Provide information related to E-Card.
6) Provide all assistance related to Cashless Claims.

2.1.2 Language

The TPA undertakes to provide the call centre service to the Insured Persons in the following languages viz. English, Hindi and local language.

2.1.3 Toll Free Number

The TPA will operate a toll free number, for general queries on cashless, claims and card statuses, auto mailers, and auto generated SMS facilities for updating claims statuses and automated email facilities. The cost of operating of the entire call centre service not limited to provision of toll free voice and fax number shall be borne solely by the TPA.

2.1.4 Call Centre Analysis

The TPA will provide general call centre statistics in a format i.e. MIS sheet for call analysis, as may be mutually agreed to by the Parties, on a monthly basis including aspects of grievance redressed and pending redressal. Any specific format, if required will have to be intimated by the Insurer in advance to the TPA.

2.1.5 Information at Local Offices

The TPA branch offices located across the country will assist the Insured Person in obtaining the necessary information during working hours of the TPA. All information required after working hours will be available from the central call center or processing house only.

2.2 Responsibilities of the Insurer in respect of the Call Centre Service

2.2.1 Insurer to inform Insured Person

The Insurer will intimate the toll free number to all Insured Persons along with addresses and other telephone numbers of the TPA's main office and regional offices.

3. CASHLESS ACCESS SERVICE

3.1 The TPA has to ensure that all the Insured Persons are provided with timely pre-authorisation to the Policy Holders as covered under the policy. This service provided by the TPA along with the responsibilities of the TPA and subject to responsibilities of the Insurer as detailed in this clause 3 is collectively referred to as the "Cashless Access Service".

3.1.1 Responsibilities of the TPA in providing the Cashless Access Service

Guidebook and other details

The TPA shall forward a user guidebook/brochure prepared by them to the Insurer for its approval, upon such approval; the guidebook/brochure shall be filed along with the agreement.

The TPA shall dispatch the approved Guidebook and related information to the Insured Person within 7 working days of receipt of information regarding the issuance of policy to the Insured Person from the Insurer along with the identity card. The Guidebook will inter-alia contain information regarding the following:

1) SMS service Details
2) Cashless request form

3) Specimen Certificate
4) List of Network providers
5) Cashless Hospitalization Process
6) Reimbursement Process
7) List of _____ branch offices and their contact numbers

3.2 Deficiencies in the Required Data

In case the data given to the TPA is not sufficient for the purpose of preparing the I.D. Card the TPA will intimate to the Head office of the Insurer immediately. The TPA shall be responsible for dispatch and delivery of the I.D. Cards to the Insured Person only after the requisite information regarding the Insured Person is submitted by the Insurer to the TPA.

3.3 I.D. Card production

The issue I.D. Cards will bear a logo of the Insurer and in a size and format mutually agreed by the Insurer and the TPA.

3.4 The I.D. Card will have:

(i) A unique specific Alpha-numerical Identification Character Set, which will be generated uniquely for each Insured Person
(ii) Name of the Insured Person and relationship with the Policy Holder
(iii) Age of the Insured Person
(iv) The photograph of the Insured Person
(v) Emergency contact number of the Insurer and the TPA
(vi) Name of the Insurer
(vii) Date of policy issue
(viii) Date of inception of first health insurance policy without break

The cost of manufacturing the I.D. Card shall be borne solely by the TPA. The Validity period of the cards can be defined by the Insurer, depending upon, whether long term cards are to be given to the Insured Person.

3.5 Dispatch of I.D. Card and other material

The I.D. card along with the Guidebook and Network Service Provider directory of the respective city/area etc will be sent directly to the Insured Person/underwriting Office as per instruction of the Insurer.

3.6 Turn Around Time for enrolment processing and I.D. Card issuance.

The TPA will complete the issuance of the I.D. Card to the Insured Person within 7 working days of receipt of complete information either from the system or the head office of the Insurer.

3.7 Deficient I.D. Cards

In case of error in data/printing mistakes etc. the Insured Person will be requested to return the I.D. Card to the TPA. TPA will rectify the mistake and redeliver the I.D. Card within 2 working days of its receipt at its office to the Insured Person.

3.8 TPA will intimate on a regular basis, the errors, which the TPA would have come across in the issue of I.D. card etc. to the Insurer.

3.9 Cost of re-issuance of the new cards arising from TPA error will be borne by TPA. Cost of re-issuance of new cards arising from error in data will be borne by the insurer/insured, as applicable, at the rate of Rs ___ per card.

3.10 Renewals of the Policy I.D. Card

Upon termination or expiry of the policy period, the cards will then have to be revalidated by the TPA on confirmation of renewal of the Policy by the Office of the Insurer without issuing fresh cards.

3.11 Reporting to Insurer Office on the Status of I.D. Card

TPA shall send a weekly report to each underwriting office via E-mail on the status of enrolment and I.D. Cards related to the particular underwriting office

3.2 Pre-Authorization for Cashless Access

The TPA shall upon getting the related medical information from the Policy Holders/ Network Service Provider, verify that the person is eligible under the policy and after satisfying itself, may recommend to insurer for pre-authorization. After receiving the recommendation from the insurer, the TPA shall issue authorization letter/guarantee of payment letter to the Network Service Provider mentioning the guarantee of the sum, duration of stay and the ailment for which the person is seeking to be admitted as a patient within 12 hrs of receipt of preauthorization request. All authorization requests received by the TPA shall have a detailed breakup of the estimated costs.

3.3 Denial of Preauthorization

In case the Provider/policy Holder fails to provide relevant medical details as required by the TPA, the TPA shall call for all the relevant details within 12

hours. If the subsequent details are also deficient the TPA shall, on the advice of the insurer, convey denial of the guarantee of payment to the Network Service Provider and may not authorize the Insured Person for cashless access. TPA shall ensure that the data received conclusively shows that the Policy holder is eligible for insurance coverage within the terms and conditions of the Policy, before the claim is forwarded to the insurer for advice.

In case of denial of pre-authorization, the TPA is expected by the Insurer to communicate to the Policyholder that denial of Cashless Access is in no way construed to be treated as denial of treatment. The Policyholder is expected to obtain the treatment as per his/her treating doctor's advice. The denial of preauthorization letter shall not be construed to mean that the Policyholder cannot claim under the terms and conditions of the Policy. The policyholder can claim for reimbursement, as and when, the Policyholder provides all the relevant medical details.

3.4 EMERGENCY CASES

In cases of emergency if the TPA is not satisfied with the medical details, it may call for all the relevant details immediately. However the TPA shall verify from the Network Service Provider about the nature of ailment and on such verification if the Policyholder is found to be eligible under the terms of the Policy, the TPA shall, on the advice of the insurer, convey the guarantee of payment letter to the Network Service Provider provided the patient is still admitted in the hospital within 4 hours. The TPA, on advice from the insurer, convey denial preauthorization within 4 hours, if the information submitted is deficient.

3.5 Responsibilities of the Insurer in providing the Cashless Access Service

3.5.1 Insurer to provide data to the TPA

The Insurer shall co-ordinate with the TPA by providing the TPA with the necessary data regarding the Policyholder so as to enable the TPA to process the applications for allotment of I.D. cards received from the Policyholders.

3.5.2 TPA not to issue I.D. Cards without sanction of Insurer

The Insurer shall ensure that the TPA issues the I.D. cards as per the terms and condition of the Policies of the Insured Persons. Any I.D. card issued without the sanction of the Insurer shall be invalid and the TPA hereby indemnifies the Insurer for any payment made under such I.D. Card not validated by the Insurer.

3.5.3 Responsibility of Collection of Data

The responsibility of making available the data to the TPA Regional office lies with the underwriting office of the Insurer the responsibility of collecting data lies with the TPA.

4. CUSTOMER RELATIONS AND CONTACT MANAGEMENT (CRCM) SERVICE

The TPA shall provide adequate services to the Policyholders and ensure that customer grievances are resolved to their satisfaction. This service provided by the TPA along with the responsibilities of the TPA and subject to responsibilities of the Insurer as detailed in this clause 4.2.1 is collectively referred to as the "CRCM" Service.

4.1 Responsibilities of the TPA in providing the CRCM Service

4.1.1 CRCM Cell

The TPA shall have a dedicated CRCM cell for receiving documents and handling individuals and groups services. The TPA shall also ensure that the CRCM cell have enough representatives and personnel in all cities/towns where Insurer has zonal offices.

4.1.2 Customer Grievance

The TPA shall act as a frontline for the redressal of Insured Person's grievances. The TPA shall also attempt to solve the grievance at their end. The grievances so recorded shall be numbered consecutively and the Insured Person who records the grievance shall be provided with the number assigned to the grievance. The TPA shall provide the Insured Person with details of the follow-up action taken as regards the grievance as and when the Insured Person requires it to do so. The TPA shall provide to the Insurer Information in pre agreed format of any complaint / grievance received by oral, written or any other form of communication.

4.1.3 Action Taken Report for Customer Grievance

The TPA shall record in details the action taken to solve the grievance of the Policyholder in the form of an action taken report [ATR] within ___ days of the recording of the grievance. The TPA shall provide the Insurer with the comprehensive action taken report ATR on the grievances reported in pre agreed format. Any grievance not solved within __ days will be intimated to the respective underwriting office.

4.1.4 Customer Satisfaction Survey

The TPA shall on annual basis carry out customer satisfaction survey from a random sample of the Insured Persons who have obtained and availed the services provided by the TPA. The TPA shall use the rating card provided in the Guidebook for the purpose of conducting the survey. The TPA is expected to provide a synopsis of the findings of the survey along with the Plan of Action to address the deficiencies, shortcomings in the service provided by the TPA, if any, or suggestions for improvement at the end of the Insurer, in a format, that may be mutually arrived at by the Parties. The Insurer reserves the sole right to carry out a survey of the Insured Persons, on its own accord, to gather customer feedback and may share the findings of the same with the TPA, who will be obliged to treat the same at par, with the findings of the survey carried out by the TPA. Further, the Insurer or agencies appointed by it or its personnel shall also have access to copies of completed survey cards, collated by the TPA, for the purposes of the survey for its audit purposes.

4.2 Responsibilities of the Insurer in providing the CRCM Service

4.2.1 Insurer to co-ordinate with TPA

The Insurer shall co-ordinate with the TPA in order to solve the grievance as and when required by the nature and circumstances of the grievance.

Annexure B

Responsibilities of the TPA in providing the Billing Service

1 Standardized Billing Pattern

The insurer will provide a standardized billing pattern in an electronic format to all their Network Service Providers and the billing and settlement shall be done by the insurer on the basis of these standardized billing patterns.

Annexure C

Responsibilities of the TPA in providing the CPP Service:-

1 Claim Intimation

The TPA shall receive claim intimation from the Insured Person/insurer. The TPA shall submit all the claim related documents to the insurer through web based platform for claim settlement/rejection by the insurer.

2 Collection of Claim documents

The TPA shall offer a single window service at the respective TPA Regional Office to the Insured Persons for receiving the claim documents. In case of pre-authorization for the Cashless Access Service, the Network Service Provider will send the claim documents along with the invoice and discharge voucher, duly signed by the Insured Person directly to the TPA. In the event that the Insured Person collects the claim documents, the Insured Person will have to submit the same to the Regional/closest office of the TPA within seven days of discharge from the medical facility. In the event that the Insured Person does not opt for a Network Service Provider the Insured Person may collect the Claim Form from either the Underwriting Office or the office of the TPA or download the form from the website of the TPA. The documents for claim will have to be submitted to TPA by the Insured Person. The TPA office will also submit the pre & post hospitalization claim documents. TPA shall give due acknowledgement of collected documents.

3 Scrutiny of Claim Documents

The TPA shall scrutinize the claim documents at the initial stage regarding the medical and eligibility aspect. Deficiency of documents, if any, shall be intimated to the Insured Person and respective underwriting Office. A reminder to send the same will again be forwarded to the insured Person after 5 working days of first intimation of the deficient documents are not received or are partially received.

4 Claim Control Number

The TPA shall issue a claim control number to all claims reported for future reference purposes.

5 Pre and Post hospitalization claims

The TPA shall receive pre and post hospitalization claim documents either along with the inpatient hospitalization papers or separately and process the same based on merit of the claim derived on the basis of documents received and refer the documents to the insurer for advice.

6 Claim Documents
The TPA shall furnish all the claim files, if any, to the insurer in accordance with the IRDA (Health Insurance) Regulations, 2012

7 Bank reconciliation

The TPA will submit Bank reconciliation Statement to the insurer on monthly basis.

Annexure D

1 Responsibilities of the TPA in providing the MIS Service:

1.1 The TPA shall ensure that the providers have furnished the standardized billing form as detail in Annexure B above.

1.2 MIS Reports will be made available to the insurer as and when required without any pre-condition by the TPA.

2 Export/Import of data through electronic media

The TPA shall arrange for export/import of data as per data formats and specifications given by the Insurer form time to time in accordance with the IRDA (Health Insurance) Regulations, 2012.

Annexure E

The TPA represents and warrants to the TPA that:

1.1 Compliance with Memorandum and Articles

Neither the making of this Agreement nor any due compliance with its terms will be in conflict with or result in the breach of or constitute a default or require any consent under:-

(a) Any provision of any Agreement or other Instrument to which the TPA is a party or by which it is bound
(b) Any judgment, injection, order, decree or award which is binding upon the TPA and/or
(c) The TPA's the memorandum and/or articles of association.

1.2 Compliance with Laws

The TPA should comply with all applicable Laws including but not limited to the Insurance Regulatory and Development Authority (Third Party Administrator – Health Services) Regulations 2001 and IRDA (Health Insurance) Regulations, 2012

1.3 Third Party Administrator License

Throughout the term of this Agreement the TPA shall continue to be licensed with the IRDA as a third party administrator.

1.4 Capability of Service

The TPA should ensure that it is capable of servicing all the health insurance policies offered by the Insurer and also has sufficient infrastructure, trained manpower and resources to carry out the activities for servicing these products and policies.

1.5 Audit of claims processed by TPA

The TPA agrees that the Insurer shall have the right to audit all claims of the Insurer processed by the TPA. The TPA further agrees to provide access to the Insurer to their books of accounts and records for the purpose. The frequency and model of audit will be decided mutually between the TPA and the Insurer, but at least on a monthly basis.

2 On execution of this Agreement and during the time it is in force the TPA agrees that it shall be responsible to and shall :

2.1 File Agreement

File a copy of this Agreement and every modification there to within 15 days of its execution to or modification, as the case may be with the IRDA

2.2 No other business

Not carry on or conduct any business other than giving third party administrator services as envisaged in the provision of the Insurance Regulatory and Development Authority (Third Party Administrator- Health Services) Regulations 2001.and IRDA (Health Insurance) Regulations, 2012

2.3 Control and Management and material change

Disclose to the Insurer the shareholding, control and management of the TPA and also intimate any material change in the shareholding, control or management of the TPA to the Insurer. Further, the TPA shall also disclose its shareholding and/or interest in control and management in any associate company/sister concern engaged in the health care services.

2.4 Intimation of change

Intimate change in the office of Chief Executive Officer (CEO) / Chief Administrative Officer (CAO) or any functional director as well as Change of Address of the Registered Office / Operation office / Regional Offices and contact details to the Insurer within one week from the date of its occurrence.

2.5 Code of Conduct

Abide by the code of conduct prescribed by the IRDA or the General Insurance Council / Life Insurance Council or the Council for Fair Business Practices, from time to time.

2.6 IRDA Regulation

Abide by the Regulations of IRDA as amended from time to time and any circular, notification or rule framed by the IRDA, from time to time.

2.7 Annual Report

Furnish to the Insurer an annual report and any other return as may be required by the IRDA on its activities.

2.8 No Separate Fees

Not charge any separate fees from the Insured Persons, which it serves under the terms of this Agreement in respect of any health insurance policies that is being serviced by the TPA on behalf of the Insurer.

2.10 Discounts and Rebates

TPA shall not demand or accept any benefits in the form of any discounts or rebates from Providers or insured.

2.11 Business Continuity Plan

Ensure that they have adequate data back up in case of any unforeseen accident for the purpose of business continuity requirement.

Annexure F

The Insurer represents and warrants to the TPA that:

1.1 Compliance with Memorandum and Articles

Neither the making of this Agreement nor compliance with its terms will be in conflict with or result in the breach of or constitute a default or require any consent under:-

(i) Any provision of any agreement or other instrument to which the Insurer is a party or by which it is bound;

(ii) Any judgment injection, order, decree or award which is binding upon the Insurer; and/or

(iii) The Insurers Memorandum and / or Articles of Association.

1.2 Compliances with Laws

It has complied with all applicable Laws including but not limited to the Insurance Regulatory and Development Authority (Third Party Administrator – Health Services) Regulations 2001.and IRDA (Health Insurance) Regulations, 2012

1.3 Insurance License

Throughout the term of this agreement the Insurer shall continue to be an insurance company under Law to carry on the activities contemplated herein.

2 On execution of this Agreement and during the time it is in force the Insurer agrees that it shall be responsible to the TPA for the following :

2.1 Inform TPA on Insured's data

Pass on the data to the TPA Regional Office on weekly/fortnightly basis as the case may be.

2.2 Insured Person to return I.D. Card

Instruct the Insured Person to return the cards upon non-renewal of the policy.

2.3 Instruct underwriting Offices

Instruct all their Underwriting Offices to utilize the services of the TPA in accordance with the agreement.

2.4 Claims Management

Forward all intimation claim documents if received by the Underwriting Offices to the respective TPA Regional Office.

Exposure Draft MoU Between Insurance Company and the Provider

Service Agreement

Between

_____

and

_____ Insurance Co. Ltd.

_____

_____

_____

This Agreement (Hereinafter referred to as “Agreement”) made at _____ on this _____ day of _____ 20__.

BETWEEN

_____(Provider) an institution located in _____, having their registered office at _____ (here in after referred to as “Provider”, which expression shall, unless repugnant to the context or meaning thereof, be deemed to mean and include it's successors and permitted assigns) as party of the FIRST PART

AND

_____ Insurance Company Limited, a Company registered under the provisions of the Companies Act, 1956 and having its registered office _____ (hereinafter referred to as “Insurer” which expression shall, unless repugnant to the context or meaning thereof, be deemed to mean and include it's successors, affiliate and assigns) as party of the SECOND PART.

The (Provider) and Insurer are individually referred to as a "Party” or “party" and collectively as "Parties” or “parties")

WHEREAS

1. Provider means a hospital or nursing home or day care center (herein after referred as “Provider”) duly recognized and authorized by appropriate authorities to impart heath care services to the public at large.
2. Insurer is registered with Insurance Regulatory and Development Authority to conduct insurance business including health insurance business.
3. Provider has expressed its desire to join Insurer's network of Providers and has represented that it has requisite facilities to extend medical facilities and treatment to beneficiaries as covered under Health Insurance Policies on terms and conditions herein agreed.
4. Insurer has on the basis of desire expressed by the Provider and on its representation agreed to empanel the Provider as empanelled provider/network provider for rendering complete health services.

In this AGREEMENT, unless the context otherwise requires:

1. the masculine gender includes the other two genders and vice versa;

2. the singular includes the plural and vice versa;
3. natural persons include created entities (corporate or incorporate) and vice versa;
4. marginal notes or headings to clauses are for reference purposes only and do not bear upon the interpretation of this AGREEMENT.
5. Should any condition contained herein, contain a substantive condition, then such substantive condition shall be valid and binding on the PARTIES notwithstanding the fact that it is embodied in the definition clause.

In this AGREEMENT unless inconsistent with, or otherwise indicated by the context, the following terms shall have the meanings assigned to them hereunder, namely:

Definition

A. Health Services shall mean all services necessary or required to be rendered by the Institution under an agreement with an insurer in connection with "health insurance business" or "health cover" as defined in regulation 2(f) of the IRDA (Registration of Indian Insurance Companies) Regulations, 2000 but does not include the business of an insurer and or an insurance intermediary or an insurance agent.
B. Beneficiaries shall mean the person/s that are covered under the health insurance policy issued by the [insurance company].
C. Confidential Information includes all information (whether proprietary or not and whether or not marked as 'Confidential') pertaining to the business of the Company or any of its subsidiaries, affiliates, employees, Companies, consultants or business associates to which the Institution or its employees have access to, in any manner whatsoever.
D. Smart Card/identification card shall mean Identification Card for health insurance policy issued by the Insurer or by its representative TPA.

NOW IT IS HEREBY AGREED AS FOLLOWS:

Article 1:

Application of Agreement

1. This Agreement shall be for a period of one year. However, it is understood and agreed between the Parties that the term of this agreement may be renewed yearly upon mutual consent of the Parties in writing, either by execution of a Supplementary Agreement or by exchange of letters on agreed terms and conditions by mutual consent of both Parties. In case the renewal process is underway and both Parties have in principle agreed to renew the agreement, all rights and obligations under this MOU may continue seamlessly.

2. Any new Provider or treatment centre that is or may in future be owned or managed by the Provider after the date of this Agreement may be added to the list of Providers by agreement between the Parties in writing.

3. [Insurance Company] reserves the right to de-empanel a Provider from the Agreement if there is a change of control affecting that Provider. The Provider shall notify [Insurance Company] in writing within 15 working days of a change of control.
4. [Insurance Company] reserves and shall always have the right to negotiate and enter in to similar agreements with other Providers and providers of healthcare services.

Article 2:

Warranties

1. By the [Insurance Company]
   a. [Insurance Company], holds a valid license from the Authority under the Act and under the Regulations to act as a Insurance Company and the said license is valid and subsisting and the same has not been revoked by the Authority under the Act and the Regulations.
   b. [Insurance Company] under this MOU is entitled to pay to the Provider for the necessary medical treatment given to the Beneficiary provided the Provider has fulfilled all the necessary conditions as mentioned.
   c. This agreement is signed by a person duly authorized by [Insurance Company] , and all the terms and conditions contained in this agreement are binding on [Insurance Company]
   d. Provider and [Insurance Company] unequivocally warrant that in the process of rendering services or documentation or billing, no illegal/unethical act/s will be committed.
2. By the Provider

The Provider warrants and represents that:

   a. It is and shall always be in compliance with all laws relating to providing Services to the Beneficiary and keeping at all times in effect all licenses, registrations, permits and other governmental approvals which may from time to time be necessary for that purpose.
   b. It has and shall continue to have the doctors, staff and employees with requisite skills, knowledge and experience to provide Services as required in this Agreement.
   c. It has never committed a criminal offence which prevents it from practicing medicines and no criminal charge has been established or are pending against it by a court of competent jurisdiction.
   d. It has procured and shall always maintain adequate insurances including but not limited to employers' liability insurance, public liability insurance, professional indemnity policy and such other insurances as required by law or as specified by the [Insurance Company].
   e. It has full power, capacity and authority to execute, deliver and perform this Agreement and has taken all necessary actions (corporate, statutory, contractual or otherwise) to authorize the execution, delivery and performance of this Agreement.

Article 3:

Scope of Services

1. The Provider shall provide packages for specified interventions/ treatment to the policyholder/insured as per the rates agreed in schedule-III. It is agreed between the parties that the package will include:

    a. The charges for medical/ surgical procedures/ interventions under the Benefit package will be no more than the package charge agreed by the Parties, for that particular year.

    b. These package rates (in case of surgical) or flat per day rate (in case of medical) will include:
        i. Registration Charges
        ii. Bed charges (General Ward in case of surgical),
        iii. Nursing and Boarding charges,
        iv. Surgeons, Anesthetists, Medical Practitioner, Consultants fees etc.
        v. Anesthesia, Blood, Oxygen, O.T. Charges, Cost of Surgical Appliances etc,
        vi. Medicines and Drugs,
        vii. Cost of Prosthetic Devices, implants,
        viii. X-Ray and other Diagnostic Tests etc,
        ix. Any other expenses related to the treatment of the patient in the Provider.

2. The Provider shall allow Insurance Company official or its representative TPA to visit the beneficiary. Insurer shall not interfere with the medical team of the Provider, however Insurer reserves the right to discuss the treatment plan with treating doctor. Further access to medical treatment records and bills prepared in the Provider will be allowed to Insurer or its representative TPA on a case to case basis with prior appointment from the Provider.

3. The Provider will convey to its medical personnel that they shall keep the beneficiary only for the required number of days of treatment and carry out only the required investigation for the particular ailment and treatment for the ailment, which he is admitted. Any other incidental investigation and consultations required by the patient during hospitalization on his request needs to be approved separately by Insurer and if it is not covered under Insurer's policy will not be paid by Insurer and the Provider needs to recover it from the patient. In all such cases, Provider will have to inform the patient that he will have to bear the cost of the same.

4. The Provider provides following services as its main operations (inclusion / exclusion may vary for each Provider
    a. Inpatient / Outpatient treatment to general public
    b. Day care procedures
    c. Preventive health check-ups
    d. Other curative treatments
    e. Pharmacy

f. Other medical or paramedical services.
g. Ambulance Service

5. The Provider hereby agrees to provide medically necessary healthcare services as may be required by the beneficiary admitted as the patient on Cashless basis in pursuance of terms and conditions of this MOU and shall follow its standard procedures for admission of patients and their standard protocols for providing necessary care to the patients.

6. General Obligations
    a. The Provider undertakes to provide the service in a precise, reliable and professional manner to the satisfaction of [Insurance Company], in accordance with the applicable legal, regulatory and ethical obligations and in accordance with additional instructions issued by [Insurance Company] in writing from time to time.
    b. The Provider shall treat the beneficiaries of [Insurance Company] according to good business practice. It shall equip itself with qualified and experienced doctors, medical and para - medical staff, nurses, etc., and also all other infrastructure essential to maintain the desired quality and standard of medication at all times.
    c. Provider shall not discriminate any beneficiary of [Insurance Company] in rendering or providing agreed healthcare services and offers to extend the kind or type of services, which a beneficiary is entitled as per his / her policy terms and conditions which will be specified in his letter of authorization.
    d. Provider shall not under any circumstances suggest or recommend or inform the beneficiary approaching the Provider for cashless service, that he/she may opt for Medical Reimbursement either in lieu of or in addition to cashless facility extended by the Insurance Company.
    e. Provider shall maintain factual medical record documentation as per Indian law and medical ethics.
    f. The Provider shall not inflate rates or indulge in excess billing or unnecessary Providerisation.
    g. The Provider shall inform personnel concerned of the [Insurance Company] of all the relevant details as and when the patient or any relative requests or asks the Provider to furnish any information which is false or untrue or fraudulent for the purpose of procuring pre-authorization or claim reimbursement, or any other related purpose.
    h. The Provider will extend priority admission facilities to the beneficiaries of the [Insurance Company] ,whenever possible.
    i. The Provider shall ensure that medical treatment/facility with all due care and accepted standards is extended to the beneficiary
    j. The Provide shall allow [Insurance Company] officials to visit the beneficiary during the hospitalization and check the indoor papers/treatment papers. The [Insurance Company] shall not interfere with the medical treatment of the Provider, however the [Insurance Company] reserves the right to discuss the treatment plan with

treating doctor. Access to medical treatment records and bills prepared in the Provider will be allowed to [Insurance Company] based on a specific request to the Provider.

Article 4

Tariff

1. The agreement is subject to the detailed schedule of fees submitted by the Provider, which has to be accepted by [Insurance Company] – included in Schedule III. Tariffs may be modified only by an amendment to the relevant Schedule executed by both the Parties in writing.
2. The Provider has to submit the fee schedule in the requisite format (specified in Schedule III). Provider should also separately list package charges. Such package charges must be inclusive of stay, medicines, consumables, surgical fees operation theatre etc. No additional payment would be entertained unless the medical team of [Insurance Company] agrees with treating consultant for any deviation.
3. Any revision in the fee schedule will be submitted to [Insurance Company] at least 15 days prior to the effective date. The [Insurance Company] reserves the right to accept or discontinue the contract after assessing the revised fee schedule.
4. In case the [Insurance Company] is not intimated regarding the revision, [Insurance Company] will pay for the services only as per the then existing agreed schedule of fees.
5. Provider agrees that the schedule of fee submitted is the lowest and if any other schedule of fees during the tenure is found lower, provider will refund such additional charges levied.
6. The Provider agrees to submit clear and unambiguous tariff and related information as well as details/change in Provider infrastructure, staffing and management changes to the [Insurance Company].

Package rates

7. Rates are as per attached Schedule III
8. Unless otherwise stated, the above package prices are fully inclusive of all costs, including (without limitation): accommodation charges, critical care (including ICU, ITU, HDU, CCU, NICU, PICU etc), laboratory, blood handling and phlebotomy, imaging, theatre fees, surgeon's fees, anaesthetist's fees, surgeon's follow-up visits in Provider, equipment usage, recovery, nursing, theatre consumables, prosthesis/implants, theatre drugs (including anaesthesia), physiotherapy, occupational therapy, hydrotherapy and dietician's fees.
9. The above package prices are valid regardless of the length of the stay in the Provider, except in exceptional circumstances (where an unexpected medical complication arises during Treatment which is not due to the mistake or negligence of the Provider and/or treating doctor). In such circumstances, Pre-Authorisation must be obtained from the [Insurance Company] for any additional costs above the package price.

Article 5:

Display of Information

1. For the ease of beneficiary, the Provider shall display the recognition and promotional material, network status and procedures for admission supplied by the [Insurance Company] at prominent location, preferably at the reception and admission counter and Casualty/Emergency departments.
2. A provider also needs to inform their reception and admissions facilities regarding the procedures of admission and obtaining Pre-authorization and discharge as per the procedures laid down in Schedule I
3. Provider agrees to the [Insurance Company] displaying the fee schedule on their website and at the Provider's reception and admission counter and Casualty/Emergency departments .

Article 6:

Provider Services- Admission Procedure

1. *Identification of Beneficiaries*
    a. The beneficiaries will be identified by the Provider on the basis of an Smart card/ ID card issued by the [Insurance Company] – which would bear the logo and wordings of the [Insurance Company]. The Smart card/ ID card may have the photograph or signature or thumb impression of the beneficiary.
    b. The Provider shall also ask for additional identity proof such as a voter's identity card, PAN Card, passport or driving license to verify the beneficiary's identity (in the event that the beneficiary is a minor, the principal policy holder's proof of identity will be required).
    c. In certain cases where Smart card/ ID cards are not yet issued by [Insurance Company or its representative TPA], Beneficiary may have only the policy document issued by [Insurance Company]. In such cases, the Provider would be required to extend services to the beneficiary.
    d. The Provider is required to take a photocopy of the Smart card/ ID card, to be submitted later with the bill or to keep as proof of the beneficiary being treated.

2. *Planned Admission*

It is agreed between the parties that on receipt of request for hospitalization on behalf of the beneficiary the process to be followed by the Provider is prescribed in Schedule I.

3. *Emergency admission*
    a. The Parties agree that the Provider shall admit the Beneficiary in the case of emergency but pre-authorization request will need to made within 24 hours of the admission.
    b. Provider upon deciding to admit the Beneficiary should inform/ intimate over phone immediately to the 24 hours Insurer's helpdesk or the local/ nearest Insurer office or its representative TPA.

c. The data regarding admission shall be sent electronically to the server of the insurance company.
d. On receipt of the preauthorization form for the Provider giving the details of the ailments for admission and the estimated treatment cost, which is to be forwarded within 12 hours of admission, Insurer directly or through its representative TPA undertakes to issue the confirmation letter for the admissible amount within 4 hours of the receipt of the preauthorization form subject to policy terms & conditions.
e. In case the ailment is not covered or given medical data is not sufficient for the medical team to confirm the eligibility, Insurer can deny the guarantee of payment, which shall be addressed, to the Insured under intimation to the Provider. The Provider will have to follow their normal practice in such cases.
f. Denial of Authorization/ guarantee of payment in no way mean denial of treatment. The Provider shall deal with each case as per their normal rules and regulations.
g. Pre-Authorization certificate will mention the amount guaranteed class of admission, eligibility of beneficiaryor various sub limits for rooms and board, surgical fees etc. wherever applicable. Provider must take care to ensure compliance.
h. The guarantee of payment is given only for the necessary treatment cost of the ailment covered and mentioned in the request for Providerization. Any investigation carried out at the request of the patient but not forming the necessary part of the treatment also must be collected from the patient.
i. In case the sum available is considerably less than the estimated treatment cost, Provider should follow their normal norms of deposit/ running bills etc., to ensure that they realize any excess sum payable by the policyholders/insured under the health insurance policy, not provided for by indemnity.

Article 7:

Checklist for the Provider at the time of Patient Discharge

1. Original discharge summary and billing format as stipulated in Schedule-IV and Schedule-V respectively, counterfoil generated at the time of discharge, original investigation reports, all original prescription & pharmacy receipt etc. must not be given to the patient. These are to be shared on a real time basis to billing department of the insurer or its representative TPA who will compile and preserve with the insurer.

2. The Discharge card/Summary must mention the duration of ailment and duration of other disorders like hypertension or diabetes and operative notes in case of surgeries etc as per the format.

3. Signature or thumb impression of the patient policyholders/insured on final Provider bill must be obtained.

Article 8:

Billing & Payment terms

1. The Provider will submit all the original medical bills, discharge summary, investigation reports along with all the documents of hospitalization and the treatment carried on in the Provider along with the final preauthorization request.

2. The Provider will submit the final docket to the corporate office or designated local office of the [Insurance Company].

3. The final docket must contain the following:
   a. Preauthorization letter, beneficiary acceptance letter and duly signed claim form,
   b. Original final bill with detailed break up of miscellaneous, consumables and other charges.
   c. Original and complete discharge card/ summary mentioning the duration of ailment and duration of other disorders Like hypertension or diabetes if any.
   d. Original investigation reports with corresponding prescription/ request.
   e. Pharmacy bill if supplied by Provider with corresponding request.
   f. Any other statutory documentary evidence required under law or policy terms and conditions
   g. Status of deposit paid if any by policyholder.

2. All the payments shall be made by direct electronic fund transfer to the extent possible within 24 hours of submission of completd electronic claim documents in the prescribed format. However if required, the [Insurance Company or its representative TPA] can:
   a. call for further document related to treatment to process the case, in which case the Provider acknowledges that payment may be delayed.
   b. visit Provider to gather further documents related to treatment to process the case.

3. If payments are not made within 24 hours of such submission, the insurer shall make payment of all eligible bills within the twenty one days from the date of receipt of such submission.

4. All payments made by the [Insurance Company] shall be subject to deduction of tax at source as applicable under the relevant laws.

5. Provided that the [Insurance Company] shall have a right to reject the payment of the claims that are not in accordance with the terms and conditions of the insurance policy . The [Insurance Company] shall also not be liable to pay the due bills to the Provider within 24 hours if the sufficient documents and the further information as may be required is not provided. However, the Provider shall furnish all the required information within 2 working days of discharge of the patient.

6. Provider shall approach to the Insurance Company for the recovery of any such denied payment.

7. The [Insurance Company] shall have a right to deduct such items from the final bills as are not correlated with corresponding report. However, the Provider may send these reports within 30 days of receiving the payment to get the amount so deducted. Due reason for deductions if any will be given at the time of settlement of the bills by the insurer

8. The Provider shall be liable to refund any such amounts which has been paid to them due to concealment of material facts or misleading information, or difference in the information in the discharge summary/ documents from the Pre authorization.
9. If the Provider submits an invoice for Charges that are not in accordance with Schedule III (on tariffis) or as set out in this Agreement, such invoices may be rejected or shortfalled by [Insurance Company].

10. The [Insurance Company] shall not be obliged to pay any invoice issued by the Provider for a claim for Treatment that was provided more than 6 months prior to the date of issue of the invoice.

Payment Reconciliation process

11. On a regular basis – but at least quarterly, the [Insurance Company] would provide a list of all outstanding payments to the Provider.

12. This report would be provided in a standard format as agreed between the parties

13. The parties shall meet regularly, but at least once in two months – to review all such pending claims to discuss a suitable solution

14. Provider will submit online claim report alongwith the discharge summary in accordance with the rates as prescribed in the Schedule-III on a daily basis.

Network Rejections

15. A "Network Rejection" is defined as a situation where part or whole of an Authorization Letter (AL) is revoked by the [Insurance Company] on account of further information which comes to light when the Provider submits the claims to the [Insurance Company] for payment.

16. Reauthorizations are an essential control to ensure that network rejections – and the consequent disputes between [Insurance Company] and Providers are minimized.

17. Where the preauthorization / reauthorization was wrongly given by the [Insurance Company] to the Provider, the Provider would have full recourse upto the amount of the preauthorization to the [Insurance Company].

18. Where there was a change in the clinical line of treatment after admission, and a reauthorization was obtained, the reauthorization limits and decision would apply.

19. Where there was a change in the clinical line of treatment after admission, and no reauthorization was obtained, the Provider would have recourse to the patient only, for the entire amount of the preauthorization.

20. Where the case papers provided at claims stage show the existence of pre-existing diseases which are not disclosed under the policy, the [Insurance Company] would not be liable to pay the claim – and the preauthorization or reauthorization would stand void.
21. Where the case has been investigated by the clinical team of the [Insurance Company] and found to be fraudulent – the preauthorization / reauthorization would stand void and the Provider would not have recourse to the [Insurance Company] for the amounts.

22. Where the claim amount includes a secondary or subsequent ailment for which no AL has been obtained the [Insurance Company] would not be liable to pay for costs linked to the secondary ailment.

Article 9:

Declarations and Undertakings of a Provider

1. The Provider undertakes that they have obtained all the registrations/ licenses/ approvals required by law in order to provide the services pursuant to this agreement and that they have the skills, knowledge and experience required to provide the services as required in this agreement.

2. The Provider undertakes to uphold all requirement of law in so far as these apply to him and in accordance to the provisions of the law and the regulations enacted from time to time, by the local bodies or by the central or the state govt. The Provider declares that it has never committed a criminal offence which prevents it from practicing medicines and no criminal charge has been established against it by a court of competent jurisdiction.

Article 10:

General responsibilities & obligations of the Provider

1. Ensure that no confidential information is shared or made available by the Provider or any person associated with it to any person or entity not related to the Provider without prior written consent of Insurer.

2. The Provider shall provide cashless facility to the beneficiary in strict adherence to the provisions of the agreement.

3. The Provider will have this facility covered by proper indemnity policy including errors, omission and professional indemnity insurance and agrees to keep such policies in force during entire tenure of the MoU. The cost/ premium of such policy shall be borne solely by the Provider.

4. The Provider shall provide the best of the available medical facilities to the policyholders/insured under the health insurance policy.

5. The Provider shall endeavor to have an officer in the administration department assigned for insurance patient and the officers will eventually learn the various types of medical benefits offered under the different insurance plans.

6. The Provider shall display their status of preferred service provider at their reception/ admission desks along with the display and other materials supplied by Insurer whenever possible for the ease of the policyholders/insured.

7. The Provider shall at all times during the course of this agreement maintain a helpdesk to manage all insurance patients. This helpdesk would contain the following:
    a. Facility of telephone
    b. Facility of fax machine
    c. PC Computer
    d. Internet/ Any other connectivity to the Insurance Company Server
    e. A person to man the helpdesk at all times.
    f. Get Two persons in the Provider trained

8. The above should be installed within 15 days of signing of this agreement. The Provider also needs to inform and train personnel on the process of obtaining Authorization for conditions not covered under the list of packages, and have a manned helpdesk at their reception and admission facilities for aiding in the admission procedures for policyholders/insured under the health insurance policy.

9. The Provider shall admit, on priority and expeditiously, a beneficiary to the Provider for the purpose of Treatment without seeking any deposit or advance payment from the Beneficiary or the [Insurance Company].

10. For Planned and Emergency Admissions, the Provider shall, without any delay, arrange to secure Pre-Authorization in respect of Services and Treatment to be provided to a beneficiary and shall comply with the Pre-Authorization Procedure as detailed in Schedule I.

11. The Provider shall ensure that all relevant information in relation to the condition of, and the Treatment to be received by, the Beneficiary is fully detailed to enable [Insurance Company] to determine whether the Treatment is covered within the terms of the Beneficiary's Plan and whether any amounts would be payable by the Beneficiary towards the cost of Treatment.

12. The Provider shall ensure that the proposed cost of treatment in the submitted Pre-Authorization form against each case is reasonable, appropriate and within the defined code of conduct under medical terminology.

13. If the [Insurance Company] at any time discovers that the Provider, advertently fraudulently or negligently provided untrue, incorrect or insufficient information the [Insurance Company] reserves the right to withdraw the Pre-authorization and refuse payment of the resulting claim.

14. The Provider shall take Pre-authorization from [Insurance Company] each time the period covered by the Pre-authorization has expired, or if any aspect of the Treatment has changed.
15. Whenever request is made for additional Authorization (called Re-authorization), the Provider shall request the [Insurance Company] for such additional preauthorization not less than 8 hours before discharge

16. The [Insurance Company] shall not be responsible for costs or claims in respect of Treatment not covered by Pre-Authorisation or for which there is no Pre-Authorisation. These costs are to be recovered by the Provider from the Beneficiary. Typically these include the following:
    a. Cost of services not covered by Pre-authorization, including the list of non-medical items specified in Schedule VI
    b. Services which are excluded under the Beneficiary's Plan
    c. Level of service or entitlement higher than the Beneficiarys Plan entitlement (E.g. Room category)
    d. Costs in relation to excess / deductible / copays.

17. The Provider will comply with the Case Management Procedure – where this has been agreed with the [Insurance Company] in advance.

18. Provider warrants that at no point of time will the cashless facility be revoked without tendering a minimum XX day prior notice in writing, signed and sealed and providing adequate reasons to the Chief Operating Officer of the [Insurance Company]. Further the [Insurance Company] shall be given a minimum of 15 days time to response to the notice/ resolve the problem or accept the decision of provider. During this period, beneficiarys would continue to be provided cashless facility for treatment.

19. The Provider shall also Endeavour to comply with future requirement of the [Insurance Company] to provide for standardized billing, /ICD coding etc and if mandated by industry standards or by by statutory requirement both parties agree to review the same.

Article 11:

General responsibilities of Insurer

1. Insurer has a right to avail similar services as contemplated herein from other institution for the Health services covered under this agreement.

2. Turn around times

Preauthorization / Reauthorizations

Preauthorizations	
Planned Admissions	
Emergency Admissions	
Road Traffic Accidents / Medico Legal Cases	
Outpatient services	
Reauthorization	

3. Any cost with respect to the non-medical items listed in Schedule VI shall not be payable to the Provider by the [Insurance Company] , and Payment for Medical Benefits shall only be as per the Schedule III and the terms of this Agreement.

Product coverage and Tariffs

4. The [Insurance Company] shall intimate the Provider regarding modification of the terms of Policies and also regarding new packages made available by the [Insurance Company] for its policyholders/insured and provides sufficient notice to the Provider to adopt the same.

Article 12:

Relationship of the Parties

Nothing contained herein shall be deemed to create between the Parties any partnership, joint venture or relationship of principal and agent or master and servant or employer and employee or any affiliate or subsidiaries thereof. Each of the Parties hereto agree not to hold itself or allow its directors employees/agents/representatives to hold out to be a principal or an agent, employee or any subsidiary or affiliate of the other.

Article 13:

Reporting

In the first week of each month, beginning from the first month of the commencement of this Agreement, the Provider and Insurer shall exchange information on their experiences during the month and review the functioning of the process and make suitable changes whenever required. However, all such changes have to be in writing and by way of suitable supplementary agreements or by way of exchange of letters.

All official correspondence, reporting, etc pertaining to this Agreement shall be conducted with Insurer at its corporate office/regional office at the address _____.

Article 14:
Termination

1. Insurer reserves the right to terminate this agreement as per the guidelines as given in Scheduel-II

2. This Agreement may be terminated by either party by giving three month's prior written notice by means of registered letter or a letter delivered at the office and duly acknowledged by the other, provided that this Agreement shall remain effective thereafter with respect to all rights and obligations incurred or committed by the parties hereto prior to such termination.

3. Either party reserves the right to inform public at large along with the reasons of termination of the agreement by the method which they deem fit.

4. The [Insurance Company] shall have a right to terminate this Agreement, with a prior notice of three months; the [Insurance Company] shall however ensure that the payments due in respect of medical treatment already provided or being provided shall be made as per Schedule-III.

5. The [Insurance Company] reserves the right not to pay any such bill which as per the understanding of [Insurance Company] is fraudulent and on the basis of which the termination notice is being served.

6. The Provider shall have the right to terminate the Agreement with the [Insurance Company] with prior notice of three months. However in such instances the Provider shall ensure, that all admitted patients under going treatment at the time of termination are treated completely and discharged.

7. The provider shall be obliged to provide cashless authorization to the beneficiaries during the period of notice.

Article 15:
Confidentiality

1. This clause shall survive the termination/expiry of this Agreement.

2. Each party shall maintain confidentiality relating to all matters and issues dealt with by the parties in the course of the business contemplated by and relating to this agreement. The Provider shall not disclose to any third party, and shall use its best efforts to ensure that its, officers, employees, keep secret all information disclosed, including without limitation, document marked confidential, medical reports, personal information relating to insured, and other unpublished information except as maybe authorized in writing by Insurer. Insurer shall not disclose to any third party and shall use its best efforts to ensure that its directors,

officers, employees, sub-contractors and affiliates keep secret all information relating to the Provider including without limitation to the Provider's proprietary information, process flows, and other required details.

3. In Particular the Provider agrees to:
    a. Maintain confidentiality and endeavour to maintain confidentiality of any persons directly employed or associated with health services under this agreement of all information received by the Provider or such other medical practitioner or such other person by virtue of this agreement or otherwise, including Insurer's proprietary information, confidential information relating to insured, medicals test reports whether created/ handled/ delivered by the Provider. Any personal information relating to a Insured received by the Provider shall be used only for the purpose of inclusion/preparation/finalization of medical reports/ test reports for transmission to Insurer only and shall not give or make available such information/ any documents to any third party whatsoever.
    b. Keep confidential and endeavour to maintain confidentiality by its medical officer, employees, medical staff, or such other persons, of medical reports relating to Insured, and that the information contained in these reports remains confidential and the reports or any part of report is not disclosed/ informed to the Insurance Agent / Advisor under any circumstances.
    c. Keep confidential and endeavour to maintain confidentiality of any information relating to Insured, and shall not use the said confidential information for research, creating comparative database, statistical analysis, or any other studies without appropriate previous authorization from Insurer and through Insurer from the Insured.

Article 16:
Indemnities and other Provisions

INSPECTION, AUDIT AND ACCESS RIGHTS

1. Upon reasonable notice to the Provider and subject to appropriate supervision by the Provider's staff, [Insurance Company] or its representative TPA shall have the right to reasonable access during working hours to conduct an inspection of the Provider from time to time in connection with:
    a. quality assuring specific Services;
    b. reasonable concerns about the Provider expressed by anyone; and/or
    c. audit of the Provider's compliance with the management of care and quality standards as agreed.
    d. Any other matter as required under this agreement

2. If any material issue of quality and/or any issue of safety is identified as a result of any inspection carried out under Clause 1 , [Insurance Company] shall immediately notify the Provider of the issue and the remedial action required. The Provider undertakes to take such remedial action forthwith as may be advised by [Insurance Company].

3. [Insurance Company] may, on reasonable notice to the Provider, conduct an audit of the Provider's underlying billing or clinical data in order to satisfy itself of the appropriateness of decisions made or charges billed and/or paid.

4. To the extent permitted by applicable laws, the Provider will allow [Insurance Company]'s staff to inspect and if requested will provide a copy of medical records of any Beneficiary, relevant to the respective claims or preauthorization.

5. The Provider shall allow [Insurance Company]'s staff or appointed representatives access to the Provider to visit any Beneficiary, to facilitate PreAuthorisation, case management, discuss aspects of the Treatment, discharge management, disease management, post-operative care and/or post-discharge care, utilisation management, quality assurance reviews, utilisation reviews, and grievance procedures with the Beneficiary and treating consultant where appropriate.

6. In the event that any non-compliance with any term of this Agreement (including, without limitation, any overcharges) is discovered as a result of any such audit, [Insurance Company] shall have the right to (at its own discretion):
    a. recover from the Provider the amount of any monies overcharged;
    b. widen the scope of audit and/or size of the audit sample;
    c. caution the Provider against carrying on or indulging in such practices and seek undertaking from the Provider;
    d. cause the Provider take corrective action in order to rectify non-compliances within a reasonable time-frame; and/or
    e. terminate the Agreement in accordance with Schedule-II

Adequate communication facilities:

7. The Provider shall ensure that it has adequate facsimile and communication facilities. It shall also nominate one person on its staff to serve as a central point of contact for all insured Beneficiarys.

Display and Advertisement

8. The Provider shall have no objection to [Insurance Company] using the Providers name, as a preferred Provider to [Insurance Company] and also list the Provider in the communication with Beneficiarys, etc. The provider may display a signboard stating "[Insurance Company] Approved Network Provider". But no other signage indicating any association with group companies' entities of the [Insurance Company] shall be displayed. Excepting the preceding, the Provider has not been granted any other rights or license to use the trademark, trade name, service mark, service names, copyrights, etc., belonging to the group companies of the [Insurance Company]

Others:

9. Insurer will not interfere in the treatment and medical care provided to its beneficiaries. Insurer will not be in any way held responsible for the outcome of treatment or quality of care provided by the provider.

10. Insurer shall not be liable or responsible for any acts, omission or commission of the Doctors and other medical staff of the Provider and the Provider shall obtain professional indemnity policy on its own cost for this purpose. The Provider agrees that it shall be responsible in any manner whatsoever for the claims, arising from any deficiency in the services or any failure to provide identified service

11. Notwithstanding anything to the contrary in this agreement neither Party shall be liable by reason of failure or delay in the performance of its duties and obligations under this agreement if such failure or delay is caused by acts of God, Strikes, lock-outs, embargoes, war, riots civil commotion, any orders of governmental, quasi-governmental or local authorities, or any other similar cause beyond its control and without its fault or negligence.

12. The Provider will indemnify, defend and hold harmless the Insurer against any claims, demands, proceedings, actions, damages, costs, and expenses which the company may incur as a consequence of the negligence of the former in fulfilling obligations under this Agreement or as a result of the breach of the terms of this Agreement by the Provider or any of its employees or doctors or medical staff.

Article 17:

Notices

1. All notices, demands or other communications to be given or delivered under or by reason of the provisions of this Agreement will be in writing and delivered to the other Party:
    a. By registered mail;
    b. By courier;
    c. By facsimile;

2. In the absence of evidence of earlier receipt, a demand or other communication to the other Party is deemed given

    a. If sent by registered mail, seven working days after posting it; and
    b. If sent by courier, seven working days after posting it; and
    c. If sent by facsimile, two working days after transmission. In this case, further confirmation has to be done via telephone and e-mail.

3. The notices shall be sent to the other Party to the above addresses (or to the addresses which may be provided by way of notices made in the above said manner):

a. -if to the Provider:
   Attn: ……
   Tel : …….
   Fax: ……

b. -if to _____
   _____ insurance Company Limited
   _____
   _____
   _____

Supersession

4. It is agreed between the parties that by execution of this agreement all the prior correspondence, negotiations, minutes, MOU, Agreement and other documents shall be superseded. The terms of this agreement shall supersede all the terms and conditions of the earlier agreement executed between the parties.

Severability

5. If any provision of this MOU is held by any court or other competent authority to be invalid or unenforceable in whole or in pan. this MOU shall continue to be valid as to its other provisions and the remainder of the affected provision.

6. The invalidity or unenforceability of any provisions of this Agreement in any jurisdiction shall not effect the validity, legality or enforceability of the remainder of this Agreement in such jurisdiction or the validity, legality or enforceability of this Agreement, including any such provision, in any other jurisdiction, it being intended that all rights and obligations of the Parties hereunder shall be enforceable to the fullest extent permitted by law.

Waiver

7. No waiver by any Party of any default with respect to any provision, condition or requirement hereof shall be deemed to be waiver of any other provision, condition or requirement hereof nor act as waiver of any remedy available for breach of that very provision, condition or requirement in the future.

8. No delay or omission of any Party to exercise any right hereunder on one occasion in any manner shall impair the exercise of any such right or any other occasion

Non-solicitation

9. The [Insurance Company] and Provider , both Parties hereby agrees that they shall not solicit each other's clients, business partners, business prospects duing the validity peiod of this MOU and for a period of ive (2) years ater the expiry/termination (howsoever caused) of this MOU.

Article 18
Miscellaneous

1. This Agreement together with any Annexure attached hereto constitutes the entire Agreement between the parties and supersedes, with respect to the matters regulated herein, and all other mutual understandings, accord and agreements, irrespective of their form between the parties. Any annexure shall constitute an integral part of the Agreement.

    a. Except as otherwise provided herein, no modification, amendment or waiver of any provision of this Agreement will be effective unless such modification, amendment or waiver is approved in writing by the parties hereto.

    b. Should specific provision of this Agreement be wholly or partially not legally effective or unenforceable or later lose their legal effectiveness or enforceability, the validity of the remaining provisions of this Agreement shall not be affected thereby.

    c. The Provider may not assign, transfer, encumber or otherwise dispose of this Agreement or any interest herein without the prior written consent of Insurer, provided whereas that the Insurer may assign this Agreement or any rights, title or interest herein to an Affiliate without requiring the consent of the Provider.

    d. The failure of any of the parties to insist, in any one or more instances, upon a strict performance of any of the provisions of this Agreement or to exercise any option herein contained, shall not be construed as a waiver or relinquishment of such provision, but the same shall continue and remain in full force and effect.

    e. The Provider will indemnify, defend and hold harmless the Insurer against any claims, demands, proceedings, actions, damages, costs, and expenses which the latter may incur as a consequence of the negligence of the former in fulfilling obligations under this Agreement or as a result of the breach of the terms of this Agreement by the Provider or any of its employees/doctors/other medical staff.

    f. Law and Arbitration

        i. The provisions of this Agreement shall be governed by, and construed in accordance with Indian law.

        ii. Any dispute, controversy or claims arising out of or relation to this Agreement or the breach, termination or invalidity thereof, shall be settled by arbitration in accordance with the provisions of the (Indian) Arbitration and Conciliation Act, 1996.

iii. The arbitral tribunal shall be composed of three arbitrators, one arbitrator appointed by each Party and one another arbitrator appointed by the mutual consent of the arbitrators so appointed.

iv. The place of arbitration shall be _____ and any award whether interim or final, shall be made, and shall be deemed for all purposes between the parties to be made, in _____.

v. The arbitral procedure shall be conducted in the English language and any award or awards shall be rendered in English. The procedural law of the arbitration shall be Indian law.

vi. The award of the arbitrator shall be final and conclusive and binding upon the Parties, and the Parties shall be entitled (but not obliged) to enter judgement thereon in any one or more of the highest courts having jurisdiction.

vii. The rights and obligations of the Parties under, or pursuant to, this Clause including the arbitration agreement in this Clause, shall be governed by and subject to Indian law.

viii. The cost of the arbitration proceeding would be born by the parties on equal sharing basis.

NON – EXCLUSIVITY

2. Insurer reserves the right to appoint any other provider for implementing the packages envisaged herein and the provider shall have no objection for the same.

Declaration

3. Provider hereby declares that:
    a. Information provided to [Insurance Company] is true and authentic to the best of its knowledge and belief.
    b. In the event that the furnished information is either false or turns out to be false [Insurance Company] is entitled to dis-empanel this Provider from the list of Network Providers.
    c. [Insurance Company] has a right to comprehend that this ground i.e., act of furnishing information by Provider which is false or turns out to be false, is in addition to other grounds envisaged elsewhere in this agreement.

Representative TPA:

4. The insurer may appoint a TPA who may represent the insurer in order to assist the insurer with respect to claims processing and related matters within the scope of the Health Services to be renedered by the TPA. The insurer may change the TPA any time without giving notice to

the Provider and inform the Provider immediately. The Provider shall not get into any agreement with the TPA on this matter.

SIGNED AND DELIVERED BY the Provider.- the within named_____, by the Hand of _____ its Authorised Signatory

In the presence of:

SIGNED AND DELIVERED BY _____ INSURANCE COMPLAY LIMITED, the within named _____, by the hand of _____ it's Authorised Signatory

In the presence of:

Schedule-I
Provider Services- Admission Procedure

The beneficiaries shall be provided treatment free of cost for all such ailments covered under the policy within the limits / sub-limits and sum insured, i.e., not specifically excluded under the policy. The Provider shall be reimbursed as per the Schedule-III for different treatments or procedures.

Preauthorization Procedure – Planned Admissions

1. Request for hospitalization shall be forwarded by the provider immediately after obtaining due details from the treating doctor in the prescribed format by the Authority i.e. "request for authorization letter" (RAL). The RAL needs to be sent electronically along with all the relevant details in the electronic form to the 24-hour authorization /cashless department of the insurer or its representative TPA along with contact details of treating physician and the beneficiary. The insurer's or its representative TPA's medical team may consult the treating physician or the beneficiary, if necessary.
2. In the cases where the symptoms are vague / no effective diagnosis is arrived at, the medical team of [Insurance Company] would get in touch with treating physician /beneficiary if necessary.
3. The RAL should reach the authorization department of insurer or its representative TPA 7 days prior to the expected date of admission, in case of planned admission.
4. In failure of the above "clause 3", the clarification for the delay needs to be forwarded with the request for authorization.
5. The RAL form should be dully filled with clearly mentioning Yes or No and/or the details as required. There should be no nil, or blanks.
6. The guarantee of payment is given only for the medically necessary treatment cost of the ailment covered and mentioned in the request for hospitalization. Non covered items like Telephone usage, food provided to relatives/attendants, Provider registration fees etc must be collected directly from the insured (These are specifically and fully listed in Schedule VI). Any Investigation carried out at the request of the patient but not forming the necessary part of the treatment also must be collected from the patient.
7. The authorization letter by the insurer or its representative TPA normally mentions the amount agreed for providing cashless facility for hospitalization. Therefore in event of the cost of treatment increasing, the the provider may check the availability of further limit with [Insurance Company] by again following the process of requesting for pre-authorization for the enhanced amount.
8. In case the Beneficiary has opted for a higher accommodation / facility than the one under his plan, the Provider shall take a written consent from the beneficiary at the time of admission as regard to owing the responsibility of such expenses by the beneficiary including the proportionate expenses which have a direct bearing due to up gradation of room accommodation/facility. In all such cases the

[Insurance Company] shall pay for the expenses which are based on the eligibility limits of the beneficiary. However provider may charge any advance amount/security deposit from the beneficiary only in such cases where the beneficiary has opted for an upgraded facility to the extent of the amounts to be collected from the beneficiary.

9. Insurance company guarantees payment only after receipt of RAL and the necessary medical details. The Authorization Letter (AL) shall be issued within 12 hours of receiving the RAL
10. In case the ailment is not covered or given medical data is not sufficient for the medical team of authorization department to confirm the eligibility, insurer shall seek further clarification/ information immeidately.
11. The cash less facility is given only for the necessary treatment cost of the ailment covered and mentioned in the request for Authorisation for hospitalization.
12. Authorisation letter [AL] will mention the authorization number and the amount guaranteed for the procedure. Provider must see that these rules are strictly followed.
13. In case the balance sum available is considerably less than the cost of treatment, provider should follow their norms of deposit/running bills etc. However provider shall only charge the balance amount against the package or treatment from the policyholders/insured under the health insurance policy. Insurer upon receipt of the bills and documents would release the guaranteed amount.
14. When the cost of treatment exceeds the authorized limit, request for enhancement of authorization limit shall be made immediately during hospitalization using the same format as for the initial preauthorization. The request for enhancement would be evaluated based on the availability of further limits and would need to provide valid reasons for the same. No enhancement of limit is possible after discharge of beneficiary.
15. Further the [Insurance Company] shall accept or decline such additional expenses within a maximum of 24 hours of receiving the request for enhancement. Absence of receiving the reply from the [Insurance Company] within 24 hours shall be construed as denial of the additional amount.
16. Thereafter, once the beneficiary is to be discharged, the Provider shall make a final request for the pre-authorization for any residual amount along with the discharge summary.
17. Due to any reason if the beneficiary does not avail treatment at the Provider after the pre authorization is released the Provider would need to return the amount to the insurer.
18. All the payments shall be made electronically by the insurer to the provider within the same day of receipt of all the documents, to the extent possible, provided all the necessary documents are received by the insurer; however, if not paid on same day, reasons shall be recorded and the payment shall be paid within two days of the receipt of electronic claim documents as required.
19. Denial of authorization (DAL) for cashless is by no means denial of treatment by the health facility. The health care provider shall deal with such case as per their normal rules and regulations.
20. Insurer will not be liable for payments in case the information provided in the “request for authorization letter” and subsequent documents during the course of authorization, is found incorrect or not disclosed.

Preauthorization Procedure – Emergency Admissions

1. In case of emergencies the provider should initiate the procedure for preauthorization using the format provided in Section XX.
2. The [Insurance Company] may continue to discuss with treating doctor till conclusion of eligibility of coverage is arrived at. Any life saving, limb saving, sight saving, emergency medical attention cannot be withheld or delayed for the purpose of waiting for pre-authorisation. Provider meanwhile may consider treating him by taking a token deposit or as per their norms.
3. Once a pre-authorisation is issued after ascertaining the coverage, Provider should refund the deposit amount to the beneficiary if taken barring a token amount to take care of non covered expenses. Once the patient is medically stable, he must be transferred to the room which he is eligible for as per his health plan, which would be mentioned in the pre-authorisation certificate.

Preauthorization Procedure – RTA / MLCs

5. If requesting a pre-authorisation for any potential medico-legal case including Road Traffic Accidents, the Provider must indicate the same in the relevant section of the standard format.
6. In case of a road traffic accident and or a medico legal case if the victim was under the influence of alcohol or inebriating drugs or any other addictive substance or does intentional self injury, it is mandatory for the Provider to inform this circumstance of emergency to the [Insurance Company.

Authorization letter (AL)

1. Authorization leter will mention the amount, guaranteed class of admission, eligibility, of the patient or various sub limits for rooms and board, surgical fees etc. wherever applicable, as per the benefit plan for the patient.
2. The Authorization letter will also mention Validity of dates for admission and number of days allowed for hospitalization. The Provider must see that these rules are strictly followed; else the AL will be considered null and void.
3. In the event the room category is not available the same will be informed to the [Insurance Company] and the patient. For such cases if the patient is admitted to a class of accommodation higher than what he is eligible for, the provider shall collect the necessary difference in charges from the patient himself.
4. The AL has a limited period of validity – which is 15 days from the date of sending the authorization.
5. AL is not an unconditional guarantee of payment. It is conditional on facts presented – when the facts change the guarantee changes.

Reauthorization

1. Where there is a change in the line of treatment – a fresh authorization has to be obtained from the [Insurance Company] – this is called a reauthorization.

2. The same format is to be used for the reauthorization, and the same TATs as specified in section XX would apply.
3. In case of any change after the preauthorization – the Provider is required to obtain a reauthorization 12 hours prior to discharge.

Discharge:

1. The following documents are to be included in the list of documents to be sent along with the claim form to the [Insurance Company]. These must not be given to the Beneficiary.
   a. Original pre authorization request form,
   b. original authorization letter,
   c. Original discharge card,
   d. original investigation repots,
   e. all original prescription & pharmacy receipt etc
2. Where the patient requires the discharge card/repots he or she can be asked to take photocopies of the same at his or her own expenses and these have to be clearly stamped as "Duplicate & originals are submitted to [Insurance Company]".
3. The discharge card/Summary must mention the duration of ailment and duration of other disorders like hypertension or diabetes and operative notes in case of surgeries. The clinical detail should be sufficiently and justifiably informative. In addition, the Provider shall provide all the relevant details pertaining to past treatment availed by the Patient in the Provider.
4. Signature of the patient / beneficiary on final Provider bill must be obtained.
5. In the event of death or incapacitation of the beneficiary, the signature of the nominee or any of beneficiary's of the family who represents the beneficiary as such subject to reasonable satisfaction of Provider shall be sufficient for the [Insurance Company] to consider the claim.
6. Claim form of the [Insurance Company] must be presented to the beneficiary for signing and identity of the patient/ beneficiary again confirmed.

Billing

7. The Provider shall submit original invoices directly to [Insurance Company] and such invoices shall contain the following information:

a. the patient's full name and date of birth;
b. the patient's [Insurance Company] beneficiary ship number or policy number as appropriate;
c. the patient's address;
d. the admitting consultant;
e. the date of admission and discharge;
f. the procedure performed and procedure code according to ICD-10 PCS;
g. the diagnosis at the time treatment and diagnosis code according to ICD-10;
h. whether this is an interim or final bill/account;
i. the description of each Service performed, together with associated Charges,
j. the agreed standard billing codes associated with each Service performed and dates on which items of Service were provide; and.
k. the patient's signature (in original).

8. The Provider shall submit the following documents with the final invoice:
   a. copy of Pre-Authorisation letter;
   b. fully completed claim form (or the relevant claim section of the Pre-Authorisation letter), signed by the Beneficiary and the treating consultant for the Treatment performed;
   c. original and complete discharge summary, including the treating Consultant's operative notes;
   d. original investigation reports with corresponding prescription/request;
   e. pharmacy bill with corresponding prescription/request:
   f. any other statutory documentary evidence required under law or by the Beneficiary's Plan; and
   g. photocopy of the Beneficiary's photo identification (eg voter's Smart card/ ID card, passport or driving licence etc).
9. The Provider must not give original discharge summaries, investigation repots, or prescriptions to the Beneficiary.
10. The Provider shall submit the final invoice and all supporting documentation required within 2 days of the discharge date.

Note: <u>In the cases where the beneficiary is admitted in a Provider during the current policy period but is discharged after the end of the policy period, the claim has to be paid by the insurance company under the policy which is operating during the period in which beneficiary was admitted.</u>

Schedule-II

PROCESS NOTE FOR DE-EMPANELMENT OF PROVIDERS

Process To Be Followed For De-Empanelment of Providers:

Step 1 – Putting the Provider on "Watch-list"

1. Based on the claims data analysis and/ or the Provider visits, if there is any doubt on the performance of a Provider, the Insurance Company can put that Provider in the watch list.
2. The data of such Provider shall be analysed very closely on a daily basis by the Insurance Company for patterns, trends and anomalies.
3. The Insurance Company will immediately inform the Health Insurance Forum about the Provider which have been put in the watch list within 24 hours of this action.

Step 2 – Suspension of the Provider

4. A Provider can be temporarily suspended in the following cases:
    a. For the Providers which are in the "Watch-list" if the Insurance Company observes continuous patterns or strong evidence of irregularity based on either claims data or field visit of Providers, the Provider shall be suspended from providing services to policyholders/insured patients and a formal investigation shall be instituted.
    b. If a Provider is not in the "Watch-list", but the insurance company observes at any stage that it has data/ evidence that suggests that the Provider is involved in any unethical practice/ is not adhering to the major clauses of the contract with the Insurance Company involved in financial fraud related to health insurance patients, it may immediately suspend the Provider from providing services to policyholders/insured patients and a formal investigation shall be instituted.
5. The Health Insurance Forum should be informed of the decision of suspension of Provider within 24 hours of this action.
6. A formal letter shall be send to the Provider regarding its suspension with mentioning the timeframe within which the formal investigation will be completed.

Step 3 – Detailed Investigation

7. The Insurance Company can launch a detailed investigation into the activities of a Provider in the following conditions:
    a. For the Providers which have been suspended.
    b. Receipt of complaint of a serious nature from any of the stakeholders
8. The detailed investigation may include field visits to the Providers, examination of case papers, talking with the policyholders/insured (if needed), examination of Provider records etc.
9. If the investigation reveals that the report/ complaint/ allegation against the Provider is not substantiated, the Insurance Company would immediately revoke the suspension (in case it is suspended) and inform the same to the Health Insurance Forum.
    a. A letter regarding revocation of suspension shall be sent to the Provider within 24 hours of that decision.

Step 4 – Action by the Insurance Company

10. If the investigation reveals that the complaint/allegation against the Provider is correct then following procedure shall be followed:
    a. The Provider must be issued a "show-cause" notice seeking an explanation for the aberration and a copy of the show cause notice is sent to the Health Insurance Forum.
    b. After receipt of the explanation and its examination, the charges may be dropped or an action can be taken.
    c. The action could entail one of the following based on the seriousness of the issue and other factors involved:
        i. A warning to the concerned Provider,
        ii. De-empanelment of the Provider.

11. <u>The entire process should be completed within 30 days from the date of suspension.</u>

Step 5 – Actions to be taken after De-empanelment

12. Once a Provider has been de-empanelled by insurer, following steps shall be taken:
    a. A letter shall be sent to the Provider regarding this decision with a copy to the Health Insurance Forum
    b. This information shall be sent to all the other Insurance Companies which are doing health insurance business.
    c. An FIR shall be lodged against the Provider by the insurer at the earliest in case the de-empanelment is on account of fraud or a fraudulent activity.
    d. The Insurance Company which had de-empanelled the Provider, may be advised to notify the same in the local media, informing all policyholders/insured about the de-empanelment, so that the beneficiaries do not utilize the services of that particular Provider.
    e. If the Provider appeals against the decision of the Insurance Company, all the aforementioned actions shall be subject to the decision of the concerned Committee of the Health Insurance Forum.

Grievance by the Provider

13. The Provider can approach the Grievance Redressaal Committee constituted by the Health Insurance Forum for the redressal. The Grievance Redressal Committee will take a final view within 30 days of the receipt of representation. However, the Provider will continue to be de-empanelled till the time a final view is taken by the Grievance Redressal Committee.

Special Cases for De-empanelment

In the case where at the end of the Insurance Policy if an Insurance Company does not want to continue with a particular Provider in a district it can de-empanel that particular Provider. However, it should be ensured that adequate number of Providers are available in that area for the policyholders/insured.

Schedule III:

Tariffs and fees

Explanatory notes

1. Tariff rates are attached in the tables below. The following serve to provide explanations for the same

Accommodation charges	The above accommodation charges are inclusive of: room, bed, all in-room furniture, equipment and facilities, ward equipment usage, nursing, resident medical oficers, ward dressings/consumables, ward drugs, patient meals, laundry, linen, housekeeping, cleaning, and removal of sutures.
Theatre charges, surgeon's and anaesthetist fees	The charges are inclusive of: operating room costs including all equipment and facilities, nursing and support staf, instrumentation, theatre dressings and consumables (excluding drugs, prosthesis / implants unless stated). Where more than one procedure is performed at the same time the Provider may charge 100% of the charge for the most complex procedure and 75% of the charge for any other procedure performed.-the surgeries will be billed as per the tarif approved separately and not as per the % mentioned above if it is 2 diferent incisions

2. Accommodation

Beneficiarys are entitled to stay in accommodation up to a cetain standard, depending on their scale of cover, as notified by [Insurance Company] to the Provider from time-to-time.

If a Beneficiary is accommodated in a room categorized and charged at a higher rate than that Beneficiary's entitlement the Provider will only be reimbursed by the [Insurance Company] for the room for which the Beneficiary is entitled to.

The Provider may only recover any additional Charge for a higher standard room from the Beneficiary if the Beneficiary's entitled room standard is available but the Beneficiary chooses to be accommodated in a higher standard room and the Provider has obtained the prior written consent of the Beneficiary.

In the event that the Beneficiary is accommodated in a higher standard room due to lack of room availability, then neither the [Insurance Company] nor the Beneficiary shall be obliged to pay for any additional Charges.

Schedule-IV and Scheduel-V attached separately.

Schedule VI

List of Non Medical Items

List of non-medical items not covered under [Insurance Company] insurance Policies,as prescribed by the Authority.

SUGGESTED STANDARD FORMAT FOR PROVIDER BILLS

Contents

1. Objective

- Standardizing billing formats and enabling mapping of hospital information systems to specific data requirements of the Insurance companies for faster claim processing and enhanced analysis of data

2. Components of standardization

Standardization involves three components:

- Bill Format
- Codes for billing items and nomenclature
- Standard guidelines for preparing the bills so that the interpretations of the headings in the bill are uniform.

3. Background

There is a huge variation in the billing formats and understanding of various items in a provider bill. Each provider provides a format specific to their organization which often has insufficient or redundant information. In many cases the same information may have been interpreted differently by the hospital and provider. This creates inefficiencies in the claim processing resulting in higher costs of healthcare and lower quality for the patients. Standardisation of Billing Procedures in the hospitals promotes transparency and removes the friction between the insured, providers and payers.

FICCI constituted a committee with the purpose of looking at "standardizing the billing procedures in various hospitals to avoid any ambiguity between the health insurance stakeholders". The Objective of the working group was to look at how billing items and formats could be standardized with integration into the standard suggested claim form. The group would also look at how hospitals can map their existing information system to a particular requirement of the Insurance companies. This exercise was aimed at standardization of formats rather than fixing tariffs and rates.

The ultimate objective of this exercise is to facilitate electronic transmission of provider bills to the payers for processing and payment. The standardized format would be shared with providers for implementation and could be included as part of the standard contract between insurers/TPA's and the providers.

The committee had representatives from all stakeholders including insurers, TPA's, providers and consultancy companies and was headed by Shri. S L Mohan, Secretary General, General Insurance Council.

4. Methodology

1) Collecting various bill formats from multiple hospitals of different sizes and also take into cognizance the existing bill processing systems of the TPA's and Insurance companies as also the HIS of hospitals.
2) Defining and listing the above into main components and various sub-components of the bill. The first level components were mapped to the Standardized Claims Form which was developed by IRDA last year.
3) Discussing each component of the bill in detail with the multi-stakeholder group ensuring that the data in the format is not reported in any other document and is sufficient for claim processing without being too difficult for the hospital to report.
4) Developing a coding system for each component. The group has evaluated procedure codes to be used in the bill and have agreed on using ICD-10-PCS level 5 codes in line with requirement of Tariff Advisory Committee's Health data requirements. Codifying the billing components will be useful for enabling faster and accurate processing of the bills TPA's and also aid electronic transmission of bills.. The codes were discussed with the representatives from providers and also IT companies.
5) Testing the evolving the Bill Format from both IT and hospital perspective to check its adaptability electronically. Any feedback would be incorporated.
6) Providing guidance notes in the format for the reference of Doctor's and patients detailing and defining the components.
7) Disseminating this format with the large advisory group for review and feedback. Finalizing the format based on the feedback from the working group.

5. Format Suggested

The bill is expected to be in two formats.

- The summary bill and
- The detailed breakup of the bills.

Explanation of headings – Summary Bill

The suggested summary format is annexed in the report (Annexure I)

The Bill is expected to be generated on the letter head of the provider and in A4 size to aid scanning.

Field Name	**Remarks**
Provider Name	Legal entity name and not the trade name
Provider Registration Number	Registration number of the provider with local authorities. once the clinical establishments (registration and regulation) bill, 2007 is passed, then registration number under this act
Address	Address of the Facility where member is admitted. A provider can have more than one facility.
IP No	Unique number identifying the particular hospitalization of the member
Patient Name	Full name of the patient
Payer Name	Name of the Insurance company with whom the member is insured. In case of cash patient then the field is to be left blank. If the bill is raised to more than one insurer then the primary insurer who has given cashless is to be mentioned. The name of insurance company needs to be mentioned and not the TPA.
Member address	Full address of the member
Bill Number	Bill number of the provider
Bill Date	Date on which the bill is generated.

PAN Number	PAN Number – Mandatory
Service Tax Regn No	Registration number from service tax authorities. Mandatory in case service tax is charged in the bill
Date of admission	Date of admission of the member in case of IPD cases. In case of Day care procedures, this is the date of procedure
Date of discharge	Date of discharge of the member in case of IPD cases. In case of Day care procedures, this is the date of procedure(same as date of admission)
Bed Number	Bed number in which the patient is admitted. In case the member is admitted under more than one bed number, all the numbers have to be mentioned.
SL No 1 of billing Summary	All items under the primary head '100000' in the detailed bill have to be summarized into this. In case the procedure is packages, then only bills amount beyond the package needs to be mentioned here.
SL No 2 of billing Summary	All items under the primary head '200000' in the detailed bill have to be summarized into this. In case the procedure is packages, then only bills amount beyond the package needs to be mentioned here.
SL No 3 of billing Summary	All items under the primary head '300000' in the detailed bill have to be summarized into this. In case the procedure is packages, then only bills amount beyond the package needs to be mentioned here.
SL No 4 of billing Summary	All items under the primary head '400000' in the detailed bill have to be summarized into this. In case the procedure is packages, then only bills amount beyond the package needs to be mentioned here.
SL No 5 of billing Summary	All items under the primary head '500000' in the detailed bill have to be summarized into this. In case the procedure is packages, then only bills amount beyond the package needs

	to be mentioned here.
SL No 6 of billing Summary	All items under the primary head '600000' in the detailed bill have to be summarized into this. In case the procedure is packages, then only bills amount beyond the package needs to be mentioned here.
SL No 7 of billing Summary	All items under the primary head '700000' in the detailed bill have to be summarized into this. In case the procedure is packages, then only bills amount beyond the package needs to be mentioned here.
SL No 8 of billing Summary	All items under the primary head '800000' in the detailed bill have to be summarized into this. In case the procedure is packages, then only bills amount beyond the package needs to be mentioned here.
SL No 9 of billing Summary	All items under the primary head '900000' in the detailed bill have to be summarized into this. If more than one procedure is done, the total amount of the two procedures needs to be summarized
Total Bill amount	Sum total of all items 1 to 9 in the bill
Amount paid by the member	Amount of bill paid by the member including co-pay, deductible, non-medical items etc incl discount offered to member, if any.
Amount charged to Payer	Amount payable by Insurance company
Discount Amount	Amount offered as discount to the insurance company
Service tax	Service Tax chargeable to insurance company
Amount Payable	Total amount payable by insurance com[any including service tax
Amount in words	Above mount in words for the sake of clarity
Patients signature	Signature of the patient or the attendant of the patient needs to be mandatorily taken
Authorized signatory	The signature of the authorized signatory at

	the provider

Explanation of headings – Detailed Breakup of the Bill

The suggested summary format is annexed in the report (Annexure II)

The Bill is expected to be generated on the letter head of the provider and in A4 size to aid scanning.

The first section of the bill is same as the bill summary.

Field Name	**Remarks**
Date	Date on which service is rendered. For example, this is the date of investigation, date of procedure etc.
Code	Level 2 or 3 code of the billing item as per the codes(annex III)
Particulars	Text explanation of the item charged
Rate	Per unit price (per day room rent, per consultation charge)
Unit	No of units charged(hours, days, number as appropriate)
Amount	Rate*unit(s)

6. Standard guidelines

Summary Bill

- The summary bill should not have any additional items (only 9)
- The provide has to mention the service tax number in case they charge service tax to the insurance company/TPA
- The payer mentioned in the bill has to be necessarily the insurance company and not the TPA.
- In case of package charged for any procedure/treatment, the provider is expected to mention the amount in serial no 9. Only items beyond the package are to be mentioned in sl nos 1 to 8.
- The patient/attendant signature is mandatory on the summary bill

Detailed breakup

- The billing has to be done at level 2 or 3
- In case of medicines/consumables , the relevant level code three has to be mentioned (40100, 401002) and the text should indicate the actual medicine used
- Some providers have outsourced the pharmacy to external vendors. In such cases the providers can attach the original bills separately. However, the summary of this has to be mentioned in the summary bill.
- In case of pharmacy returns the same code originally used is to be used with a negative sign in the units
- In case of cancellation of any service the same code originally used is to be used with a negative sign indicating reversal

- The date on which the service is rendered is to be mentioned in the bill. This would be
    - the date of requisition in case of investigations
    - date of consultation for professional fees
    - date of requisition in case of pharmacy/consumables irrespective of when they were used
    - Date of return of pharmacy items for pharmacy returns

Implementation Plan

Post final adoption of this plan by all stakeholders the plan for implementation would ,inter alia, need to incorporate the following steps:

- Central body for maintenance, dissemination and addition of billing codes
- Integrating it as a standard format with provider HIS and as part of EDI mechanism for electronic data transfer between insurers and providers
- Publicity plan to create user awareness to promote usage before making it mandatory as part of provider empanelment norms

8. Annexures

Annexure I

SUMMARY BILL FORMAT

Provider Name	……	Bill Number	……
Provider registration No.		Bill Date	
Address		PAN Number	
IP No		Service Tax Regn No	
Patient Name		Date of admission	
Payer Name	XXXX Insurance Company Ltd	Date of Discharge	
Member Address		Bed Number	

Billing Summary

Sl No	Primary Code	Particulars	Amount
1	100000	Room & Nursing Charges	
2	200000	ICU Charges	
3	300000	OT Charges	
4	400000	Medicine & Consumables	
5	500000	Professional Fees'	
6	600000	Investigation Charges	
7	700000	Ambulance Charges	
8	800000	Miscellaneous Charges	
9	900000	Package Charges	

Total Bill Amount	0
Amount paid by member	…… 0
Amount charged to Payer	0
Discount Amount	0
Service Tax	0
Amount Payable	0
Amount in Words	Rupees Zero Only

Patients Signature

Authorized Signatory

Annexure II

DETAILED BREAKUP FORMAT

Provider Name	……	Bill Number	……
Provider registration No.		Bill Date	
Address		PAN Number	
IP No		Service Tax Regn No	
Patient Name		Date of admission	
Payer Name		Date of Discharge	
Member Address		Bed Number	

Billing Details

Sl No	Date	Code	Particulars	Rate	Nos(Unit)	Amount
1		101001	General Ward Charges	500	1	500.00
2		401001	XXX medicine	50	2	100.00
3		401001	XXX Medicine – return	50	-1	-50.00

Annexure III

Annexed in excel sheet

Level 1 Code	Level 1	Level 2 Code	Level 2	Level 3 Code	Level 3	Remarks
100000	Room & Nursing Charges					
100000	Room & Nursing Charges	101000	Room Charges			
100000	Room & Nursing Charges	101000	Room Charges	101001	General Ward charges	
100000	Room & Nursing Charges	101000	Room Charges	101002	Semi-private room charges	
100000	Room & Nursing Charges	101000	Room Charges	101003	Single Room charges	
100000	Room & Nursing Charges	101000	Room Charges	101004	Single Deluxe room charges	
100000	Room & Nursing Charges	101000	Room Charges	101005	Deluxe room charges	
100000	Room & Nursing Charges	101000	Room Charges	101006	Suite charges	
100000	Room & Nursing Charges	101000	Room Charges	101007	Electricity charges	
100000	Room & Nursing Charges	101000	Room Charges	101008	Bed sheet charges	
100000	Room & Nursing Charges	101000	Room Charges	101009	Hot water charges	
100000	Room & Nursing Charges	101000	Room Charges	101010	Establishment Charges	
100000	Room & Nursing Charges	101000	Room Charges	101011	Alpha/Water Bed Charges	
100000	Room & Nursing Charges	101000	Room Charges	101012	Attendant Bed Charges	
100000	Room & Nursing Charges	102000	Nursing charges			
100000	Room & Nursing Charges	102000	Nursing charges	102001	Nursing fees	
100000	Room & Nursing Charges	102000	Nursing charges	102002	Dressing	
100000	Room & Nursing Charges	102000	Nursing charges	102003	Nebulization	
100000	Room & Nursing Charges	102000	Nursing charges	102004	Injection charges	
100000	Room & Nursing Charges	102000	Nursing charges	102005	Infusion pump charges	
100000	Room & Nursing Charges	102000	Nursing charges	102006	Aya Charges	
100000	Room & Nursing Charges	102000	Nursing charges	102007	Blood Transfusion Charges	
100000	Room & Nursing Charges	103000	Duty Doctor fee			
100000	Room & Nursing Charges	103000	Duty Doctor fee	103001	Duty Doctor fee	
100000	Room & Nursing Charges	103000	Duty Doctor fee	103002	RMO Fees	
100000	Room & Nursing Charges	104000	Monitor charges			
100000	Room & Nursing Charges	104000	Monitor charges	104001	Pulse Oxymeter charges	If used in normal Room
200000	ICU Charges					
200000	ICU Charges	201000	ICU Charges			
200000	ICU Charges	201000	ICU Charges	201001	Burns Ward	
200000	ICU Charges	201000	ICU Charges	201002	HDU charges	
200000	ICU Charges	201000	ICU Charges	201003	ICCU charges	
200000	ICU Charges	201000	ICU Charges	201004	Isolation ward charges	
200000	ICU Charges	201000	ICU Charges	201005	Neuro ICU charges	
200000	ICU Charges	201000	ICU Charges	201006	Pediatric/neonatal ICU charges	
200000	ICU Charges	201000	ICU Charges	201007	Post Operative ICU	
200000	ICU Charges	201000	ICU Charges	201008	Recovery Room	
200000	ICU Charges	201000	ICU Charges	201009	Surgical ICU	

200000	ICU Charges	202000	ICU Nursing charges			If ICU nursing charged seperately
200000	ICU Charges	202000	ICU Nursing charges	202001	Nursing fees	If ICU nursing charged seperately
200000	ICU Charges	202000	ICU Nursing charges	202002	Dressing	If ICU nursing charged seperately
200000	ICU Charges	202000	ICU Nursing charges	202003	Nebulization	If ICU nursing charged seperately
200000	ICU Charges	202000	ICU Nursing charges	202004	Injection charges	If ICU nursing charged seperately
200000	ICU Charges	202000	ICU Nursing charges	202005	Infusion pump charges	
200000	ICU Charges	203000	Monitor charges			
200000	ICU Charges	203000	Monitor charges	203001	Monitor charges	
200000	ICU Charges	203000	Monitor charges	203002	Pulse Oxymeter charges	If used in ICU
200000	ICU Charges	203000	Monitor charges	203003	Cardiac Monitor charges	
200000	ICU Charges	204000	Monitor charges	203004	IABP charges	
200000	ICU Charges	204000	Monitor charges	203005	Phototherapy Charges	
200000	ICU Charges	204000	ICU Supplies & equipment			
200000	ICU Charges	204000	ICU Supplies & equipment	204001	Oxygen charges	
200000	ICU Charges	204000	ICU Supplies & equipment	204002	Ventilator charges	
200000	ICU Charges	204000	ICU Supplies & equipment	204003	Suction pump charges	
200000	ICU Charges	204000	ICU Supplies & equipment	204004	Bipap charges	
200000	ICU Charges	204000	ICU Supplies & equipment	204005	Pacing Charges	Temporary Pacemaker

200000	ICU Charges	204000	ICU Supplies & equipment	204006	Defibrillator Charges	
300000	OT Charges					
300000	OT Charges	301000	OT rent			
300000	OT Charges	301000	OT rent	301001	Major OT charge	
300000	OT Charges	301000	OT rent	301002	Minor OT Charge	
300000	OT Charges	301000	OT rent	301003	Cath Lab Charges	
300000	OT Charges	301000	OT rent	301004	Theatre charges	
300000	OT Charges	301000	OT rent	301005	Labour Room Charges	
300000	OT Charges	302000	OT Equipment charges			
300000	OT Charges	302000	OT Equipment charges	302001	C-arm charges	
300000	OT Charges	302000	OT Equipment charges	302002	Endoscopy charges	
300000	OT Charges	302000	OT Equipment charges	302003	Laproscope charges	
300000	OT Charges	302000	OT Equipment charges	302004	Equipment charges	If not specified
300000	OT Charges	302000	OT Equipment charges	302005	Monitor charges	for OT monitoring
300000	OT Charges	302000	OT Equipment charges	302006	Instrument charges	for OT instruments
300000	OT Charges	303000	OT Drugs & Consumables			
300000	OT Charges	303000	OT Drugs & Consumables	303001	OT Drugs	
300000	OT Charges	303000	OT Drugs & Consumables	303002	Implants	
300000	OT Charges	303000	OT Drugs & Consumables	303003	OT Consumables	includes guidewires, catheter etc
300000	OT Charges	303000	OT Drugs & Consumables	303004	OT Materials	
300000	OT Charges	303000	OT Drugs & Consumables	303005	OT Gases	
300000	OT Charges	303000	OT Drugs & Consumables	303006	Anaesthetic drugs	
300000	OT Charges	304000	OT Sterlization			
300000	OT Charges	304000	OT Sterlization	304001	CSSD Charges	
400000	Medicine & Consumables charges					
400000	Medicine & Consumables charges	401000	Medicine & Consumables charges			

400000	Medicine & Consumables charges	401000	Medicine & Consumables charges	401001	Ward Medicines	OT drugs under OT charges
400000	Medicine & Consumables charges	401000	Medicine & Consumables charges	401002	Ward Consumables	
400000	Medicine & Consumables charges	401000	Medicine & Consumables charges	401003	Ward disposables	
400000	Medicine & Consumables charges	401000	Medicine & Consumables charges	401004	Ward Materials	
400000	Medicine & Consumables charges	401000	Medicine & Consumables charges	401005	Vaccination drugs	
500000	Professional fees charges					
500000	Professional fees charges	501000	Visit charges			
500000	Professional fees charges	501000	Visit charges	501001	Consultation Charges	
500000	Professional fees charges	501000	Visit charges	501002	Medical Supervision Charges	
500000	Professional fees charges	501000	Visit charges	501003	Professional fees	
500000	Professional fees charges	502000	Surgery Charges			
500000	Professional fees charges	502000	Surgery Charges	502001	Surgeons Charges	
500000	Professional fees charges	502000	Surgery Charges	502002	Assisstant Surgeons Fee	Would also include Standby Surgeon
500000	Professional fees charges	503000	Anaesthetists fee			
500000	Professional fees charges	503000	Anaesthetists fee	503001	Anaesthetists fee	
500000	Professional fees charges	503000	Anaesthetists fee	503002	OT standby charges	Providers charge for standby anaesthetist
500000	Professional fees charges	504000	Intensivist Charges	504000		
500000	Professional fees charges	505000	Technician Charges	505000	OT /Cath Lab Technician	
500000	Professional fees charges	505000	Physiotherapy			
500000	Professional fees charges	504000	Procedure charges			
500000	Professional fees charges	504000	Procedure charges	504001	Bedside procedures	Catheterization, Central IV Line, Tracheostomy, Venesection
500000	Professional fees charges	504000	Procedure charges	504002	Suture charges	
600000	Investigation Charges					

600000	Investigation Charges	601000	Bio Chemistry			Serum Sodium, Ueres etc
600000	Investigation Charges	602000	Cardiology charges			for procedures like echo, ECG etc
600000	Investigation Charges	603000	Haemotology charges			cross matching etc
600000	Investigation Charges	604000	Microbiology charges			blood culture, C&S
600000	Investigation Charges	605000	Neurology			for EMG, EEG etc
600000	Investigation Charges	606000	Nuclear medicine			PET CT, Bone scan etc
600000	Investigation Charges	607000	Pathology charges			
600000	Investigation Charges	608000	Radiology services			X-ra, CT, MRI etc
600000	Investigation Charges	609000	Serology charges			
600000	Investigation Charges	610000	Medical Genetics			Chrosomal Analysis etc
600000	Investigation Charges	611000	Profiles			Profiles instead of individual tests (Lipid profile, LFT etc)
700000	Ambulance Charges					
700000	Ambulance Charges	701000	Ambulance Charges			
800000	Miscellaneous charges					
800000	Miscellaneous charges	801000	Admission charges			
800000	Miscellaneous charges	802000	Attendant food charges			
800000	Miscellaneous charges	803000	Patient food charges			
800000	Miscellaneous charges	804000	Registration charges			
800000	Miscellaneous charges	805000	MRD Charges			
800000	Miscellaneous charges	806000	Documentation charges			
800000	Miscellaneous charges	807000	Telephone charges			

800000	Miscellaneous charges	808000	Bio Medical Waste Charges			
800000	Miscellaneous charges	809000	Taxes		Luxury Tax/Surcharge/Service Charge	Excluding VAT & Service Tax
900000	Package Charges					To be used only in case of packages
900000	Package Charges	901000	Cardiac Surgery	ICD-10-PCS	CABG	To be used only in case of packages
900000	Package Charges	902000	CardiologyPackages	ICD-10-PCS	PTCA	To be used only in case of packages
900000	Package Charges	903000	Cath Lab	ICD-10-PCS	CAG	To be used only in case of packages
900000	Package Charges	904000	Dental Procedures	ICD-10-PCS	Root Canal Treatment	To be used only in case of packages
900000	Package Charges	905000	ENT	ICD-10-PCS	FESS	To be used only in case of packages
900000	Package Charges	906000	Gastroenterology	ICD-10-PCS	Gastrectomy - Partial	To be used only in case of packages
900000	Package Charges	907000	General Surgery	ICD-10-PCS	Inguinal hernia	To be used only in case of packages
900000	Package Charges	908000	Gynaecology	ICD-10-PCS	LSCS	To be used only in case of packages
900000	Package Charges	909000	Nephrology	ICD-10-PCS	Nephrectomy	To be used only in case of packages
900000	Package Charges	910000	Neuro Surgery	ICD-10-PCS	Craniotomy	To be used only in case of packages

900000	Package Charges	911000	Oncology Procedures	ICD-10-PCS	IMRT	To be used only in case of packages
900000	Package Charges	912000	Opthalmology procedures	ICD-10-PCS	Cataract	To be used only in case of packages
900000	Package Charges	913000	Orthopaedic Surgery	ICD-10-PCS	Bilateral TKR	To be used only in case of packages
900000	Package Charges	914000	Plastic Surgery	ICD-10-PCS	Skin Grafting	To be used only in case of packages
900000	Package Charges	915000	Pulmonology Packages	ICD-10-PCS	Pleural Tapping	To be used only in case of packages
900000	Package Charges	916000	Urology	ICD-10-PCS	ERCP	To be used only in case of packages
900000	Package Charges	917000	Vascular Surgery	ICD-10-PCS	Embolectomy	To be used only in case of packages

Company Logo

Company Name

Company Address

APPLICATION FORM FOR NETWORK SERVICE PROVIDER

Objective of this document

This document forms part of (Insert Insurance Company / TPA's) hospital empanelment process
This document is a self assessment questionnaire which is completed by a hospital that wants to provide services to our customers

This should be completed and returned to

Name _____

Address _____

_____

_____

Note : By completing this document you are declaring that your hospital meets certain criteria as set out in the form.

Company Logo

Company Name

Company Address

APPLICATION FORM FOR NETWORK SERVICE PROVIDER

(To be filled in block letters)

SECTION A

HOSPITAL INFORMATION

a) Name of the hospital:

b) Address:

City: State:

c) Phone number: d) Fax no. e) PAN no.

f) Registration number:

g) Email address:

h) Website:

SECTION B

CONTACT DETAILS

a) Chief executive of hospital:

i) Name:

ii) Phone number: iii) Email address:

b) Main point of contact for TPA / Insurance company:

i) Name:

ii) Designation: iii) Phone number:

iv) Email address:

c) Insurance / TPA coordinator:

i) Name:

ii) Designation: iii) Phone number:

iv) Email address:

SECTION C

BANK DETAILS

a) Bank name and branch:

b) Address:

City: State:

c) Account number: d) Do you prefer payment by ECR / Cheque? ☐ Yes ☐ No

e) 9 Digit code number appearing on the MICR cheque: f) IFSC code:

g) Payee name

SECTION D

TAX DETAILS

a) Are you exempt from tax deduction at source? ☐ Yes ☐ No i) If yes, please attach income tax registration & income tax exemption certificate.

b) Service tax registration number:

Note: Additional information may be required

Company Logo

Company Name

Company Address

APPLICATION FORM FOR NETWORK SERVICE PROVIDER

SECTION E | SECTION F | SECTION G | SECTION H

OWNERSHIP

a) Type (Only tick one)

☐ i) Government ☐ ii) Non profit ☐ iii) Private

TOTAL NUMBER BEDS

a) Room category wise

i) General ☐☐☐ ii) Twin sharing ☐☐☐ iii) Single ☐☐☐ iv) Single AC ☐☐☐ v) Day care ☐☐☐

vi) ICU ☐☐☐

LEVEL OF CARE

a) Type (Only tick one)

☐ i) Secondary + Single speciality ☐ ii) Secondary + Multi speciality ☐ iii) Tertiary + Single speciality ☐ iv) Tertiary + Multiple speciality

b) List of specialties (Tick ALL that apply)

☐ i) Internal medicine ☐ ii) Cardiology ☐ iii) Nephrology ☐ iv) Paediatrics ☐ v) Pulmonology

☐ vi) Gastro-enterology ☐ vii) General surgery ☐ viiii) Orthopaedics ☐ ix) Gynaecology ☐ x) Obstetrics

☐ xi) Oncology ☐ xii) Urology ☐ xiii) Obstetrics

c) Nurse bed ratio

i) General ☐☐☐ ii) Twin sharing ☐☐☐ iii) Single ☐☐☐ iv) Single AC ☐☐☐ v) ICU ☐☐☐

d) Availability

i) Full time physicians ☐☐☐

CLINICAL SERVICES

a) Emergency (Tick ALL that apply)

☐ i) Emergency room / Minor OT ☐ ii) 24 hour ambulance service ☐ iii) Burns unit ☐ iv) Trauma center

b) Outpatient services

i) Number of consulting rooms ☐☐☐ ii) OPD working hours ☐☐ : ☐☐ am / pm to ☐☐ : ☐☐ am / pm

c) Diagnostic facilities

Investigations: (Tick ALL that apply)

☐ i) Blood biochemistry ☐ ii) Haemotology ☐ iii) Microbiology ☐ iv) Cytology ☐ v) Immunology ☐ vi) Blood bank

Radiology

☐ i) X-ray ☐ ii) USG ☐ iii) CT Scan ☐ iv) MRI ☐ v) Nuclear medicine

Inpatient facilities

i) Number of major operating rooms ☐☐☐ ii) Number of minor operating rooms ☐☐☐ iii) Cath lab facility ☐☐☐

Pharmacy

i) Day / Night ☐☐ : ☐☐ am / pm to ☐☐ : ☐☐ am / pm

Company Logo

Company Name

Company Address

APPLICATION FORM FOR NETWORK SERVICE PROVIDER

INFRASTRUCTURE AND SUPPORT SERVICE (Tick ALL that apply)

- ☐ i) Waste disposal system
- ☐ ii) CSSD
- ☐ iii) Laundry service
- ☐ iv) Power back up
- ☐ v) Central gas supply
- ☐ vi) Water purification / filtration
- ☐ vii) Disabled friendly

COMPUTERIZATION (Tick ALL that apply)

- ☐ i) IT connectivity
- ☐ ii) Hospital information systems
- ☐ iii) Digitisation of records
- ☐ iv) Coding
- ☐ v) IT enabled services

CERTIFICATION (Requires photocopy of certification) (Tick ALL that apply)

- ☐ i) JCI accredited
- ☐ ii) ISO certified
- ☐ iii) NABH certified

Any other certification (Please specify) _____

OUTCOME DATA (Does hospital collect data on the following?) (Tick ALL that apply)

- ☐ i) Inpatient mortality
- ☐ ii) Neonatal mortality
- ☐ iii) Perioperative mortality
- ☐ iv) Surgical site infections
- ☐ v) Hospital acquired infections
- ☐ vi) Unplanned return to theatre
- ☐ vii) Unplanned readmissions
- ☐ viii) Transfers to other hospitals
- ☐ ix) Complications of anaesthesia
- ☐ x) Transfusion reactions

CHECK LIST FOR ENCLOSURES

- ☐ Tariff list
- ☐ Hospital brochure
- ☐ Copy of the hospital registration certificate with the local government authority
- ☐ Copy of certification (ISO / NABL / JCI / Others)

DETAILS OF OFFICIAL WHO COMPLETED THIS FORM

Name of person _____ Mobile number _____

Designation _____ Email address _____

Authorised Signatory

Seal of Hospital

SECTION I SECTION J SECTION K SECTION L SECTION M SECTION N