Bajaj Allianz General Insurance Company Limited. Regd. & Head Office: Bajaj Allianz House, Airport Road, Yerawada, Pune 411 006 CIN: U66010PN2000PLC015329

Allianz (II) Caringly yours

Health Administration Team: *A - Wing 2nd Floor, Bajaj Finserv Building, Behind Weikfield IT Park, Off Nagar Road, Viman Nagar | Pune - 411 014 Phone No.: 020-30305858/ 1800-103-2529 Fax: 020-30512224/ 6/7 | Email: preauth@bajajallianz.co.in

(To be filled in block letters)

CASHLESS FORM

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

DETAILS OF THE PROVIDER	The state of the s
Hospital Name/nursing Home Name:	
City Name:	
City Name:	
State Name:	
Landmark:	
Hospital Contact No: Fax No:	TPA desk NoEmail id:
TO BE FILLED BY THE INSURED/PATIENT a) Name of the Patient:	
by current Address of Insured patient.	
c) Gender: Male Female d) Age: Years Y	Months M M a) Data of highly D D Hadadly Lydydd
f) Name of the Attendant:	
	i) Insured card ID number:
j) Occupation of Insured patient:	k) Policy number I Name of corporate:
1) Employee ID:	
n) Name of the Proposer	m) Pan No:
CKYC of the proposer	
	I had be
Currently do you have any other Mediclaim / Health insuran Company Name:	
Company Name:	
2 2 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
r) Contact number, if any:	e of the family physician:
s) Insured E-mail id	
TO BE FILLED BY THE TREATING DOCTOR / HOSPITA	(PLEASE COMPLETE DECLARATION ON THE REVERSE SIDE OF THIS FORM)
a) Name of the treating doctor:	
c) Nature of ILLNESS / Disease with presenting complaints	
d) Relevant clinical findings:	
e) Duration of the present ailment: Days i. Date of	ffirst consultations DIDIMIMILY IVIVI
i. Past history of present ailment if any:	Thist consultation; D D M M T T T T T
f) Provisional diagnosis	: ICD 10 C
g) Proposed line of treatment: Medical Management	i. ICD 10 Code:i Intensive care
Investigation	Surgical Management Intensive care Non allopathic treatment
h) If Investigation & I or Medical Management provide details	- 지, (1 888) - 1
y route of drug duffillistration,	
i) If Surgical, name of surgery:	i, ICD 10 PCS Code:
j) If other treatments provide details:	
k) How did injury occur:	
I) In case of accident: i. Is it RTA: Yes No ii. Date of	injury: DDDMMMYYYYY iii. Reported to Police: Yes No
iv. FIR No . V. Injury/Disease cau	used due to substance abuse/alcohol consumption: Yes No
	Yes attach reports)
I) In case of Maternity: G P L A Expected	d date of Delivery: D D M M Y Y Y Y LMP: D D M M Y Y Y Y

Details of the patient admitted		Mandatory: Past History of any
a) Date of admission: DDDMMMYY	h) Time: Lit Li Idaa Laal	chronic illness (If yes, since (month / year)
c) Is this an emergency/a planned hospitalization event?:	b) Time: H H H M M	Diabetes
	_ ,	Heart Disease
d) Expected no. of days stay in hospital: Days	e) Room Type	Hypertension
f) Expected no.of days in ICU Days		Hyperlipidemia
g) Per Day Room Rent + Nursing &		Osteoarthritis
Service Charges + Patient's Diet:	Rs	Asthma / COPD / Bronchitis
h) Expected cost for investigation + diagnostics.:	Rs	Cancer
i) ICU Charges:	Rs.	Alcohol or drug abuse
j) OT Charges:	Rs.	Any HIV or STD / Related ailments
k) Professional fees Surgeon + Anesthetist Fees +	Rs.	Any other Ailment give details:
consultation Charges		
l) Medicines + Consumables + Cost of Implants	Rs.	
specify).		
Other hospital expenses if any:	Rs	I confirm that the Past Medical
m) All inclusive package charges if any applicable	Rs.	history with duration written in
n) Sum Total expected cost of hospitalization	Rs.	Pre-Authorization form is correct
	,	(PLEASE READ VERY CAREFULLY)
DECLARATION		(FELASE READ VERT CAREFOLLY)
National Securities Depository Limited Portal for the Consent/Declaration to be added in proposal and I/we hereby give my/our consent to the Company Goods and Service Tax Portal or Ministry Of Corpo undertaking KYC. For Group Policies: Consent/Declaration to be added in claim form Of the Consent/Declaration to be added in claim form Of the Consent/Declaration to be added in claim form Of the Consent/Declaration to be added in claim form Of the Consent/Declaration to be added in claim form Of the Consent/Declaration to be added in claim form Of the Consent/Declaration to be added in claim form Of the Consent/Declaration to be added in claim form Of the Consent/Declaration to be added in claim form Of the Consent/Declaration to be added in claim form Of the Consent/Declaration to be added in claim form Of the Consent/Declaration to be added in claim form Of the Consent/Declaration to be added in claim form Of the Consent/Declaration to be added in claim form Of the Consent/Declaration to be added in claim form Of the Consent/Declaration to be added in claim form Of the Consent/Declaration to be added in claim form Of the Consent/Declaration to be added in claim form Of the Consent/Declaration to be added in claim form Of the Consent/Declaration to Declaration to	to verify and obtain my/our identhe purpose of undertaking KYC d claim for CKYC no.: to verify and obtain my/our identhe Affairs Portal or National Se	ntity/address proof through Central KYC Registry or verification. ntity/address proof through Central KYC Registry or curities Depository Limited portal for the purpose of ntity/address proof through Central KYC Registry for the
I. For Juridical person/non-individual customer and Consent/Declaration to be added in claim form Consent to the Company UIDAI or through any other modes for the purpose	CKYC no.: to verify and obtain my/our ide	ntity/address proof through Central KYC Registry or
a) Name of the treating doctor:	9 E	
b) Qualification:		th State Code:
Hospital Seal (Must include Hospital ID)		
Hospital Seal (Must include Hospital ID)		Patient Insured Name & Signature

SECTION D

PAGE 3: NOT TO BE FAXED/SCANNED

DECLARATION BY THE PATIENT / REPRESENTATIVE

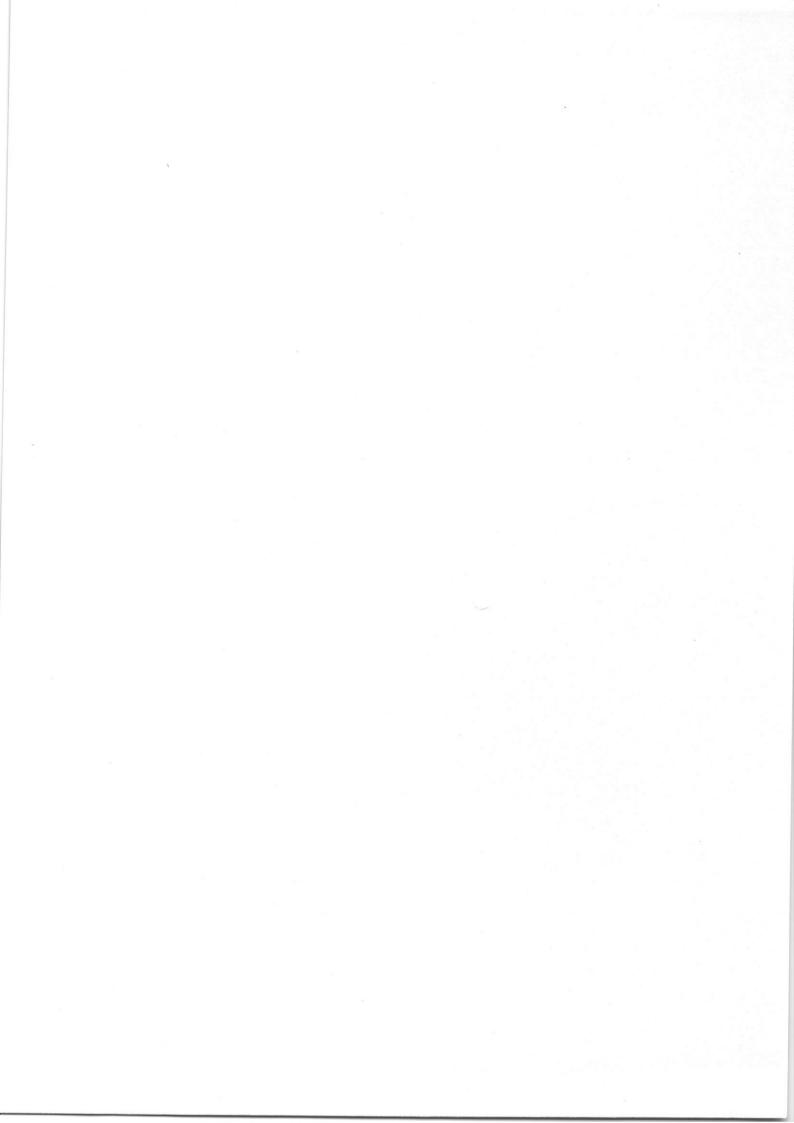
- A. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Bajaj Allianz General Insurance Company Limited after the discharge. I agree to sign on the Final Bill & the Discharge Summary, before my discharge.
- B. Payment to hospital is governed by the terms and conditions of the policy. In case the Bajaj Allianz General Insurance Company Limited is not liable to settle the hospital bill, I undertake to settle the bill as per the terms and conditions of the policy.
- C. All non-medical expenses and expenses not relevant to current hospitalization and the amounts over & above the limit authorized by the Bajaj Allianz General Insurance Company Limited not governed by the terms and conditions of the policy will be paid by me.
- D. I hereby declare to abide by the terms and conditions of the policy and if at any time the facts disclosed by me are found to be false or incorrect I forfeit my claim and agree to indemnify the Bajaj Allianz General Insurance Company Limited
- E. I agree and understand that Bajaj Allianz General Insurance Company Limited is in no way warranting the service of the hospital & that the Bajaj Allianz General Insurance Company Limited is in no way guaranteeing that the services provided by the hospital will be of a particular quality or standard.
- F. I hereby warrant the truth of the forgoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement suppression or concealment with respect to the claim, my right to claim reimbursement of the said expenses shall be absolutely forfeited.
- G . I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Bajaj Allianz General Insurance Company Limited

I. I/We authorize Insurance Company/TPA to contact me/us through S	MS/Email/WhatsApp for any undate on this claim		
a) Patient's /Insured's Name:	processing traces up to any appeare on this claim.		
b) Contact number: d) Email ID (optional)	c) Patient's / Insured's Signature:		
o) Email 15 (optional)			
Date Time			

HOSPITAL DECLARATION

- We have no objection to any authorized Bajaj Allianz General Insurance Company Limited official verifying documents pertaining to hospitalization.
- 2. All valid original documents duty countersigned by the insured I patient as per the checklist below will be sent to Bajaj Allianz General Insurance Company Limited within 2 days of Patient Discharge.
- 3. WE AGREE THAT BAJAJ ALLIANZ GENERAL INSURANCE COMPANY LIMITED 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.
- 4. The patient declaration has been signed by the patient or by his representative in our presence.
- 5. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications.
- 6. We will abide by the terms and conditions agreed in the MOU.
- 7. We confirm that no additional amount would be collected liom the insured in excess of Agreed Package Rates except costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility choosing separate line of treatment which is not envisaged/considered in package).
- 8. We confirm that no recoveries would be made from the deposit amount collected from the insured except for costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility/choosing separate line of treatment which is not envisaged/considered in package).
- In the event of unauthorized recovery of any additional amount from the Insured in excess of Agreed Package Rates, the authorized TPA / Insurance Company reserves the right to recover the same from us (the Network Provider) and,/or take necessary action, as provided under the MOU or applicable laws

Hospital Seal	Doctor's Signature
	Date Time



CENTRAL KYC REGISTRY | Know Your Customer (KYC) Application Form | Individual Important Instructions: A) Fields marked with "" are mandatory fields. E) List of State / U.T code as per Indian Motor Vehicle Act, 1988 is available at the end. B) Please fill the form in English and in BLOCK letters. F) List of two character ISO 3166 country codes is available at the end. C) Please fill the date in DD-MM-YYYY format. G) KYC number of applicant is mandatory for update application. D) Please read section wise detailed guidelines / instructions H) For particular section update, please tick () in the box available before the at the end section number and strike off the sections not required to be updated. Application Type* For office use only New Update (To be filled by financial institution) **KYC Number** (Mandatory for KYC update request) Account Type □ Normal Simplified (for low risk customers) ☐ Small OTP based E-KYC 1. PERSONAL DETAILS (Please refer instruction A at the end) First Name Middle Name Last Name ■ Name* (Same as ID proof) Maiden Name Father / Spouse Name Mother Name Date of Birth* РНОТО Gender* ☐ M- Male ☐ F- Female ☐ T-Transgender Marital Status* ☐ Married Unmarried Others Citizenship* □ IN- Indian Others (ISO 3166 Country Code Residential Status* Resident Individual ☐ Non Resident Indian ☐ Foreign National Person of Indian Origin Occupation Type* ☐ S-Service (☐ Private Sector) ☐ Public Sector ☐Government Sector) □ O-Others (□ Professional ☐ Self Employed ☐ Retired ☐ Housewife □Student) □ B-Business ☐ X- Not Categorised 2. TICK IF APPLICABLE RESIDENCE FOR TAX PURPOSES IN JURISDICTION(S) OUTSIDE INDIA (Please refer instruction B at the end) ADDITIONAL DETAILS REQUIRED* (Mandatory only if section 2 is ticked) ISO 3166 Country Code of Jurisdiction of Residence* Tax Identification Number or equivalent (If issued by jurisdiction)* Place / City of Birth* ISO 3166 Country Code of Birth* 3. PROOF OF IDENTITY (Pol)* (Please refer instruction C at the end) (Certified copy of any one of the following Proof of Identity[Pol] needs to be submitted) A- Passport Number Passport Expiry Date □ B- Voter ID Card C- PAN Card D- Driving Licence Driving Licence Expiry Date ☐ E- UID (Aadhaar) F- NREGA Job Card Z- Others (any document notified by the central government) Identification Number ☐ S- Simplified Measures Account - Document Type code Identification Number 4. PROOF OF ADDRESS (PoA)* 4.1 CURRENT / PERMANENT / OVERSEAS ADDRESS DETAILS (Please see instruction D at the end) (Certified copy of any one of the following Proof of Address [PoA] needs to be submitted) Address Type Residential / Business Residential ☐ Business Registered Office Unspecified Proof of Address* Passport □ Driving Licence UID (Aadhaar) ☐ Voter Identity Card ☐ NREGA Job Card ☐ Others ☐ Simplified Measures Account - Document Type code Line 1* Line 2 Line 3 City / Town / Village District* Pin / Post Code State / U.T Code* ISO 3166 Country Code³

	anent Overseas Address	details (In case of multiple	correspondence / local addresses, please fill	'Annexure A1')
Line 1*				
Line 2				
Line 3			City / Town / V	illage*
District*		Pin / Post Code*	State / U.T Code*	ISO 3166 Country Code*
4.3 ADDRESS IN THE JU	JRISDICTION DETAILS \	WHERE APPLICANT IS RE	SIDENT OUTSIDE INDIA FOR TAX PURPOS	ES* (Applicable if section 2 is ticked)
Same as Current / Perma	anent / Overseas Address		Same as Correspondence / Local Address of	
Line 1*				
Line 2				
Line 3			City / Town / Vi	llane*
State*			ZIP / Post Code*	ISO 3166 Country Code*
5. CONTACT DETAILS	(All communications will be	sent on provided		
	(i as communications will be	sent on provided		
Tel. (Off)		Tel. (Res)	- Mobile	
FAX		Email ID		
6. DETAILS OF RELAT	ED PERSON (In case of	f additional related persons, pl	e ase fill 'Annexure B1') (please refer instruction (G at the end)
Addition of Related Person	Deletion of Related Pe		'C Number of Related Person (if available*)	
Related Person Type*	Guardian of Minor	Assignee	☐ Authorized Representative	
Name *	Prefix	First Name	Middle Name	Last Name
Name*	/If KVC number and name			
DDOOF OF IDENTIFY ID		e are provided, below details o		
	OF RELATED PERSON* (Please see instruction (H) at t	he end)	
A- Passport Number			Passport Expiry Date	DID-MM-NYNY
B- Voter ID Card				
C- PAN Card				
D- Driving Licence			Driving Licence Expiry Date	DD-REE-VIVIVIV
E- UID (Aadhaar)				
F- NREGA Job Card				
Z- Others (any document	t notified by the central go	overnment)	Identification Number	
			Identification Number	
S- Simplified Measures				
☐ S- Simplified Measures ☐ 7. REMARKS (If any)		Mobile no. / En	nail-ID) (Please refer instruction F at the end)	
COLD DESCRIPTION OF THE PROPERTY OF THE PROPER		Mobile no. / Em	nail-ID) (Please refer instruction F at the end)	
		Mobile no. / Em	nail-ID) (Please refer instruction F at the end)	
		Mobile no. / Em	nail-ID) (Please refer instruction F at the end)	
		Mobile no. / Em	nail-ID) (Please refer instruction F at the end)	
7. REMARKS (If any) 8. APPLICANT DECLA	ARA TION			
7. REMARKS (If any) 8. APPLICANT DECLA I hereby declare that the details furni	ARA TION ished above are true and correct to	the best of my knowledge and helicity	ef and I undertake to inform you of any changes representing, I am aware that I may be held liable	
7. REMARKS (If any) 8. APPLICANT DECLA I hereby declare that the details furnitherein, immediately. In case any of the for it.	ARA TION ished above are true and correct to the above information is found to b	o the best of my knowledge and beli e false or untrue or misleading or mise	ef and I undertake to inform you of any changes representing, I am aware that I may be held liable	(Styles et al. Thereof tress execut.
8. APPLICANT DECLA I hereby declare that the details furnitherein, immediately. In case any of the for it. I hereby consent to receiving information.	ARA TION ished above are true and correct to the above information is found to b ation from Central KYC Registry the	o the best of my knowledge and beli e false or untrue or misleading or mise	ef and I undertake to inform you of any changes epresenting, I am aware that I may be held liable ared number/email address,	Share of Applicant Ingression of Applicant
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BREACH CANDY HOSPITAL TRUST

CONSENT FORM - CASHLESS CLAIM

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

- 1) Fully Filled pre-authorization form (provided by the hospital).
- 2) Pan card & Adhaar card of the Patient & primary insured
- 3) Duly filled KYC form (with signature & photograph of Primary Insured)
- 4) Relevant Investigation Reports.
- 5) Vaild Insurance ID.
- 6) Cancelled Cheque of Patient Account.

Highlights:

- For all planned cases the pre-authorization form has to be processed a week prior to hospitalization. For emergency admissions the pre-authorization form has to be submitted to the TPA desk within 24 hours of hospitalization.
- In the absence of a valid initial authorization letter, the patient will be admitted as a Cash patient and will be required to pay the requisite deposit on admission as per the protocol.
- At the time of submission of the pre-authorization form the patient has to pay Rs. 30,000/- as a deposit towards admission. This deposit is adjustable/refundable depending upon the final bill and the final approval amount of the patient.
- If a TPA inpatient undergoes an additional procedure which is not mentioned in the Preauthorisation form then the additional documents will be processed by the TPA desk. If the approval is not received before the surgery the patient will be treated as a Cash patient & 90% of the estimated amount needs to be paid as a deposit.
- In case of an Emergency/Unplanned surgery the patient will be treated as a Cash patient & 90% of the estimated amount needs to be paid as a deposit within 24 hours of the surgery.
- On the day of discharge once all required documents are sent to the Insurance Co. /TPA, it takes up to 4hrs. for the approval to come. Patientcan be physically discharged only after final approval is received by the hospital.
- At the time of discharge the hospital will retain make it up to 10% of the final approval amount as a Security deposit which will be refunded to the patient after the final settlement from the Insurance Company, the duration of which is variable (minimum is 45 days).
- Half day charges will be levied for patients if the discharge process is initiated between 11.00 am to 1.00pm.
 All discharges processed after 1.00 pm will attract full day charges.

Consent:

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

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

Patient Name:

BH No.

DOA:

Patient Name :	BH NoDOA :					
Name & Signature of person submitting Claim Documents :						
Date :						
	For Office Use Only					
Received by :	Date & Time :					

BREACH CANDY HOSPITAL TRUST

IMPORTANT INFORMATION REGARDING YOUR CASHLESS CLAIM

- For all planned cases the pre-authorization form has to be processed a week prior to hospitalization, For emergency admissions the pre-authorization form has to be submitted to the TPA desk within 24 hours of hospitalization.
- 2. Admission will be on the basis of the authorization letter received from the TPA/Insurance Company which is only a provisional authorization. Please show a copy of this letter on the Admission Desk at the hospital at the time of Admission.
- 3. In the absence of a vaild initial authorization letter, the patient will be admitted as a Cash patient and will be required to pay the requisite deposit on admission as per the protocol.
- 4. If any query is raised before or during the hospitalization which requires to furnish additional information of the Medical condition of the patient then the clarification will be provided by the Consultant/Surgeon and may be delayed depending upon the availability of the Consultant/Surgeon.
- 5. If the query requires to provide any details which are non-medical in nature the TPA desk will reply to them as soon as possible which may require help from the patient relative.
- 6. At the time of submission of the pre-authorization form the patient has to pay Rs. 30,000/- as a deposit towards admission. This deposit is adjustable/refundable depending upon the final bill and the final approval of the patient.
- 7. In a single hospitalization one can avail cashless only with one TPA/Insurance Company, if the patient has more than one policy they can avail the reimbursement facility. Please contact the TPA Desk for further details.
- 8. For knowing the coverage of any particular (Medical/Surgical) condition under your Policy, please read the T & C of your policy document or speak to your agent.
- For Room Eligibility of the patient please contact your agent for criterion of admission as per the policy of the patient.
- 10. If a TPA inpatient undergoes an additional procedure which is not mentioned in the Preauthorisation form then the additional document will be processed by the TPA desk. If the approval is not received before the surgery the patient will be treated as a Cash patient & 90% of the estimated amount needs to be paid as a deposit.
- 11. In case of an Emergency/Unplanned surgery the patient will be treated as a Cash patient & 90% of the estimated amount needs to be paid as a deposit within 24 hours of the surgery.
- 12. On the day of discharge once we send all required documents to Insurance Co. / TPA, it takes up to 4 hrs. for approval to come. The patient can be physically discharged only after approval comes as per the policy.
- 13. Half day charges will be levied for patients if the discharge process is initiated between 11.00 am to 1.00 pm. All discharges processed after 1.00 pm will attract full day charges.
- 14. The original reports and bill will be handed over to the TPA/Insurance Company for processing of the claim. A copy of all the reports will be available at the reports counter, 7 days after the discharge.
- 15. A copy of the Discharge Summary will be provided to the patient at the time of discharge.
- 16. At the time of discharge the hospital will retain <u>up to 10%</u> of the Final Approval amount as a Security deposit which will be refunded to the patient after the final settlement from the Insurance Company, the duration of which is variable (minimum is 45 days).
- 17. Any deductions towards non-medical items, exclusions, class based billing etc. will have to be borne by the patient (this will not be adjusted against the security deposit).
- 18. Please submit a cancelled cheque to get the refund into your account directly.
- 19. In case of denial of the cashless claim (due to withdrawal or rejection of the claim) during the hospitalization or at the time of discharge the patient will be treated as a cash patient and will be expected to clear the entire bill of the hospital and proceed for the reimbursement process.
- 20. Only approval letters received on the Email or the Portal will be considered vaild.
- 21. There may be a delay in receiving the approval on Public Holidays or Sundays.

BCHT/TPA/INFO/4/12-23