REQUESTFORCASHLESSHOSPITALISATION

PART C (Revised)

SBI general INSURANCE
SURAKSHA AUR BHAROSA DONO

E-MAIL ID.: cashless.health@sbigeneral.in

TO BE FILLED IN BLOCK LETTERS ONLY

Hospital ID: SBIGHS018385
Name of Hospital: P.D.Hinduja Hospital And Medical Research Centre
Hospital Location: Mumbai,Mahim **Hosp ID:** SBIGHS018385
Hospital Email ID: tpacell@hindujahospital.com **ROHINI ID:** 8900080102194

DETAILS OF CLAIMS ADMINISTRATOR

a)NameofInsurer: SBI General Insurance Company Limited b)E-mail ID.: cashless.health@sbigeneral.in c) Toll Free no.: 1800 210 3366 / 1800 210 6366

TO BE FILLED BY INSURED/PATIENT

a) Name of the patient:

b) Gender: ☐ Male ☐ Female ☐ Third Gender c) Contact no.: d) Alternate Contact

e) Age: Years [Y][Y] Months [M][M] f) Date of Birth: [D][D][M][M][Y][Y][Y][Y] g) Insurer ID Card No.:

h) Policy number / Name of corporate: i) Employee ID:

j) Currently do you have any other medical claim / health insurance: ☐ Yes ☐ No j1) Insurer name:

j2) Give details:

k) Do you have family physician, if yes: Name: k1) contact No.:

l) Occupation of insured patient :

m) Address of insured patient:

TO BE FILLED BY THE TREATING DOCTOR / HOSPITAL

a) Name of the treating doctor : b) contact No.:

c) Name of illness / disease with presenting complaints:

d) Relevant clinical findings:

e) Duration of the present ailment: ☐ Days e.1) Date of first consultation: [D][D][M][M][Y][Y][Y][Y]

e.2) Duration of the present ailment:

f) Provisional diagnosis:

f.1) ICD 10 Code:

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

h) If investigation and/or medical management, provide details:

h.1) Route of drug administration ☐ IV ☐ Oral ☐ Other

i) If surgical, name of surgery:

i.1) ICD 10 PCS Code:

j) If other treatments, provide details:

k) How did injury occur:

l) In case of accident: i) Is it RTA: ☐ Yes ☐ No ii) Date of Injury: [D][D][M][M][Y][Y][Y][Y] iii) Reported to Policy: ☐ Yes ☐ No iv) FIR No.:

v) Injury / disease caused due to substance abuse/alcohol consumption: ☐ Yes ☐ No vi) Test conducted to establish this, if yes attach report: ☐ Yes ☐ No

m) In case of Maternity: G ☐ P ☐ L ☐ A ☐ n) Expected date of delivery: [D][D][M][M][Y][Y][Y][Y]

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DETAILS OF PATIENT ADMITTED

A) Date of admission: D D M M Y Y Y Y b) Time of admission: H H M M c) This is an ☐ An emergency / ☐ A planned hospitalization event

d) Date of admission: ☐ Days e) Days in ICU: ☐ Days f) Room Type: ☐

g) Per Day Room Rent + Nursing & Service charges + Patient's Diet : Rs ☐

h) Expected cost for investigation + diagnostics: Rs ☐

i) ICU Charges: Rs ☐

J) OT Charges: Rs ☐

k) Professional fees Surgeon + Anesthetist fees + Consultation charges: Rs ☐

l) Medicines + Consumables cost of Implants: (specify if applicable): Rs ☐

m) Other hospital expenses if any Rs ☐

n) All inclusive package charges if any applicable : Rs ☐

o) Sum Total expected cost of hospitalization Rs ☐

p. Mandatory past history of any chronic illness. If yes (since month/ year)

1.	Diabetes	M M Y Y
2.	Heart Disease	M M Y Y
3.	Hypertension	M M Y Y
4.	Hyperlipidemias	M M Y Y
5.	Osteoarthritis	M M Y Y
6.	Asthma / COPD / Bronchitis	M M Y Y
7.	Cancer	M M Y Y
8.	Alcohol or drug abuse	M M Y Y
9.	Any HIV or STD / Related Ailments	M M Y Y

☐

DECLARATION (PLEASE READ VERY CAREFULLY)

We confirm having read understood and agreed to the declaration of this form

a. Name of the treating doctor ☐

b. Qualification ☐ c) Registration No. with State code: ☐

DECLARATION BY THE PATIENT / REPRESENTATIVE

a. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Insurer/TPA after the discharge. I agree to sign on the Final Bill & the Discharge Summary, before my discharge.

b. 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 condi- tions 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 Insurer/TPA 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 insurer / TPA

e. I agree and understand that TPA is in no way warranting the service of the hospital & that the Insurer / TPA is in no way guaranteeing that the services provided by the hospital will be of a particular quality or standard.

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 Insurer/ TPA.

h. "I/We authorize Insurance Company/TPA to contact me/us through mobile/email for any update on this claim"

a. Patient's / Insured's Name: ☐

b. Contact Number: ☐ c) Email ID: (Optional) ☐

c. Patient's / Insured's Signature ☐

Date: D D M M Y Y Y Y ☐ Time: H H M M ☐

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HOSPITAL DECLARATION

a. We have no objection to any authorized TPA / Insurance Company official verifying documents pertaining to hospitalization.

b. 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.

c. 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.

d. The patient declaration has been signed by the patient or by his representative in our presence.

e. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications.

f. We will abide by the terms and conditions agreed in the MOU.

g. We confirm that no additional amount would be collected from the insured in excess of Agreed Package Rates 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).

h. 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).

i. 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.

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.

Hospital Seal: | Doctor's Signature:

Date: D D M M Y Y Y Y Time: H H M M