Schedule – A

Provider Services – Cashless Facility Admission Procedure

The insured shall be provided treatment free of cost for all such ailments covered under the policy within the limits / sub-limits and the sum insured, i.e., coverages not specifically excluded under the policy. The Provider shall be reimbursed as per the tariff agreed under the service level agreement for different treatments or procedures. The procedure to be followed for providing cashless facility shall be:

I. 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 preauthorization form prescribed by the Authority i.e. “request for authorization letter” (RAL). The RAL shall be sent electronically along with all the relevant details in 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 Insured. The insurer’s or its representative TPA’s medical team may consult the treating physician or the insured, if necessary.
2. If the treating physician of the provider identifies any disease or ailment as pre-existing, the treating physician shall record it and also inform the insured immediately.
3. In cases where the symptoms appear vague / no effective diagnosis is arrived at, the medical team of the insurer or its representative TPA may consult with treating physician / insured, if necessary.
4. The RAL shall reach the authorization department of insurer or its representative TPA 7 days prior to the expected date of admission, in case of planned admission.
5. If “clause 3” above is not followed, the clarification for the delay needs to be forwarded along with the request for authorization.
6. The RAL form shall be dully filled in clearly mentioning Yes or No and/or the details as required. The form shall not be sent with nil or blank replies.
7. The guarantee of payment shall be given only for the medically necessary treatment cost of the ailment covered and mentioned in the request for hospitalization. Non covered items as per terms and conditions of the policy, like Telephone usage, food provided to relatives/attendants, Provider registration fees etc must be collected directly from the insured.
8. The authorization letter by the insurer or its representative TPA shall clearly indicate the amount agreed for providing cashless facility for hospitalization.

9. In the event of the cost of treatment increasing, the provider may check the availability of further limit with the insurer or its representative TPA.
10. 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 shall be evaluated based on the availability of further limits and the hospital may be required to provide valid reasons for the same. No enhancement of limit is possible after discharge of insured.
11. Further, the insurer or the TPA who is acting on behalf of the Insurer 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.
12. In case the insurer has opted for a higher accommodation / facility than the one eligible under the policy, the Provider shall explain the effect of such option and also take a written consent from the beneficiary at the time of admission as regard to owing the responsibility of such expenses by the insured including the proportionate expenses which have a direct bearing due to upgradation of room accommodation/facility. In all such cases the Insurer [Insurance Company] shall pay for the expenses which are based on the eligibility limits of theinsured. However provider may charge any advance amount/security deposit from the insured only in such cases where the insured has opted for an upgraded facility to the extent of the amounts to be collected from the insured .
13. Insurance company guarantees payment only after receipt of RAL and the necessary medical details. The Authorization Letter (AL) shall be issued within 48 hours of receiving the RAL.
14. In case the ailment is not covered or the given medical data is not sufficient for the medical team of the authorization department to confirm the eligibility, insurer or its representative TPA shall seek further clarification/ information immediately.
15. Authorization letter [AL] shall mention the authorization number and the amount guaranteed for the procedure.
16. In case the balance sum available is considerably less than the cost of treatment, provider shall follow their norms of deposit/running bills etc. However provider shall only charge the balance amount over and above the amount authorized under the health insurance policy against the package or treatment from the insured.
17. Once the insured is to be discharged, the Provider shall make a final request for the pre-authorization for any residual amount along with the standard discharge summary and the standard billing format. Once the provider receives final pre-authorization for a specific amount, the insured shall be allowed to get discharged by paying the difference between the pre-authorized amount and actual bill, if any.

Insurer upon receipt of the complete bills and documents shall make payment of the guaranteed amount to the provider directly.

18. Due to any reason if the insured does not avail treatment at the Provider after the pre authorization is released and any payment is made in this regard, the Provider shall return the amount to the insurer immediately.
19. All the payments in respect of pre-authorised amount shall be made electronically by the insurer to the provider as early as possible but not later than a week, provided all the necessary electronic claim documents are received by the insurer.
20. Denial of authorization (DAL) for cashless is by no means denial of treatment by the health facility. The provider shall deal with such case as per their normal rules and regulations.
21. Insurer shall not be liable for payments to the providers 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.
22. Provider, insurer and its representative TPA shall ensure that the procedure specified in this Schedule is strictly complied in all respects.

II. Preauthorization Procedure – Emergency Admissions:

1. In case of emergencies also, the procedure specified in Clause (I) (1), (2) and (3) shall be followed.
2. The insurer or its representative TPA may continue to discuss with treating doctor till conclusion of eligibility of coverage is arrived at. However, 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 shall refund the deposit amount to the insured if taken barring a token amount to take care of non covered expenses.

III. <u>Preauthorization Procedure – RTA / MLCs:</u>

1. If requesting a pre-authorisation for any potential medico-legal case including Road Traffic Accidents, the Provider shall indicate the same in the relevant section of the standard format.
2. 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 resort to intentional self injury, it is mandatory for the Provider to inform this circumstance of emergency to the Insurer or its representative TPA.

IV. Authorization letter (AL):

1. Authorization letter shall 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 Pre-Authorization letter shall also mention Validity of dates for admission and number of days allowed for hospitalization, if any. The Provider shall see that these rules are strictly followed; else the AL will be considered null and void.
3. In the event of the room category, if any, not being available the same shall be informed to the Insurer or its representative TPA and the Insured. For such cases if the Insured is admitted to a class of accommodation higher than what he is eligible for, the provider shall collect the necessary difference, if any, in charges from the Insured.
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.

V. Reauthorization:

1. Where there is a change in the line of treatment – a fresh authorization shall be obtained from the insurer immediately – this is called a reauthorization.
2. The same pre-authorization form shall be used for the reauthorization, and the same turnaround times as specified shall apply.

VI. Discharge:

1. The following documents shall be included in the list of documents to be sent along with the claim form to the Insurer or its representative TPA . These shall not be given to the Insured.
   a. Original pre authorization request form,
   b. original authorization letter,
   c. Original discharge card,
   d. original investigation repots,
   e. all original prescription and pharmacy receipt etc
2. Where the Insured requires the discharge card/reports 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]". Where, the insured requests for any of the original reports, the insurer shall arrange forwarding the originals by duly endorsing the settlement of the claim on such original reports. However, the insurer or its representative TPA may retain a copy of such reports as per their operational requirements.

3. The discharge card/Summary shall mention the duration of ailment and duration of other disorders like hypertension or diabetes and operative notes in case of surgeries. The clinical detail shall be sufficiently and justifiably informative. In addition, the Provider shall provide all the relevant details pertaining to past treatment availed by the Insured with the Provider.
4. Signature of the Insured on final Provider bill must be obtained.
5. In the event of death or incapacitation of the Insured , the signature of the nominee or any of Insured's family who represents the Insured subject to reasonable satisfaction of Provider shall be sufficient for the Insurer to consider the claim.
6. Standard Claim form duly filled in duly presented to the Insured for signing and identity of the Insured shall be confirmed by the provider.

VII. Billing:

1. The Provider shall submit original invoices directly to Insurer or its representative TPA and such invoices shall contain, at the minimum, following information:

   a. the Insured's full name and date of birth;
   b. the policy number;
   c. the Insured'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 or any other Code as specified by the Authority from time to time;
   g. the diagnosis at the time of treatment and diagnosis code according to ICD-10 or any other Code as specified by the Authority from time to time;;
   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 provided; and.
   k. the Insured signature (in original).

2. 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 Insured and the treating consultant for the Treatment performed;
   c. original and complete discharge summary in the standard form and billing

form in the standard form, 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 Insured's policy; and
g. photocopy of the Insured's photo identification (eg voter's Smart card/ ID card, passport or driving licence etc).

3. The Provider shall submit the final invoice and all supporting documentation required within 2 days of the discharge date.