CHOLAMANDALAM MS GENERAL INSURANCE COMPANY LIMITED
Registered Office: 2nd Floor, "DARE House", 2, N.S.C. Bose Road, Chennai - 600 001.
Toll free: 1800 208 9100 | website: www.cholainsurance.com
Pre Authorization Request: faxhealth@cholams.murugappa.com | **Queries & Complaints:** customercare@cholams.murugappa.com

REQUEST FOR CASHLESS HOSPITALISATION FOR MEDICAL INSURANCE POLICY

BASIC INFORMATION - (TO BE FILLED IN BLOCK LETTERS)			
Rohini ID		Patient ABHA ID	
Hospital Facility Registry (HFR) ID			

2) TO BE FILLED BY THE INSURED/ PATIENT			
a) Name of the Patient			
b) Gender	☐ Male ☐ Female ☐ Third Gender		c) Age Years ☐ Months ☐
d) Contact Number		Contact Number of attending Relative	
e) Insured card ID number		Policy number/ Corporate	
g) Employee ID		h) Currently do you have any other Medi claim / Health insurance	
i) Company Name		1) Give details	
2) Sum Insured		3) Contact number	
j) Name of the family physician			
K) Current Address of Insured Patient			
l) Occupation of Insured Patient		m) PAN	

Note : PAN No. Mandatory , Incase of Non availability of PAN CARD – FORM 60 as per the annexure need to be provided.

3) TO BE FILLED BY THE TREATING DOCTOR / HOSPITAL			
a) Name of the Patient		b) Contact Number	
c) Nature of Illness/ Disease with Presenting Complaints		d) Relevant Clinical Findings	
e) Duration of the Present Ailment	Days		
1) ICD 10 Code		2) Past history of present ailment if any	
f) Proposed line of treatment ☐ Medical Management ☐ Surgical Management ☐ Intensive care ☐ Investigation ☐ Non Allopathic Treatment			
g) If Investigation& / or Medical Management provide details		h) Route of drug administration	
i) If Surgical, name of surgery		j) ICD 10 PCSCode	

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k) If other treatments provide details	l) How did injury occur

m) In case of accident
1) Is it RTA ☐ Yes ☐ No 2) Reported toPolice ☐ Yes ☐ No
3) Injury / Disease caused due to substance abuse/ alcohol consumption ☐ Yes ☐ No
Test conducted to establish this ☐ Yes ☐ No (If Yes, attach reports)

m) In case of Maternity:	LMP

Details of the patient admitted		**Past History of any chronic illness**	**If yes, since (month/year)**
a) Date admission b) Time		Diabetes	
c) Is this an emergency / a planned hospitalization event? ☐ Emergency ☐ Planned		Heart Disease	
d) Expected no. of days stay in hospital Days		Hypertension	
e) Room Type f) Days in ICU		Hyperlipidemia	
g) Per Day Room Rent + Nursing & Service Charges + Patient's Diet	₹	Osteoarthritis	
h) Expected cost for Investigation + Diagnostics	₹	Asthma / COPD / Bronchitis	
i) ICU Charges	₹	Cancer	
j) OT Charges	₹	Alcohol or drug abuse	
k) Professional fees Surgeon+Anaesthetist Fees + Consultation Charges	₹	Any HIV or STD I Related ailments	
l) Medicines + Consumables + Cost of Implants (if applicable please specify)	₹	Any other Ailment give details	
m) Other hospital expenses if any	₹		
n) All inclusive package charges if any applicable	₹		
o) Sum Total expected cost of hospitalization	₹	(PLEASE READ VERY CAREFULLY)	

4) DECLARATION

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

a) Name of the treating doctor

b) Qualification c) Registration No. with State Code

d) Healthcare Professionals Registry (HPR) ID

Signature of Treating Doctor	Hospital Seal (Must include Hospital ID)	Patient/ Insured Name & Signature:

(IMPORTANT: PLEASE TURN OVER)

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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 / IPA 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 fate 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.
8. I confirm that I had already received the Customer Information Sheet along with the Policy Document and all the terms and conditions of the Policy / claim process/ coverage and exclusions, amongst other terms, were understood by me.

Patient's/ Insured's Name _____

Contact number _____ 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.
8. 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).

9. 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).

10. 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 from 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**

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 Ihe Hospitals / Chemists supported by proper prescription.
3. Receipts and Pathological Test Reports from Pathologists, supported by note from the attending Medical Practitione- / 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.
6. Original Final Bills has to be signed by the Patient/ Insured.

DOCUMENTS TO BE PROVIDED BY THE PATIENT/ INSURED IN SUPPORT OF THE CLAIM

1. Aadhar card copy (Optional).
2. Pan card copy.
3. In case of Non availability of PAN CARD - FORM 60 as per the annexure need to be provided.

Income-tax Rules, 1962

FORM NO. 60

[See second proviso to rule 114B]

Form for declaration to be filed by an individual or a person (not being a company or firm) who does not have a permanent account number and who enters into any transaction specified in rule 114B

First Name			
Middle Name			
Surname			
Date of Birth / Incorporation of Declarant	DD:MM:YYYY		
Father's Name (in case of individual)			
First Name			
Middle Name			
Surname			
Flat/ Room No.		Floor No.	
Name of premises		Block Name/No.	
Road/ Street/ Lane		Area/ Locality	
Town/ City		District	
State		Pin code	
Telephone Number (with STD code)		Mobile Number	
Amount of Transaction (Rs.)			
Date of Transaction	DD:MM:YYYY		
In case of transaction in joint names, number of persons involved in the transaction			
Mode of transaction	☐ Cash, ☐ Cheque, ☐ Card, ☐ Draft/Banker's Cheque, ☐ Online transfer, ☐ Other		
Aadhaar Number issued by UIDAI (if available)			
If applied for PAN and it is not yet generated enter date of application and acknowledgement number			
If PAN not applied, fill estimated total income (including income of spouse, minor child etc. as per section 64 of Income-tax Act, 1961) for the financial year in which the above transaction is held			
a. Agricultural income (₹)			
b. Other than agricultural income (₹)			

Details of document being Document produced in support of identify in Column 1 (Refer Instruction overleaf)	Document Code	Document Identification Number	Name and address of the authority issuing the document
Details of document being produced in support of address in Columns 4 to 13 (Refer Instruction overleaf)	Document Code	Document Identification Number	Name and address of the authority issuing the document

Verification

I, _____ do Hereby declare that whatis stated above is true to the best of my knowledge and belief. I further declare that I do not have a Permanent Account Number and my/ our estimated total income (including income of spouse, minor child etc. as per section 64 of Income-tax Act, 1961) computed in accordance with the provisions of Income-tax Act, 1961 for the financial year in which the above transaction is held will be less than maximum amount not chargeable to tax.

Verified today, the _____ day of _____ 20 _____

Place _____ (Signature of declarant)

Classification: Public

Hospital Provider Information Sheet		
Name of the Hospital		
Hospital address, City, State		
Key Decision maker - Contact person Name and Contact Details		
Admin / Insurance / TPA Coordinator - Contact person Name and Contact Details		
Rohini ID*		
Total No of Bed & ICU		
OT	Yes / No Minor	Major:
No of Doctor / Consultant	In House	Visiting
No of Paramedic Staff		
Pharmacy	In House	Outsourced
Lab	In House	Outsourced
NABH / Pre-Entry NABH Code		
Patient name		
Surgery / Ailment		
Approx amount		
Patient admitted room category		
Documents required from Hospital		
Hospital Registration certificate		
Pollution control board certificate		
Hospital rate list		
PAN card & Pan card declaration if name difference		
Cancel Cheque		
Enclosure		
Cashless Pre-auth form		
One page MOU		

LETTER OF AGREEMENT (HOSPITAL)

Ref No: - **Date: -**

Hospital Name:
Hospital Address:

Dear Sirs,

Sub: Letter of Consent for extending cashless facility to Mr/Mrs , the insured with / policyholder of Cholamandalam MS General Insurance Co. Ltd.

Cholamandalam MS General Insurance Co. Ltd., (hereinafter referred to as "the Company ") has agreed to enter into a business arrangement with " Hospital Name " (hereinafter referred to as "Hospital") for providing cashless facilities to the policyholders of the Company who have taken Health Insurance Policy. This letter sets out the terms and conditions governing the arrangement contemplated herein:

1. The Hospital undertakes to provide the service in a precise, reliable and professional manner to the satisfaction of the Company and in accordance with additional instructions issued by the Company.

2. The Hospital shall allow the Company to conduct audits of their systems policies, process as and when deemed necessary by the Company. Such audits shall be conducted by the Company audit team or any independent third party appointed by the Company with prior intimation to the Hospital for all cases those directly relate to the services under this agreement

3. The Hospital may permit the Company personnel or its agent to inspect the premises any time and to meet the policy holder during the period of hospitalization. Further,the Hospital shall allow the Company to conduct audits of the bills as and when deemed necessary by the Company. Such audits shall be conducted by the Company audit team without prior intimation to the Hospital.

4. Hospital will submit all the documents within 2 days from the date of the discharge of the patient/Insured Beneficiary and the Company will make payment of eligible and undisputed bills within 30 working days from the date of receipt of such submission, subject to verification and validation and after applicable tax deductions. However, if required, the Company can call for further document related to treatment to process the case, in which case the payment may be delayed beyond 30 working days as contemplated herein (depending on the response received from the Hospital for the query raised by the Company).

5. The Hospital shall defend, hold harmless, indemnify and keep indemnified the Company for Hospital's breach of any representations and warranties, or for its not obtaining license or registration under local, state or National Laws, and also registered with such agency/authority as prescribed IRIDAI, from time to time, as may be applicable and also if the doctors who treat the insured/patients in Hospital are not duly qualified holding required Degree/qualifications from the authority competent to issue such Degree/qualifications or for any inadequate or deficiency of services/Health Checkup services, or for breach of confidentiality or for acts, commissions and omissions of the Hospital, its employees, Doctors, Nurses or other staff/persons who are involved in the process of providing the cashless facility / medical treatment or healthcare services to the insured/patients or for acts, commissions and omissions of Hospital, its staff, employees, doctors, agents etc., or for breach of this arrangement, resulting in any claims, damages, actions, proceedings suits [including the advocate fees incurred by our company, if any etc.,] against the Company. For all these obligations and indemnities, the Hospital shall also be liable to the insured/patients who suffer due to various aspects mentioned in this clause.

6. All payments shall be made through direct electronic fund transfer subject to deduction of tax at source as applicable under the relevant laws.

7. Hospital shall keep and maintain confidential any or all information of the Company and its policyholders / insured/ patients and relating to all matters and issues dealt with by the parties in the course of the business contemplated by and relating to this arrangement. The Hospital 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, medical reports, personality identifiable information / personal information relating to insured, and other unpublished information except as maybe authorized in writing by the Company. In case of any breach whatsoever, Hospital shall fully indemnify the Company. This clause shall survive expiry or termination of this arrangement.

8. All the claim documents shall be dispatched to the Company at the following address within 2 days from the date of discharge of the policyholder to the Company's address or such other address as may be informed by the Company:

   Cholamandalam MS General Insurance Company Ltd
   Chola MS HELP - Health Claims Department,
   New No. 2, Old No. 234,
   Dare House, II Floor,
   N. S. C. Bose Road, Parrys Corner,
   Chennai - 600 001.

9. Hospital shall provide the documents as listed below:

   a. Original cancelled cheque
   b. Duly filled and signed EFT Mandate form
   c. Contact detail sheet
   d. EFT terms & condition sheet
   e. Payee name confirmation letter
   f. PAN card photo copy

10. This cashless arrangement is specific for the particular claim referred above. Final approval shall be given based on the receipt of full and requisite documents for cashless Pre-authorization and if any discrepancy found during the time of claim settlement, approval shall not be provided. In case of any discrepancy / fraud, Chola MS reserves the right to deny the claim, while reserving its rights to take appropriate action. The Company's decision shall be final and binding. It is agreed that the any matters related to claim shall be subject to policy terms and conditions.

Please sign and return a copy of this document as a token of your acceptance and confirmation to what is stated above. This letter shall come in to force upon the Hospital executing the same.

For Cholamandalam MS General Insurance Co. Ltd.,

Authorized Signatory
Name:
Designation:

For Hospital Name**,**

Authorized Signatory
Name:
Designation:

Chola MS Anywhere Cashless Consent Form (Insured)

To

Chola MS

Policy number:

I Mr./Mrs. _____ (Name) wanted to avail the Chola MS Anywhere Cashless facility at

_____

_____

_____

(Hospital name & Address) and going to get admitted on _____ (date).

I give my consent for processing anywhere cashless facility in this Hospital

Signature

Name of the Insured/Attender:

Mobile no.: