Instructions for filling the Cashless Pre-Auth Request form

1) Please take a print of all the forms attached; the submission of filled pre-auth forms for planned cases can be done at the TPA desk only, located on the Gr. Floor of the Hospital, from Mon to Sat (10 am to 6 pm).
2) Kindly confirm the **name of your TPA** as mentioned on your policy papers
3) Kindly fill the **patient's & insurer's details**
4) Please ask the treating doctor to fill the Doctors part, mention the past history and provide with his/her signature on the same.
5) In case of a surgery, kindly ask your doctor to mention the category of the same
6) If your insurance company is one of the following and the patient is undergoing surgery, then special **GIPSA** (**G**eneral **I**nsurance **P**ublic **S**ector **A**ssociation) packages may be applicable to you. Kindly approach the TPA desk for further details
   a) New India Assurance Insurance
   b) National Insurance
   c) Oriental Insurance
   d) United India Insurance
7) The estimate section mentioned in the form will be filled by the TPA desk. Kindly get photocopies of all the following documents to submit your pre-auth form.
   a) Current and previous Policy papers of past 4 years (In case of PSU Insurance)
   b) TPA card
   c) Photo id proof (PAN card is mandatory)
   d) Address proof (Aadhar Card/Electricity Bill)
   e) Patients Photograph
   f) Doctors past consultation papers
   g) Investigation reports related to the ailment
   h) Employee ID (in case of a corporate policy)
8) Please contact the **TPA desk** for further assistance
9) Cashless services are not applicable for OPD, Dialysis & Radiation Oncology cases

Kindly Note: The filled Pre-auth form can be submitted at the TPA Desk, located on the Gr. floor of Kokilaben Dhirubhai Ambani Hospital only

STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED

Regd. & Corporate Office: 1, New Tank Street, Valluvarkottam High Road, Chennai - 600 034.
Phone : 044 -28288800 Fax No. 044- 28306700/01 Website : www.starhealth.in

Toll free No. 1800 425 2255
Toll Free Fax. 1800 425 5522
Board No. 044 – 28263300

PRE-AUTHORISATION REQUEST FORM

PART - I (TO BE FILLED BY THE INSURED)

Policy No.....I.D. No.....
Name of the Patient.....Age.....Yrs. Sex : M F
Patient Tel. No. (Office) :.....Fax :.....Mobile No. :.....Res. No.....
If Corporate, Name of the Employee :.....Corporate Name :.....
Relation to the Proposer / Employee (In case of Corporate) Spouse Child Parent Siblings, please specify (others) :.....
Name of the Family Physician.....Tel. No.....Mobile No.....
Your Claim may be rejected, if these information's are not given.

PART - II (TO BE FILLED BY THE HOSPITAL) - ALL COLUMNS ARE COMPULSORY

A. Hospital and Treating Doctor details :
Name of Hospital / Nursing Home.....Tel. No.....
Address of Provider.....
Name of Treating Doctor..... Tel. No.....Mobile No.....Regn. No.....Qualification.....
B. Clinical Data
Presenting Complaints with exact duration.....
.....
Relevant Clinical Findings (Present illness).....
.....
General Examination: CVS ☐ RS ☐ GI ☐ CNS ☐ PA ☐ PR ☐ PV ☐ OTHERS ☐
C. MEDICAL HISTORY

Sl. No	Particulars	Yes/No	If yes, Since	If yes, remarks
1	Diabetes			
2	Hypertension			
3	Heart Disease			
4	Br. Asthma			
5	COPD			
6	Osteo Arthritis			
7	Cancer			
8	Glaucoma / Cataract			
9	Any other Pre Existing Disease			
10	STD related Diseases			

H/O past illness relevant to present illness.....
Whether present illness is a complication of any pre-existing disease/operation/past diseases.....
D. Any Evidence of Alcohol / Drug addiction & intoxication
E. Positive findings of investigation done.....
F. Provisional Diagnosis.....
G. Plan of Treatment.....
In case of **R.T.A.** was the patient under the influence of Alcohol/Any other Drugs Yes No M.L.C. No.....
(Please fax a copy of the M L C Report)
In case of **Maternity,** No of Live Children ..... OBSTETRICALHISTORY ..... LMP ..... E.D.D ....
Probable duration of stay :Room ..... ICU/REASON ..... Total.....

(Attach Doctors First Prescription) Signature of Treating M.O with seal.....QUALIFICATION.....
H. Admission and Financial details:
Admission: Planned ☐ Emergency ☐ Date of Admission.....Time of Admission.....Class of Accommodation.....
Cost Estimation Break-ups: Room rent.....Investigation.....Surgeon Fees.....Doctor Fees.....
Consumables/Implants.....Packages.....Approximate Total Exps..... .....
Whether Telephonic intimation given to Star Health Yes No If yes, Date.....Time.....

Signature of Billing Head.....Stamp of Hospital.....Date.....Time.....

PART - III (TO BE FILLED BY THE INSURED) - INSURED CONSENT / AUTHORISATION

I hereby declare that I am having Medical Insurance Policy since.....without any break from.....Insurance Company. My previous year Policy No.....from period.....to.....issued by ..... office.

Consent by the patient / insured / beneficiary:

I/we have NO OBJECTION to STAR officials visiting hospitals/nursing home to verify details of treatment/obtain copies of necessary documents from the hospital/nursing home. I/we have provided the information to the best of my knowledge. I/we agree to pay cost of hospitalization, if authorization given by STAR HEALTH ANDALLIED INSURANCE COMPANY LIMITED becomes null and void due to wrong and incorrect information regarding the duration of ailments and past history.

This consent is also final discharge for hospitalization part of the claim where it has effected the payment. I reserve the right to submit pre and post hospitalization or other claims separately as and when required and as per the policy terms and conditions.

Signature of the Patient / Relative(s)
(Name of the Signatory / Relationship with the Patient)

Kindly Note: The filled Pre-auth form can be submitted at the TPA Desk, located on the Gr. floor of Kokilaben Dhirubhai Ambani Hospital only

Category of Surgery -

Kokilaben Dhirubhai Ambani Hospital (A Unit Of Mandke Foundation)
Rao Saheb Achutrao Patwardhan Marg, Four Bungalows,
Andheri (W) Mumbai, India 400053
Phone: + 91 22 30696969 , 9022263999

CHECK LIST

S.No	Details		✓ / FORM GIVEN BY (CCO)
			DATE & TIME
1	NAME OF THE PATIENT		
2	UHID		
3	INSURANCE COMPANY		
4	TPA		
5	CORPORATE		

LIST OF MANDATORY DOCUMENTS TO BE SUBMITED WITH PRE - AUTHORIZATION (PHOTOCOPIES)

1	PRE AUTH FORMS	CATEGORY OF SURGERY ,CATEGORY OF ROOM ,DOA	
2	CONSENTS	All consents on forms to be signed by patient/relative	
3	POLICY PAPERS	4YRS POLICY (On Request)	
4	TPA CARD		
5	PHOTO ID PROOF	e.g-PAN CARD, AADHAR CARD , PASSPORT , DRIVING LICENSE , ELECTION ID	
6	ADDRESS PROOF	e.g- AADHAR CARD , PASSPORT , DRIVING LICENSE, ELECTRICITY BILL,RATION CARD , ELECTION ID	
7	PHOTOGRAPH	PASSPORT SIZE SELF ATTESTED XEROX COPY	
8	DR'S CONSULTATION LETTER		
9	REPORTS		
10	OTHERS	MLC , DISCHARGE SUMMARY (TRANSFERS) , ACCIDENT & EMERGENCY NOTES	
	SUBMITTED BY		
	RELATIONSHIP		
	CONTACT NO		
	DATE & TIME		
	ANY COMMENTS		
	CHECKED(CCO)		
	DATE & TIME		

* THE HOSPITAL WILL NOT BE HELD RESPONSIBLE FOR ANY DELAYS CAUSED DUE TO MISSING DOCUMENTS FROM THE PATIENTS
* THE PROOFS PROVIDED WILL BE ONLY WITH RESPECT TO THE PATIENTS IDENTITY & NAME

Kokilaben Dhirubhai Ambani
hospital & medical research institute

Every Life Matters

TPA UNDERTAKING

I Mr./Ms _____ UHID No: _____
a subscriber of _____ Insurance Co / TPA,
under Dr _____ am fully aware of
the following and would abide by them :

1. Patient is admitted on the basis of the authorization letter received from the Insurance Co/TPA which is only a provisional authorization.

2. Patient hereby would have to clear all the hospital bills (before discharge) :-
   a. In the event that the insurance claim i.e. the cashless facility is fully denied
   b. If partial payment approval is received from the insurance company
   c. For the payment of non medical items (5 % Security Deposit)
   d. For the higher package voluntarily opted by patient/patient relative
   e. For equipment charges / consumables not covered by the insurance company

3. In case of Emergency admission, if the authorization is not received from the Insurance Co. /TPA, the patient would be required to place requisite deposit on admission & subsequently clear all hospital bills.

4. The hospital is not responsible for refusal on part of TPA for the past history/ family history mentioned on the hospital records.

5. The hospital is not responsible for refusal on part of TPA for reimbursement of claims of the patient.

6. All original reports & discharge summary will be handed over to the Insurance Co./TPA as the requirement of the Insurance Co./TPA.

7. The hospital authority is entitled to share data/records related to the admission with the representatives/agents appointed by the Insurance Co/TPA/Employer

8. Incase the patient / patient relative opts to take discharge before final approval / authorization is received from the TPA / Insurance Company then entire billing amount needs to be settled by the patient / patient relative before taking the physical discharge.

9. On an average it takes 4-5 hours for final discharge after the relevant documents are sent to the Insurance /TPA Company on the day of discharge

10. Hospital TPA department will act as facilitator for forwarding relevant information to the insurance / TPA company , however the authorization by the Insurance / TPA Company is final & binding

11. Patient has been explained the details regarding the GIPSA package, if applicable in the case.

Signature of the Patient: X _____ Policy Amount/ Sum Insured: _____

Name of the Witness: _____ Date: _____

Relation to Patient: _____ Mobile No: _____

Signature of Witness: _____ Telephone No. : _____

KOKILABEN DHIRUBHAI AMBANI HOSPITAL AND MEDICAL RESEARCH INSTITUTE

HIGHER CLASS ACCOMMODATION DECLARATION

I Mr. /Ms _____UHID No: _____
a subscriber of _____
Insurance Co / TPA, under Dr _____
am fully aware of the following and would abide by them :

I have read and understood the policy terms & conditions including the room rent eligibility and other sub-limits as defined under the policy.

I hereby undertake to bear and pay all non-admissible expenses, expenses not related to hospitalised ailment, expenses arising due to availing higher room rent/ category over and above my policy limit, all expenses which are over and above the reasonable, customary and necessary expenses for treatment of this ailment and any other expenses which are not admissible and are excluded in the policy. I understand and agree that the above mentioned expenses shall not be reimbursed by the Insurance Company and shall be paid to the Hospital by me. I am willing to bear the proportional difference for the part of room category chosen and settle the hospital bill at the time of discharge.

Signature of the Patient: X Policy Amount/ Sum Insured:

Relation to Patient/Beneficiary: Mobile No:

Signature of CCO: Telephone No. :

Date:

Kokilaben Dhirubhai Ambani
hospital & medical research institute

Every Life Matters

General Insurance Public Sector Association (GIPSA) Declaration: Applicable to Insurance / TPA Patients

(In order to avail benefits of GIPSA packages, eligible patients / patient relatives are requested to provide following declaration)

I Mr / Ms / Mrs _____ patient / relative of patient Mr/Ms / Master / Baby _____, declare that I have been thoroughly counselled by staff of Kokilaben Dhirubhai Ambani Hospital about the rules , regulations as well as terms & conditions related to availing of services under GIPSA network hospitals; the narration of the same is provided below:

IMPORTANT POINTS:

1. KDAH currently offers **agreed surgical packages at special GIPSA rates** to patients covered under Public Sector Undertaking Insurance Companies.
2. The billing for the above mentioned **packages** will be done as single line items & each package has certain inclusions & exclusions.
3. The **length of stay** under particular package with respect to room stay & ICU stay is thoroughly explained to me; **any stay beyond the stipulated duration will attract additional charges** as per hospital rules & regulations
4. GIPSA rates are **applicable** only for patients under **General, Twin, Single Economy / Regular category & Single Classic.** Incase patient opts for higher category of room than the ones mentioned above he / she will be billed as per the standard hospital rates. **Note:** All rooms are subject to availability & hospital does not guarantee admission under particular category for the GIPSA patients
5. **Emergency charges** are applicable to patients admitted on **Public Holidays, Sundays** & during emergency hour admission i.e. from **8:00 PM to 8:00 AM**
6. GIPSA packages **will be applied** to your bill **from the day of your admission in planned cases and from the day of surgery in unplanned cases** The stipulated duration of stay for a particular GIPSA package will start from the day package is applied.

	Category of Room			
Particular	**Gen/Daycare**	**Twin Sharing**	**Single Economy / Regular**	**Single Classic**
Total				

P.T.O

7. On the day of discharge, patient can be physically discharged from the hospital only after receipt of final authorization from the concerned TPA / Insurance Company. Incase you wish to leave before the final approval is received, you can do so by settling the total bill amount.

Note: GIPSA rates will not be applicable for any patient not having valid PSU policy.

8. Incase patient gets converted from cash patient to cashless patient under GIPSA procedures , then the deposit taken at the time to cash admission will be refunded 7 working days post discharge of the patient from the hospital.
9. It is mandatory to provide **5%** deposit for items, services, consumables etc not covered by insurance company **at the time of discharge / admission** (incase pre approved cashless).
10. Each GIPSA package has certain standard consumables included or excluded in the package. Incase you opt for higher value / quality of consumables for a particular procedure / service. The same will be charged to you as per the hospital standard rate. Hospital will not be liable for the non reimbursement of such items by the TPA / Insurance Companies.
11. Outstanding amount if any during my treatment at the hospital due to denial of cashless by TPA / Insurance Company, due to any reason (as provided by TPA / Insurance Company) will be cleared by patient / patient relatives.
12. All standard rules & regulations applicable by the hospital administration will be abided by the patient / patient relatives.
13. It is mandatory to provide details in PPN Declaration Forms instructed by your TPA/Insurance Company

I have read & understood the terms, conditions, rules & regulations related to the GIPSA network hospital. I **accept** and **agree** to abide by the same. I also fully understand that hospital is only the facilitator for the cashless service, the onus & final responsibility of approving, partially approving or rejecting the claim is at the discretion of the approving TPA / Insurance companies.

I **wish** to opt for the GIPSA packages.

X

CCO Signature

Patient / Patient Relatives

Date :

KOKILABEN DHIRUBHAI AMBANI HOSPITAL

GUIDELINES FOR CASHLESS FACILITY

Documents required (Photocopies):
Policy papers, TPA card, Photo ID proof, Address proof, Photograph , Drs consultation letter, Reports, Employee Id (If corporate)

Before Admission:

1. Pre –Authorization-The patient /relative needs to get the pre auth form filled by the treating doctor.
2. The documents and the dully filled pre-authorization form are to be submitted to the TPA via fax/mail.
3. On receipt of the details the TPA sends either-an approval or a query is raised.
4. Once the approval is received the patients/relative is informed about the same. In case of query –The TPA desk helps patient to respond to the query with help of doctors and get the case approved.
5. In case where part approval is received or certain conditions are highlighted by the TPA the same is conveyed /explained to the patient/relative.
6. OPD procedures and Radiation will not be considered for cashless in the hospital and need to be reimbursed as per hospital policy .
7. Pre-Authorization for daycare patients will not be accepted on the day of the procedure.

On Admission;

1. The patient gets admitted by paying 5%security deposit **and the balance deposit amount (in case where partial approval is received)**

2. In case where the patient declares the insurance status at the time of admission, the admission is done by collecting deposit amount and the patient is directed to the TPA desk to complete the TPA formalities. This process can be done by the relative. On receipt of the approval the same is applied to the patient's "In-patient account"

3. In situation where the patient has applied for the TPA approval however no reply /approval has been received by the hospital, then the patient gets admitted by paying the full requisite deposit.

Interim Approvals: For long stay patients-Interim bills are forwarded to the TPA for enhancement. Response received from the TPA in the form of Approval or Query is then applied or responded back.

A & E notes	
Treatment sheet	
MLC /FIR	
OT/Anesthesia notes	

At Discharge:

1. The final bill and the discharge summary are forwarded to the TPA for the final approval once the patient is for discharge.

2. There can be query at the time of discharge because of which the discharge can get delayed.

3. The time taken for the final approval to be received by hospital maybe in range of 1 to 5 hrs (approx) depending on the case. In case the patient wishes to take discharge before the approval arrives, the same can be done by settling the bill. The patient could then claim from the TPA directly. The patient must wait for final approval even if the sum insured exhausted.

4. TPA formalities cannot be started on the day of discharge.

Some More information:

1. Non medical expenditures, room rent capping & copayment applies to certain cases. Kindly understand the same before the admission.

2. Room rent is applicable on the day of discharge.

3. The deposit amount (if any) paid by the patient will be refunded within 8 days after discharge.
The refunded amount is always by cheque if it is more than Rs 10,000/-

4. The security deposit is refunded once the approved amount is received by the hospital from the TPA / Insurance.

5. Deductions by TPA after the approval is given (Post Discharge) - Incase the TPA/Insurance does not pay the approved amount ; the balance outstanding is settled with the security deposit. This stands valid for any emergency charges levied on the bill.

6. The hospital is not responsible for the refusal /denial on the part of the TPA for reimbursement of claims made by the patient.

7. The original reports and the discharge summary will be handed over to the TPA/Insurance Company.

8. Admission in the hospital is subject to the availability of the bed.

9. The hospital authority is entitled to share data/records related to admission with representatives/agents from the Insurance Company, TPA or employer.

Kindly contact us on: Ph 9022263999
Email-tpa.kh@relianceada.com

As per Section 206(1D) of Income Tax Act, 1961(w.e.f-1 JUNE 2016)
There will be mandated collection of tax at source (TCS)@1% of total value of goods or services, provided the value of goods or services exceeds Rs.200,000/-.this provision is applicable for those who settle the bill partly/fully in cash ,irrespective of whether the person has submitted PAN or not .This provision is applicable to all Foreigner and NRI Patient's.