बीमा विनियामक और विकास प्राधिकरण
INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY

IRDA/ HLT/CIR/036/02/2013 20/02/2013

All CEOS of

Life Insurers, Non-Life Insurers, Standalone Health Insurers and TPAs

Re: Guidelines on Standardization in Health Insurance

Health insurance addresses a major area of public concern. Although it is rapidly growing, access to health insurance still remains limited and add to it complaints especially due to variable interpretations of key policy terms are enormous. In order to address the expectation of public more effectively, the Authority propose to stipulate the following in respect of all health insurance policies issued by life and general insurers in the country.

1. **Standard Definition for 46 commonly used terms in health insurance policies:**

Standard terms would reduce ambiguity, enable all stakeholders to provide better services and enable customers to interact more effectively with insurers, TPAs and providers. All insurers shall adhere to the stipulated definitions, annexed at **Annexure I**, while defining these 46 core terms in all health insurance policies.

2. **Standard Nomenclature and Procedures for Critical Illnesses:**

In view of resolving the differences in the definitions of terms on Critical Illnesses adopted by the different insurers which are creating confusion in the minds of consumers and the industry especially at the time when insurers and re-insurers have to arrive at a point where lump sum payment is made, 11 Critical Illness terms have been standardized to be adopted uniformly across industry, if offered under the product. All products offering the 11 critical illness coverage shall ensure that definitions of the stated 11 terms are in line with the stipulated definitions annexed at **Annexure II**.

3. **Standard Pre-authorization and Claim form:**

A common industry wide pre-authorization and claim form will significantly streamline processes at all stages. This will enhance the ability of providers to obtain a timely prior authorization. By implementing it in an optical character recognition (OCR) format, the ability to transfer data from a handwritten paper based form to IT systems has been enhanced thus reducing the data entry issues for TPAs and insurers. Every company shall attach set of claim forms along with policy terms and conditions to the policyholder. The forms are attached at **Annexure III**.

4. **Standard List of Excluded Expenses in Hospitalization Indemnity policies:**

Hospitalization indemnity products are the commonest products in the Indian market and account for most of the health insurance sold in the country. The standard listing of 199 excluded items, an area which has otherwise been fairly variable in its interpretation and

implementation, has been finalized. The same is annexed at **Annexure IV**. However, Insurers may include these exclusions, if the product design allows for, or if the insurer wants to include these as part of hospitalization expenses.

5. **Standard File and Use Application Form, Database Sheet and Customer Information Sheet:**

The existing F&U form used by the non-life insurers is designed keeping in view largely the characteristics of Non Life products other than Health. With this, the essential information like the sum insured, the minimum and maximum age, term of the product etc that gets captured in the F&U form is very minimal. In order to capture the relevant product design information, the modified File and Use Application form along with the Database sheet and Customer information sheet as annexed in the **Annexure: V, VI and VII** respectively shall be submitted under File and Use procedure by the insurers.

This circular supersedes all the existing circulars /guidelines on File and Use Procedure for health insurance products offered by life insurers/non-life insurers/health insurers. All the insurers shall comply with the File and Use procedure specified in this circular.

6. **Standard agreement between TPA & Insurer and Provider (Hospital) & Insurer**:

The insurers enter into agreements with the TPAs for health services under health insurance contracts and with the Providers (Hospitals) for health care services under health insurance contracts. The Service Level Agreement shall include the minimum standard clauses as annexed in **Annexure: VIII and IX**, as applicable.

This is issued under section 14(2) of IRDA Act, 1999 and shall be effective from 1st July 2013 for group products and 1st October 2013 for other products.

(J. Hari Narayan)
Chairman

20-02-2013

Annexure - I

Standard Definitions of terminology used in Health Insurance Policies

1. **Accident**
   An accident is a sudden, unforeseen and involuntary event caused by external and visible means.
   [Insurance companies can define the term accidental injury in the context of the term 'accident'].

2. **Co-Payment**
   A co-payment is a cost-sharing requirement under a health insurance policy that provides that the policyholder/insured will bear a specified percentage of the admissible costs. A co-payment does not reduce the sum insured.

3. **Day Care Treatment**
   Day care treatment refers to medical treatment, and/or *surgical procedure* which is:
   i. undertaken under General or Local Anesthesia in a *hospital/day care centre* in less than 24 hrs because of technological advancement, and
   ii. which would have otherwise required a hospitalization of more than 24 hours.

   Treatment normally taken on an out-patient basis is not included in the scope of this definition.
   [Insurers may, in addition, restrict coverage to a specified list].

4. **Deductible**
   A deductible is a cost-sharing requirement under a health insurance policy that provides that the Insurer will not be liable for a specified rupee amount of the covered expenses, which will apply before any benefits are payable by the insurer. A deductible does not reduce the sum insured.
   [Insurers to define whether the deductible is applicable per year, per life or whether per event and specific deductible limits would be applied].

5. **Dependent Child**
   A dependent child refers to a child (natural or legally adopted), who is financially dependent on the primary insured or proposer and does not have his / her independent sources of income.

   [Insurers can add additional criteria relating to age, marital status, education and disablement].

6. **Domiciliary Hospitalisation**
   Domiciliary hospitalization means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a *hospital* but is actually taken while confined at home under any of the following circumstances:

- the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
- the patient takes treatment at home on account of non availability of room in a hospital.

7. Emergency Care

Emergency care means management for a severe illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a *medical practitioner* to prevent death or serious long term impairment of the insured person's health.

8. Grace Period

Grace period means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of continuity benefits such as waiting periods and coverage of *pre-existing diseases*. Coverage is not available for the period for which no premium is received.

9. Hospital

A hospital means any institution established for *in- patient care* and *day care treatment* of sickness and / or injuries and which has been registered as a hospital with the local authorities, wherever applicable, and is under the supervision of a registered and qualified *medical practitioner* AND must comply with all minimum criteria as under:

- has at least 10 inpatient beds, in those towns having a population of less than 10,00,000 and 15 inpatient beds in all other places;
- has qualified nursing staff under its employment round the clock;
- has qualified medical practitioner (s) in charge round the clock;
- has a fully equipped operation theatre of its own where surgical procedures are carried out
- maintains daily records of patients and will make these accessible to the Insurance company's authorized personnel.

10. Intensive Care Unit

Intensive care unit means an identified section, ward or wing of a *hospital* which is under the constant supervision of a dedicated *medical practitioner(s)*, and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

11. Inpatient Care

Inpatient care means treatment for which the insured person has to stay in a *hospital* for more than 24 hours for a covered event.

12. Medical Practitioner

A Medical practitioner is a person who holds a valid registration from the medical council of any state of India and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his license.

[Insurance companies can specify additional or restrictive criteria to the above, e.g. that the registered practitioner should not be the insured or close family members].

13. Medically Necessary

Medically necessary treatment is defined as any treatment, tests, medication, or stay in *hospital* or part of a stay in *hospital* which

- is required for the medical management of the illness or injury suffered by the insured;
- must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
- must have been prescribed by a *medical practitioner*;
- must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

14. Network Provider

"Network Provider" means hospitals or health care providers enlisted by an insurer or by a TPA and insurer together to provide medical services to an insured on payment by a cashless facility.

15. Non- Network

Any *hospital*, day care centre or other provider that is not part of the *network.*

16. Pre-Existing Disease

Any condition, ailment or injury or related condition(s) for which you had signs or symptoms, and / or were diagnosed, and / or received medical advice / treatment within 48 months to prior to the first policy issued by the insurer.

[Life Insurers can define norms for applicability at reinstatement].

17. Qualified Nurse

Qualified nurse is a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

18. Reasonable Charges

Reasonable charges means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the

geographical area for identical or similar services, taking into account the nature of the illness / injury involved .

19. Surgery

Surgery or Surgical Procedure means manual and / or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed in a hospital or day care centre by a *medical practitioner*

20. OPD treatment

OPD treatment is one in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

21. Hospitalisation

Means admission in a Hospital for a minimum period of 24 In patient Care consecutive hours except for specified procedures/ treatments, where such admission could be for a period of less than 24consecutive hours.

22. Illness

Illness means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment.

23a Acute condition - Acute condition is a medical condition that can be cured by Treatment

23b. Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:—it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests—it needs ongoing or long-term control or relief of symptoms— it requires your rehabilitation or for you to be specially trained to cope with it—it continues indefinitely—it comes back or is likely to come back.

23. Day care centre

A day care centre means any institution established for day care treatment of sickness and / or injuries or a medical set –up within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under:- has qualified nursing staff under its employment ;- has qualified medical practitioner (s) in charge ;- has a fully equipped operation theatre of its own where surgical procedures are carried out- maintains daily records of patients and will make these accessible to the Insurance company's authorized personnel.

24. Injury

Injury means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a Medical Practitioner.

25. Medical Advise

Any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.

26. Medical expenses

Medical Expenses means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

27. Pre-hospitalization Medical Expenses

Medical Expenses incurred immediately before the Insured Person is Hospitalised, provided that:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

28. Post-hospitalization Medical Expenses

Medical Expenses incurred immediately after the Insured Person is Hospitalised, provided that:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

29. New Born Baby

Newborn Baby means those babies born to you and your spouse during the Policy Period Aged between 1 day and 90 days.

30. Cumulative Bonus

Cumulative Bonus shall mean any increase in the sum assured / Mallus granted by the insurer without an associated increase in premium.

31. Maternity expense/

Maternity expense / treatment shall include the following Medical treatment Expenses:

i. Medical Expenses for a delivery (including complicated deliveries and caesarean sections) incurred during Hospitalization;
ii. The lawful medical termination of pregnancy during the Policy Period limited to 2 deliveries or terminations or either during the lifetime of the Insured Person;
iii. Pre-natal and post-natal Medical Expenses for delivery or termination.

32. Dental Treatment

Dental treatment is treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery excluding any form of cosmetic surgery/implants.

33. Any one illness

Any one illness means continuous Period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital/Nursing Home where treatment may have been taken.

34. Congenital Anomaly

Congenital Anomaly refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

34a. Internal Congenital Anomaly

which is not in the visible and accessible parts of the body is called Internal Congenital Anomaly

34b. External Congenital Anomaly

which is in the visible and accessible parts of the body is called External Congenital Anomaly.

35. Unproven/Experimental treatment

Unproven/Experimental treatment is treatment, including drug Experimental therapy, which is based on established medical practice in India, is treatment experimental or unproven.

36. Condition Precedent

Condition Precedent shall mean a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

37. Notification of Claim

Notification of claim is the process of notifying a claim to the insurer or TPA by specifying the timelines as well as the address / telephone number to which it should be notified.

38. Disclosure to information norm

The Policy shall be void and all premium paid hereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.

39. Cashless facility

"Cashless facility" means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre-authorization approved.

40. Subrogation

Subrogation shall mean the right of the insurer to assume the rights of the insured person to recover expenses paid out under the policy that may be recovered from any other source.

41. Contribution

Contribution is essentially the right of an insurer to call upon other insurers, liable to the same insured, to share the cost of an indemnity claim on a ratable proportion.

42. Renewal

Renewal defines the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of all waiting periods.

43. Portability

Portability means the right accorded to an individual health insurance policy holder (including family cover) to transfer the credit gained by the insured for pre-existing conditions and time bound exclusions if the policyholder chooses to switch from one insurer to another insurer or from one plan to another plan of the same insurer, provided the previous policy has been maintained without any break.

44. Room rent

Room Rent shall mean the amount charged by a hospital for the deductibles occupying of a bed and associated medical expenses. Deductible is a cost sharing requirement that provides that We will not be liable for the amount of covered Medical Expenses, as specifically mentioned in the Policy Schedule, which has to be borne by You for each and every Claim during the Policy Period, before it becomes

payable by Us under the Policy. This is to clarify that a deductible does not reduce the sum insured.

45. Alternative treatments

Alternative treatments are forms of treatments other than treatment "Allopathy" or "modern medicine" and includes Ayurveda, Unani, Sidha and Homeopathy in the Indian context

20-02-2013

Annexure - II

Standard Nomenclature and Procedures for Critical Illnesses

1. CANCER OF SPECIFIED SEVERITY

I. A malignant tumour characterised by the uncontrolled growth & spread of malignant cells with invasion & destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy & confirmed by a pathologist. The term cancer includes leukemia, lymphoma and sarcoma.

II. The following are excluded –

i. Tumours showing the malignant changes of carcinoma in situ & tumours which are histologically described as premalignant or non invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 & CIN-3.
ii. Any skin cancer other than invasive malignant melanoma
iii. All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0.....
iv. Papillary micro - carcinoma of the thyroid less than 1 cm in diameter
v. Chronic lymphocyctic leukaemia less than RAI stage 3
vi. Microcarcinoma of the bladder
vii. All tumours in the presence of HIV infection.

2. FIRST HEART ATTACK – OF SPECIFIED SEVERITY

I. The first occurrence of myocardial infarction which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for this will be evidenced by all of the following criteria:

i. a history of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain)
ii. new characteristic electrocardiogram changes
iii. elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

II. The following are excluded:

i. Non-ST-segment elevation myocardial infarction (NSTEMI) with elevation of Troponin I or T
ii. Other acute Coronary Syndromes
iii. Any type of angina pectoris.

3. OPEN CHEST CABG

I. The actual undergoing of open chest surgery for the correction of one or more coronary arteries, which is/are narrowed or blocked, by coronary artery bypass graft (CABG). The

diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a specialist medical practitioner.

II. The following are excluded:

i. Angioplasty and/or any other intra-arterial procedures
ii. any key-hole or laser surgery.

4. OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES

I. The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease-affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner. Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty are excluded.

5. COMA OF SPECIFIED SEVERITY

I. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:
   i. no response to external stimuli continuously for at least 96 hours;
   ii. life support measures are necessary to sustain life; and
   iii. permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

II. The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

6. KIDNEY FAILURE REQUIRING REGULAR DIALYSIS

I. End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (hemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

7. STROKE RESULTING IN PERMANENT SYMPTOMS

I. Any cerebrovascular incident producing permanent neurological sequelae.This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

II. The following are excluded:

i. Transient ischemic attacks (TIA)
ii. Traumatic injury of the brain
iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

8. MAJOR ORGAN /BONE MARROW TRANSPLANT

I. The actual undergoing of a transplant of:

i. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
ii. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

II. The following are excluded:

i. Other stem-cell transplants
ii. Where only islets of langerhans are transplanted

9. PERMANENT PARALYSIS OF LIMBS

I. Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.

10. MOTOR NEURONE DISEASE WITH PERMANENT SYMPTOMS

I. Motor neurone disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

11. MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

I. The definite occurrence of multiple sclerosis. The diagnosis must be supported by all of the following:
i. investigations including typical MRI and CSF findings, which unequivocally confirm the diagnosis to be multiple sclerosis;
ii. there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months, and

iii. well documented clinical history of exacerbations and remissions of said symptoms or neurological deficits with atleast two clinically documented episodes atleast one month apart.

II. Other causes of neurological damage such as SLE and HIV are excluded.

20.02.2013

PLEASE FAX / SCAN PAGE 1 ONLY

REQUEST FOR CASHLESS HOSPITALISATION FOR MEDICAL INSURANCE POLICY

DETAILS OF THE THIRD PARTY ADMINISTRATOR

(To be filled in block letters)

a) Name of TPA / Insurance company:

b) Toll free phone number:

c) Toll free FAX:

TO BE FILLED BY THE INSURED / PATIENT

a) Name of the Patient:

b) Gender : ☐ Male ☐ Female c) Age: Years Y Y Months M M d) Date of birth : D D M M Y Y Y Y

e) Contact number : f) Insured card ID number:

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

h) Currently do you have any other Mediclaim / Health insurance: ☐ Yes ☐ No Company Name

Give details

i) Do you have a family physician: ☐ Yes ☐ No j) Name of the family physician:

k) Contact number, if any:

(PLEASE COMPLETE DECLARATION ON THE REVERSE SIDE OF THIS FORM)

TO BE FILLED BY THE TREATING DOCTOR / HOSPITAL

a) Name of the treating doctor: b) Contact number:

c) Nature of ILLNESS / Disease with presenting complaints

d)Relevant clinical findings:

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

ii. Past history of present ailment if any:

f) Provisional diagnosis:

i. ICD 10 Code:

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

h) If Investigation & / or Medical Management provide details

i) Route of drug administration:

j) If Surgical, name of surgery :

i. 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 iii. Reported to Police : ☐ Yes ☐ No iv. FIR No ☐☐☐

v. Injury / Disease caused due to substance abuse / alcohol consumption : ☐ Yes ☐ No vi. Test conducted to establish this : ☐ Yes ☐ No (If Yes attach reports)

l) In case of Maternity: ☐ G ☐ P ☐ L ☐ A Date of Delivery: D D M M Y Y

Details of the patient admitted

a) Date of admission: D D M M Y Y b) Time: H H : M M

c) Is this an emergency / a planned hospitalization event?: ☐ Emergency ☐ Planned

d) Expected no. of days stay in hospital: ☐☐☐ Days e) Room Type

f) Per Day Room Rent + Nursing & Service Charges + Patient's Diet: Rs.

g) Expected cost for investigation + diagnostics. : Rs.

h) ICU Charges: Rs.

i) OT Charges: Rs.

j) Professional fees Surgeon + Anesthetist Fees + consultation Charges Rs.

k) Medicines + Consumables + Cost of Implants (if applicable please specify) . Other hospital expenses if any: Rs.

l) All inclusive package charges if any applicable Rs.

m) **Sum Total expected cost of hospitalization** **Rs.**

Mandatory: Past History of any chronic illness — **If yes, since (month / year)**

☐ Diabetes	M M	Y Y
☐ Heart Disease	M M	Y Y
☐ Hypertension	M M	Y Y
☐ Hyperlipidemias	M M	Y Y
☐ Osteoarthritis	M M	Y Y
☐ Asthma / COPD / Bronchitis	M M	Y Y
☐ Cancer	M M	Y Y
☐ Alcohol or drug abuse	M M	Y Y
☐ Any HIV or STD / Related ailments	M M	☐ Y

Any other Ailment give details:

(PLEASE READ VERY CAREFULLY)

DECLARATION

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

a) Name of the treating doctor: SURNAME FIRST NAME MIDDLE NAME

b) Qualification: c) Registration No. with State Code:

Hospital Seal (Must include Hospital ID)

Patient / Insured Name & Signature:

(IMPORTANT: PLEASE TURN OVER)

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.
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 / TPA 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 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.
7. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer / TPA.

a) **Patient's / Insured's Name:** _____

b) **Contact number:** _____ d) **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.

Hospital Seal **Doctor's Signature**

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.

20-02-2013

CLAIM FORM – PART A
TO BE FILLED IN BY THE INSURED
The issue of this Form is not to be taken as an admission of liability

(To be filled in block letters)

SECTION A | SECTION B | SECTION C | SECTION D | SECTION E | SECTION F | SECTION G

DETAILS OF PRIMARY INSURED:

a) Policy No: b) Sl. No/ Certificate No:

c) Company/ TPA ID No:

d) Name : SURNAME FIRST NAME MIDDLE NAME

e) Address :

City: State:

Pin Code: Phone No: Email ID :

DETAILS OF INSURANCE HISTORY:

a) Currently covered by any other Mediclaim / Health Insurance: ☐ Yes ☐ No b) Date of commencement of first Insurance without break: D D M M Y Y

c) If yes, company name: Policy No.

Sum Insured (Rs.) d) Have you been hospitalized in the last four years since inception of the contract? ☐ Yes ☐ No Date: M M Y Y

Diagnosis: e) Previously covered by any other Mediclaim / Health insurance : ☐ Yes ☐ No

f) If yes, Company Name

DETAILS OF INSURED PERSON HOSPITALIZED:

a) Name: SURNAME FIRST NAME MIDDLE NAME

b) Gender: Male ☐ Female ☐ c) Age: years Y Y months M M d) Date of Birth: D D M M Y Y

e) Relationship to Primary insured: Self ☐ Spouse ☐ Child ☐ Father ☐ Mother ☐ Other ☐ (Please Specify)

f) Occupation: Service ☐ Self Employed ☐ Homemaker ☐ Student ☐ Retired ☐ Other ☐ (Please Specify)

g) Address (if different from above):

City: State:

Pin Code: Phone No: E-mail ID:

DETAILS OF HOSPITALIZATION:

a) Name of Hospital where Admitted:

b) Room Category occupied: Day care ☐ Single occupancy ☐ Twin sharing ☐ 3 or more beds per room ☐

c) Hospitalization due to: Injury ☐ Illness ☐ Maternity ☐ d) Date of Injury / Date Disease first detected /Date of Delivery: D D M M Y Y

e) Date of Admission: D D M M Y Y f) Time: H H : M M g) Date of Discharge: D D M M Y Y h) Time: H H : M M

i) If Injury give cause: Self inflicted ☐ Road Traffic Accident ☐ Substance Abuse / Alcohol Consumption ☐ i. If Medico legal: ☐ Yes ☐ No

ii. Reported to police: ☐ Yes ☐ No iii. MLC Report & Police FIR attached: ☐ Yes ☐ No j) System of Medicine:

DETAILS OF CLAIM:

a) Details of the treatment expenses claimed

i. Pre-hospitalization Expenses: Rs. ii. Hospitalization Expenses: Rs.

iii. Post-hospitalization Expenses: Rs. iv. Health-Check up Cost: Rs.

v. Ambulance Charges: Rs. vi. Others (code): Rs.

Total **Rs.**

vii. Pre-hospitalization period: days viii. Post-hospitalization period: days

b) Claim for Domiciliary Hospitalization: ☐ Yes ☐ No (If yes, provide details in annexure)

c) Details of Lump sum / cash benefit claimed:

i. Hospital Daily Cash: Rs. ii. Surgical Cash: Rs.

iii. Critical Illness Benefit: Rs. iv. Convalescence: Rs.

v. Pre/Post hospitalization Lump sum benefit: Rs. vi. Others: Rs.

Total **Rs.**

Claim Documents Submitted- Check List:

- ☐ Claim Form Duly signed
- ☐ Copy of the claim intimation, if any
- ☐ Hospital Main Bill
- ☐ Hospital Break-up Bill
- ☐ Hospital Bill Payment Receipt
- ☐ Hospital Discharge Summary
- ☐ Pharmacy Bill
- ☐ Operation Theatre Notes
- ☐ ECG
- ☐ Doctor's request for investigation
- ☐ Investigation Reports (Including CT / MRI / USG / HPE)
- ☐ Doctor's Prescriptions
- ☐ Others

DETAILS OF BILLS ENCLOSED:

Sl. No	Bill No	Date	Issued by	Towards	Amount (Rs)
1.		D D M M Y Y		Hospital Main Bill	
2.		D D M M Y Y		Pre-hospitalization Bills: Nos	
3.		D D M M Y Y		Post-hospitalization Bills: Nos	
4.		D D M M Y Y		Pharmacy Bills	
5.		D D M M Y Y			
6.		D D M M Y Y			
7.		D D M M Y Y			
8.		D D M M Y Y			
9.		D D M M Y Y			
10		D D M M Y Y			

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT:

a) PAN: b) Account Number:

c) Bank Name and Branch:

d) Cheque/ DD Payable details: e) IFSC Code:

(IMPORTANT: PLEASE TURN OVER)

DECLARATION BY THE INSURED:

I hereby declare that the information furnished in this claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent & authorize TPA / insurance company, to seek necessary medical information / documents from any hospital / Medical Practitioner who has attended on the person against whom this claim is made. I hereby declare that I have included all the bills / receipts for the purpose of this claim & that I will not be making any supplementary claim except the pre/post-hospitalization claim, if any.

SECTION H

Date: D D M M Y Y Place: Signature of the Insured

GUIDANCE FOR FILLING CLAIM FORM – PART A (To be filled in by the insured)			
	DATA ELEMENT	DESCRIPTION	FORMAT
	SECTION A - DETAILS OF PRIMARY INSURED		
a)	Policy No.	Enter the policy number	As allotted by the insurance company
b)	Sl. No/ Certificate No.	Enter the social insurance number or the certificate number of social health insurance scheme	As allotted by the organization
c)	Company TPA ID No.	Enter the TPA ID No	License number as allotted by IRDA and printed in TPA documents.
d)	Name	Enter the full name of the policyholder	Surname, First name, Middle name
e)	Address	Enter the full postal address	Include Street, City and Pin Code
	SECTION B - DETAILS OF INSURANCE HISTORY		
a)	Currently covered by any other Mediclaim / Health Insurance?	Indicate whether currently covered by another Mediclaim / Health Insurance	Tick Yes or No
b)	Date of Commencement of first Insurance without break	Enter the date of commencement of first insurance	Use dd-mm-yy format
c)	Company Name	Enter the full name of the insurance company	Name of the organization in full
	Policy No.	Enter the policy number	As allotted by the insurance company
	Sum Insured	Enter the total sum insured as per the policy	In rupees
d)	Have you been Hospitalized in the last four years since inception of the contract?	Indicate whether hospitalized in the last four years	Tick Yes or No
	Date	Enter the date of hospitalization	Use mm-yy format
	Diagnosis	Enter the diagnosis details	Open Text
e)	Previously Covered by any other Mediclaim/ Health Insurance?	Indicate whether previously covered by another Mediclaim / Health Insurance	Tick Yes or No
f)	Company Name	Enter the full name of the insurance company	Name of the organization in full
	SECTION C - DETAILS OF INSURED PERSON HOSPITALIZED		
a)	Name	Enter the full name of the patient	Surname, First name, Middle name
b)	Gender	Indicate Gender of the patient	Tick Male or Female
c)	Age	Enter age of the patient	Number of years and months
d)	Date of Birth	Enter Date of Birth of patient	Use dd-mm-yy format
e)	Relationship to primary Insured	Indicate relationship of patient with policyholder	Tick the right option. If others, please specify.
f)	Occupation	Indicate occupation of patient	Tick the right option. If others, please specify.
g)	Address	Enter the full postal address	Include Street, City and Pin Code
h)	Phone No	Enter the phone number of patient	Include STD code with telephone number
i)	E-mail ID	Enter e-mail address of patient	Complete e-mail address
	SECTION D - DETAILS OF HOSPITALIZATION		
a)	Name of Hospital where admitted	Enter the name of hospital	Name of hospital in full
b)	Room category occupied	Indicate the room category occupied	Tick the right option
c)	Hospitalization due to	Indicate reason of hospitalization	Tick the right option
d)	Date of Injury/Date Disease first detected/ Date of Delivery	Enter the relevant date	Use dd-mm-yy format
e)	Date of admission	Enter date of admission	Use dd-mm-yy format
f)	Time	Enter time of admission	Use hh:mm format
g)	Date of discharge	Enter date of discharge	Use dd-mm-yy format
h)	Time	Enter time of discharge	Use hh:mm format
i)	If Injury give cause	Indicate cause of injury	Tick the right option
	If Medico legal	Indicate whether injury is medico legal	Tick Yes or No
	Reported to Police	Indicate whether police report was filed	Tick Yes or No
	MLC Report & Police FIR attached	Indicate whether MLC report and Police FIR attached	Tick Yes or No
j)	System of Medicine	Enter the system of medicine followed in treating the patient	Open Text
	SECTION E - DETAILS OF CLAIM		
a)	Details of Treatment Expenses	Enter the amount claimed as treatment expenses	In rupees (Do not enter paise values)
b)	Claim for Domiciliary Hospitalization	Indicate whether claim is for domiciliary hospitalization	Tick Yes or No
c)	Details of Lump sum/ cash benefit claimed	Enter the amount claimed as lump sum/ cash benefit	In rupees (Do not enter paise values)
d)	Claim Documents Submitted-Check List	Indicate which supporting documents are submitted	Tick the right option
	SECTION F - DETAILS OF BILLS ENCLOSED		
	Indicate which bills are enclosed with the amounts in rupees		
	SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT		
a)	PAN	Enter the permanent account number	As allotted by the Income Tax department
b)	Account Number	Enter the bank account number	As allotted by the bank
c)	Bank Name and Branch	Enter the bank name along with the branch	Name of the Bank in full
d)	Cheque/ DD payable details	Enter the name of the beneficiary the cheque/ DD should be made out to	Name of the individual/ organization in full
e)	IFSC Code	Enter the IFSC code of the bank branch	IFSC code of the bank branch in full
	SECTION H - DECLARATION BY THE INSURED		
	Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.		

20-02-2013

CLAIM FORM – PART B
TO BE FILLED IN BY THE HOSPITAL
The issue of this Form is not to be taken as an admission of liability
Please include the original preauthorization request form in lieu of PART A

(To be filled in block letters)

SECTION A | SECTION B | SECTION C | SECTION D | SECTION E | SECTION F

DETAILS OF HOSPITAL

a) Name of the hospital:

b) Hospital ID: c) Type of Hospital: Network ☐ Non Network ☐ (If non network fill section E)

d) Name of the treating doctor: SURNAME FIRST NAME MIDDLE NAME

e) Qualification: f) Registration No. with State Code: g) Phone No.

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient: SURNAME FIRST NAME MIDDLE NAME

b) IP Registration Number: c) Gender: Male ☐ Female ☐ d) Age: Years YY Months MM e) Date of birth: DD MM YY

f) Date of Admission: DD MM YY g) Time: HH : MM h) Date of Discharge: DD MM YY i) Time: HH : MM

j) Type of Admission: Emergency ☐ Planned ☐ Day Care ☐ Maternity ☐ k) If Maternity i. Date of Delivery: DD MM YY ii. Gravida Status:

l) Status at time of discharge: Discharge to home ☐ Discharge to another hospital ☐ Deceased ☐ m) Total claimed amount

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a)	ICD 10 Codes	Description	b)	ICD 10 PCS	Description
i. Primary Diagnosis:			i. Procedure 1:		
ii. Additional Diagnosis:			ii. Procedure 2:		
iii. Co-morbidities:			iii. Procedure 3:		
iv. Co-morbidities:			iv. Details of Procedure:		

d) Pre-authorization obtained: ☐ Yes ☐ No e) Pre-authorization Number:

f) If authorization by network hospital not obtained, give reason:

g) Hospitalization due to Injury: ☐ Yes ☐ No i. If Yes, give cause Self-inflicted ☐ Road Traffic Accident ☐ Substance abuse / alcohol consumption ☐

ii. If Injury due to Substance abuse / alcohol consumption, Test Conducted to establish this: ☐ Yes ☐ No (If Yes, attach reports) iii. If Medico legal: ☐ Yes ☐ No iv. Reported to Police: ☐ Yes ☐ No

v. FIR no. vi. If not reported to police give reason:

CLAIM DOCUMENTS SUBMITTED - CHECK LIST

- ☐ Claim Form duly signed
- ☐ Original Pre-authorization request
- ☐ Copy of the Pre-authonzation approval letter
- ☐ Copy of photo ID card of patient verified by hospital
- ☐ Hospital Discharge summary
- ☐ Operation Theatre notes
- ☐ Hospital main bill
- ☐ Hospital break-up bill
- ☐ Investigation reports
- ☐ CT/MR/USG/HPE investigation reports
- ☐ Doctor's reference slip for investigation
- ☐ ECG
- ☐ Pharmacy bills
- ☐ MLC report & Police FIR
- ☐ Original death summary from hospital where applicable
- ☐ Any other, please specify

DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)

a) Address of the Hospital:

City: State:

Pin Code: b)Phone No. c) Registration No. with State Code:

d) Hospital PAN: e) Number of Inpatient beds f) Facilities available in the hospital: i. OT : ☐ Yes ☐ No ii. ICU : ☐ Yes ☐ No

iii. Others :

DECLARATION BY THE HOSPITAL **(PLEASE READ VERY CAREFULLY)**

We hereby declare that the information furnished in this Claim Form is true & correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited.

Date: DD MM YY

Place:

Signature and Seal of the Hospital Authority:

GUIDANCE FOR FILLING CLAIM FORM – PART B (To be filled in by the hospital)			
	DATA ELEMENT	DESCRIPTION	FORMAT
	SECTION A - DETAILS OF HOSPITAL		
a)	Name of Hospital	Enter the name of hospital	Name of hospital in full
b)	Hospital ID	Enter ID number of hospital	As allocated by the TPA
c)	Type of Hospital	Indicate whether In network or non network hospital	Tick the right option
d)	Name of treating doctor	Enter the name of the treating doctor	Name of doctor in full
e)	Qualification	Enter the qualifications of the treating doctor	Abbreviations of educational qualifications
f)	Registration No. with State Code	Enter the registration number of the doctor along with the state code	As allocated by the Medical Council of India
g)	Phone No.	Enter the phone number of doctor	Include STD code with telephone number
	SECTION B – DETAILS OF THE PATIENT ADMITTED		
a)	Name of Patient	Enter the name of hospital	Name of hospital in full
b)	IP Registration Number	Enter insurance provider registration number	As allotted by the insurance provider
c)	Gender	Indicate Gender of the patient	Tick Male or Female
d)	Age	Enter age of the patient	Number of years and months
e)	Date of Birth	Enter date of admission	Use dd-mm-yy format
f)	Date of Admission	Enter date of admission	Use dd-mm-yy format
g)	Time	Enter time of admission	Use hh:mm format
h)	Date of Discharge	Enter date of discharge	Use dd-mm-yy format
i)	Time	Enter time of discharge	Use hh:mm format
j)	Type of Admission	Indicate type of admission of patient	Tick the right option
k)	If Maternity		
	Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format
	Gravida Status	Enter Gravida status if maternity	Use standard format
l)	Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
m)	Total claimed amount	Indicate the total claimed amount	In rupees (Do not enter paise values)
	SECTION C – DETAILS OF AILMENT DIAGNOSED (PRIMARY)		
a)	ICD 10 Code		
	Primary Diagnosis	Enter the ICD 10 Code and description of the primary diagnosis	Standard Format and Open text
	Additional Diagnosis	Enter the ICD 10 Code and description of the additional diagnosis	Standard Format and Open text
	Co-morbidities	Enter the ICD 10 Code and description of the co-morbidities	Standard Format and Open text
b)	ICD 10 PCS		
	Procedure 1	Enter the ICD 10 PCS and description of the first procedure	Standard Format and Open text
	Procedure 2	Enter the ICD 10 PCS and description of the second procedure	Standard Format and Open text
	Procedure 3	Enter the ICD 10 PCS and description of the third procedure	Standard Format and Open text
	Details of Procedure	Enter the details of the procedure	Open text
c)	Pre-authorization obtained	Indicate whether pre-authorization obtained	Tick Yes or No
d)	Pre-authorization Number	Enter pre-authorization number	As allotted by TPA
e)	If authorization by network hospital not obtained, give reason	Enter reason for not obtaining pre-authorization number	Open text
f)	Hospitalization due to injury	Indicate if hospitalization is due to injury	Tick Yes or No
	Cause	Indicate cause of injury	Tick the right option
	If injury due to substance abuse/alcohol consumption, test conducted to establish this	Indicate whether test conducted	Tick Yes or No
	Medico Legal	Indicate whether injury is medico legal	Tick Yes or No
	Reported To Police	Indicate whether police report was filed	Tick Yes or No
	FIR No.	Enter first information report number	As issued by police authorities
	If not reported to police, give reason	Enter reason for not reporting to police	Open Text
	SECTION D – CLAIM DOCUMENTS SUBMITTED-CHECK LIST		
Indicate which supporting documents are submitted			
	SECTION E – DETAILS IN CASE OF NON NETWORK HOSPITAL		
a)	Address	Enter the full postal address	Include Street, City and Pin Code
b)	Phone No.	Enter the phone number of hospital	Include STD code with telephone number
c)	Registration No. with State Code	Enter the registration number of the doctor along with the state code	As allocated by the Medical Council of India
d)	Hospital PAN	Enter the permanent account number	As allotted by the Income Tax department
e)	Number of Inpatient beds	Enter the number of inpatient beds	Digits
f)	Facilities available in the hospital	Indicate facilities available in the hospital	Tick the right option. If others, please specify
	SECTION F - DECLARATION BY THE HOSPITAL		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign and stamp			

ANNEXURE IV
List of Generally excluded in Hospitalisation Policy

SNO.	List of Expenses Generally Excluded ("Non-Medical") in Hospital Indemnity Policy -	SUGGESTIONS
	TOILETRIES/ COSMETICS/ PERSONAL COMFORT OR CONVENIENCE ITEMS	
1	HAIR REMOVAL CREAM	Not Payable
2	BABY CHARGES (UNLESS SPECIFIED/INDICATED)	Not Payable
3	BABY FOOD	Not Payable
4	BABY UTILITES CHARGES	Not Payable
5	BABY SET	Not Payable
6	BABY BOTTLES	Not Payable
7	BRUSH	Not Payable
8	COSY TOWEL	Not Payable
9	HAND WASH	Not Payable
10	MOISTURISER PASTE BRUSH	Not Payable
11	POWDER	Not Payable
12	RAZOR	Payable
13	SHOE COVER	Not Payable
14	BEAUTY SERVICES	Not Payable
15	BELTS/ BRACES	Essential and may be paid specifically for cases who have undergone surgery of thoracic or lumbar spine.
16	BUDS	Not Payable
17	BARBER CHARGES	Not Payable
18	CAPS	Not Payable
19	COLD PACK/HOT PACK	Not Payable
20	CARRY BAGS	Not Payable
21	CRADLE CHARGES	Not Payable
22	COMB	Not Payable
23	DISPOSABLES RAZORS CHARGES (for site preparations)	Payable
24	EAU-DE-COLOGNE / ROOM FRESHNERS	Not Payable
25	EYE PAD	Not Payable
26	EYE SHEILD	Not Payable
27	EMAIL / INTERNET CHARGES	Not Payable
28	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)	Not Payable
29	FOOT COVER	Not Payable
30	GOWN	Not Payable
31	LEGGINGS	Essential in bariatric and varicose vein surgery and should be considered for these conditions where surgery itself is payable.
32	LAUNDRY CHARGES	Not Payable
33	MINERAL WATER	Not Payable
34	OIL CHARGES	Not Payable
35	SANITARY PAD	Not Payable

36	SLIPPERS	Not Payable
37	TELEPHONE CHARGES	Not Payable
38	TISSUE PAPER	Not Payable
39	TOOTH PASTE	Not Payable
40	TOOTH BRUSH	Not Payable
41	GUEST SERVICES	Not Payable
42	BED PAN	Not Payable
43	BED UNDER PAD CHARGES	Not Payable
44	CAMERA COVER	Not Payable
45	CLINIPLAST	Not Payable
46	CREPE BANDAGE	Not Payable/ Payable by the patient
47	CURAPORE	Not Payable
48	DIAPER OF ANY TYPE	Not Payable
49	DVD, CD CHARGES	Not Payable (However if CD is specifically sought by Insurer/TPA then payable)
50	EYELET COLLAR	Not Payable
51	FACE MASK	Not Payable
52	FLEXI MASK	Not Payable
53	GAUSE SOFT	Not Payable
54	GAUZE	Not Payable
55	HAND HOLDER	Not Payable
56	HANSAPLAST/ ADHESIVE BANDAGES	Not Payable
57	INFANT FOOD	Not Payable
58	SLINGS	Reasonable costs for one sling in case of upper arm fractures should be considered
	ITEMS SPECIFICALLY EXCLUDED IN THE POLICIES	
59	WEIGHT CONTROL PROGRAMS/ SUPPLIES/ SERVICES	Exclusion in policy unless otherwise specified
60	COST OF SPECTACLES/ CONTACT LENSES/ HEARING AIDS ETC.,	Exclusion in policy unless otherwise specified
61	DENTAL TREATMENT EXPENSES THAT DO NOT REQUIRE HOSPITALISATION	Exclusion in policy unless otherwise specified
62	HORMONE REPLACEMENT THERAPY	Exclusion in policy unless otherwise specified
63	HOME VISIT CHARGES	Exclusion in policy unless otherwise specified
64	INFERTILITY/ SUBFERTILITY/ ASSISTED CONCEPTION PROCEDURE	Exclusion in policy unless otherwise specified
65	OBESITY (INCLUDING MORBID OBESITY) TREATMENT IF EXCLUDED IN POLICY	Exclusion in policy unless otherwise specified
66	PSYCHIATRIC & PSYCHOSOMATIC DISORDERS	Exclusion in policy unless otherwise specified
67	CORRECTIVE SURGERY FOR REFRACTIVE ERROR	Exclusion in policy unless otherwise specified
68	TREATMENT OF SEXUALLY TRANSMITTED DISEASES	Exclusion in policy unless otherwise specified

69	DONOR SCREENING CHARGES	Exclusion in policy unless otherwise specified
70	ADMISSION/REGISTRATION CHARGES	Exclusion in policy unless otherwise specified
71	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE	Exclusion in policy unless otherwise specified
72	EXPENSES FOR INVESTIGATION/ TREATMENT IRRELEVANT TO THE DISEASE FOR WHICH ADMITTED OR DIAGNOSED	Not Payable - Exclusion in policy unless otherwise specified
73	ANY EXPENSES WHEN THE PATIENT IS DIAGNOSED WITH RETRO VIRUS + OR SUFFERING FROM /HIV/ AIDS ETC IS DETECTED/ DIRECTLY OR INDIRECTLY	Not payable as per HIV/AIDS exclusion
74	STEM CELL IMPLANTATION/ SURGERY and storage	Not Payable except Bone Marrow Transplantation where covered by policy
	ITEMS WHICH FORM PART OF HOSPITAL SERVICES WHERE SEPARATE CONSUMABLES ARE NOT PAYABLE BUT THE SERVICE IS	
75	WARD AND THEATRE BOOKING CHARGES	Payable under OT Charges, not payable separately
76	ARTHROSCOPY & ENDOSCOPY INSTRUMENTS	Rental charged by the hospital payable. Purchase of Instruments not payable.
77	MICROSCOPE COVER	Payable under OT Charges, not separately
78	SURGICAL BLADES,HARMONIC SCALPEL,SHAVER	Payable under OT Charges, not separately
79	SURGICAL DRILL	Payable under OT Charges, not separately
80	EYE KIT	Payable under OT Charges, not separately
81	EYE DRAPE	Payable under OT Charges, not separately
82	X-RAY FILM	Payable under Radiology Charges, not as consumable
83	SPUTUM CUP	Payable under Investigation Charges, not as consumable
84	BOYLES APPARATUS CHARGES	Part of OT Charges, not seperately
85	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	Part of Cost of Blood, not payable
86	Antiseptic or disinfectant lotions	Not Payable-Part of Dressing Charges
87	BAND AIDS, BANDAGES, STERLILE INJECTIONS, NEEDLES, SYRINGES	Not Payable - Part of Dressing charges
88	COTTON	Not Payable-Part of Dressing Charges
89	COTTON BANDAGE	Not Payable- Part of Dressing Charges

90	MICROPORE/ SURGICAL TAPE	Not Payable-Payable by the patient when prescribed, otherwise included as Dressing Charges
91	BLADE	Not Payable
92	APRON	Not Payable -Part of Hospital Services/ Disposable linen to be part of OT/ICU chatges
93	TORNIQUET	Not Payable (service is charged by hospitals, consumables cannot be separately charged)
94	ORTHOBUNDLE, GYNAEC BUNDLE	Part of Dressing Charges
95	URINE CONTAINER	Not Payable
	ELEMENTS OF ROOM CHARGE	
96	LUXURY TAX	Actual tax levied by government is payable.Part of room charge for sub limits
97	HVAC	Part of room charge not payable separately
98	HOUSE KEEPING CHARGES	Part of room charge not payable separately
99	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	Part of room charge not payable separately
100	TELEVISION & AIR CONDITIONER CHARGES	Payable under room charges not if separately levied
101	SURCHARGES	Part of Room Charge, Not payable separately
102	ATTENDANT CHARGES	Not Payable - Part of Room Charges
103	IM IV INJECTION CHARGES	Part of nursing charges, not payable
104	CLEAN SHEET	Part of Laundry/Housekeeping not payable separately
105	EXTRA DIET OF PATIENT(OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	Patient Diet provided by hospital is payable
106	BLANKET/WARMER BLANKET	Not Payable- part of room charges
	ADMINISTRATIVE OR NON-MEDICAL CHARGES	
107	ADMISSION KIT	Not Payable
108	BIRTH CERTIFICATE	Not Payable
109	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES	Not Payable
110	CERTIFICATE CHARGES	Not Payable
111	COURIER CHARGES	Not Payable
112	CONVENYANCE CHARGES	Not Payable
113	DIABETIC CHART CHARGES	Not Payable

114	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES	Not Payable
115	DISCHARGE PROCEDURE CHARGES	Not Payable
116	DAILY CHART CHARGES	Not Payable
117	ENTRANCE PASS / VISITORS PASS CHARGES	Not Payable
118	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE	To be claimed by patient under Post Hosp where admissible
119	FILE OPENING CHARGES	Not Payable
120	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)	Not Payable
121	MEDICAL CERTIFICATE	Not Payable
122	MAINTAINANCE CHARGES	Not Payable
123	MEDICAL RECORDS	Not Payable
124	PREPARATION CHARGES	Not Payable
125	PHOTOCOPIES CHARGES	Not Payable
126	PATIENT IDENTIFICATION BAND / NAME TAG	Not Payable
127	WASHING CHARGES	Not Payable
128	MEDICINE BOX	Not Payable
129	MORTUARY CHARGES	Payable upto 24 hrs, shifting charges not payable
130	MEDICO LEGAL CASE CHARGES (MLC CHARGES)	Not Payable
	EXTERNAL DURABLE DEVICES	
131	WALKING AIDS CHARGES	Not Payable
132	BIPAP MACHINE	Not Payable
133	COMMODE	Not Payable
134	CPAP/ CAPD EQUIPMENTS	Device not payable
135	INFUSION PUMP - COST	Device not payable
136	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)	Not Payable
137	PULSEOXYMETER CHARGES	Device not payable
138	SPACER	Not Payable
139	SPIROMETRE	Device not payable
140	SPO2 PROBE	Not Payable
141	NEBULIZER KIT	Not Payable
142	STEAM INHALER	Not Payable
143	ARMSLING	Not Payable
144	THERMOMETER	Not Payable (paid by patient)
145	CERVICAL COLLAR	Not Payable
146	SPLINT	Not Payable
147	DIABETIC FOOT WEAR	Not Payable
148	KNEE BRACES (LONG/ SHORT/ HINGED)	Not Payable
149	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER	Not Payable
150	LUMBO SACRAL BELT	Essential and should be paid specifically for cases who have undergone surgery of lumbar spine.

151	NIMBUS BED OR WATER OR AIR BED CHARGES	Payable for any ICU patient requiring more than 3 days in ICU, all patients with paraplegia/quadriplegia for any reason and at reasonable cost of approximately Rs 200/ day
152	AMBULANCE COLLAR	Not Payable
153	AMBULANCE EQUIPMENT	Not Payable
154	MICROSHEILD	Not Payable
155	ABDOMINAL BINDER	Essential and should be paid in post surgery patients of major abdominal surgery including TAH, LSCS, incisional hernia repair, exploratory laparotomy for intestinal obstruction, liver transplant etc.
	ITEMS PAYABLE IF SUPPORTED BY A PRESCRIPTION	
156	BETADINE \ HYDROGEN PEROXIDE\SPIRIT\\ \ DISINFECTANTS ETC	May be payable when prescribed for patient, not payable for hospital use in OT or ward or for dressings in hospital
157	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES	Post hospitalization nursing charges not Payable
158	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES-DIET CHARGES	Patient Diet provided by hospital is payable
159	SUGAR FREE Tablets	Payable -Sugar free variants of admissable medicines are not excluded
160	CREAMS POWDERS LOTIONS (Toileteries are not payable,only prescribed medical pharmaceuticals payable)	Payable when prescribed
161	Digestion gels	Payable when prescribed
162	ECG ELECTRODES	Upto 5 electrodes are required for every case visiting OT or ICU. For longer stay in ICU, may require a change and at least one set every second day must be payable.
163	GLOVES	Sterilized Gloves payable / unsterilized gloves not payable
164	HIV KIT	Payable - payable Pre operative screening
165	LISTERINE/ ANTISEPTIC MOUTHWASH	Payable when prescribed

166	LOZENGES	Payable when prescribed
167	MOUTH PAINT	Payable when prescribed
168	NEBULISATION KIT	If used during hospitalization is payable reasonably
169	NOVARAPID	Payable when prescribed
170	VOLINI GEL/ ANALGESIC GEL	Payable when prescribed
171	ZYTEE GEL	Payable when prescribed
172	VACCINATION CHARGES	Routine Vaccination not Payable / Post Bite Vaccination Payable
	PART OF HOSPITAL'S OWN COSTS AND NOT PAYABLE	
173	AHD	Not Payable - Part of Hospital's internal Cost
174	ALCOHOL SWABES	Not Payable - Part of Hospital's internal Cost
175	SCRUB SOLUTION/STERILLIUM	Not Payable - Part of Hospital's internal Cost
	OTHERS	
176	VACCINE CHARGES FOR BABY	Not Payable
177	AESTHETIC TREATMENT / SURGERY	Not Payable
178	TPA CHARGES	Not Payable
179	VISCO BELT CHARGES	Not Payable
180	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]	Not Payable
181	EXAMINATION GLOVES	Not payable
182	KIDNEY TRAY	Not Payable
183	MASK	Not Payable
184	OUNCE GLASS	Not Payable
185	OUTSTATION CONSULTANT'S/ SURGEON'S FEES	Not payable, except for telemedicine consultations where covered by policy
186	OXYGEN MASK	Not Payable
187	PAPER GLOVES	Not Payable
188	PELVIC TRACTION BELT	Should be payable in case of PIVD requiring traction as this is generally not reused
189	REFERAL DOCTOR'S FEES	Not Payable
190	ACCU CHECK (Glucometery/ Strips)	Not payable pre hospitilasation or post hospitalisation / Reports and Charts required/ Device not payable
191	PAN CAN	Not Payable
192	SOFNET	Not Payable
193	TROLLY COVER	Not Payable
194	UROMETER, URINE JUG	Not Payable
195	AMBULANCE	Payable-Ambulance from home to hospital or interhospital shifts is payable/ RTA as specific

		requirement is payable
196	TEGADERM / VASOFIX SAFETY	Payable - maximum of 3 in 48 hrs and then 1 in 24 hrs
197	URINE BAG	Payable where medicaly necessary till a reasonable cost - maximum 1 per 24 hrs
198	SOFTOVAC	Not Payable
199	STOCKINGS	Essential for case like CABG etc. where it should be paid.

20-2-2013

Annexure - V

FORM: IRDA-HEALTH INSURANCE PRODUCTS/ RIDERS OFFERED BY LIFE INSURERS AND NON-LIFE INSURERS

I. THIS APPLICATION IS APPLICABLE TO ALL REGISTERED INSURERS CONDUCTING HEALTH INSURANCE BUSINESS IN INDIA, EFFECTIVE FROM DATE OF ISSUE, AND SUPERSEDES THE PREVIOUS CIRCULAR S ISSUED IN THIS REGARD.

1. **Application** – This is applicable to all insurers carrying on health insurance business in India, registered in accordance with section 3 of the Insurance Act 1938, in respect of all health insurance products.

2. **Description of File and Use Procedure –**

   a. An insurer, who wishes to introduce a new product, shall **file** an application for such product with the Authority and **use** the product for sale in the market, subject to the requirements set out in para 3.
   b. An insurer, who wishes to make changes to any existing product or to withdraw an existing product, shall conform to the requirements set out in para 4 for changes and in para 5 for withdrawals.
   c. A separate application shall be made in respect of each product and each rider.

3. **Procedure to be followed for introduction of new insurance products –**
   a. An insurer, wishing to introduce a new product, shall submit an application to the Authority along with Form IRDA- HEALTH INSURANCE PRODUCT/RIDER both for individual as well as group products/riders.
   b. Within 60days of the receipt of the application referred to in sub-para (1), the Authority may seek additional information with regard to the product, and the insurer shall not commence selling the product in respect of which additional information has been sought by the Authority, until the Authority confirms in writing having noted such information. If no such information is sought by the Authority, the insurer can commence selling the product in the market, as set out in the application after the expiry of the said 60-day period.

4. **Procedure to be followed for changes in terms and conditions of existing products** – An insurer, wishing to make changes to an existing product, shall submit an application to the Authority setting out the details of the changes in the terms and conditions and giving reasons for the proposed changes, subject to procedure laid down in para 3.

5. **Procedure to be followed in case of withdrawal of existing products** – An insurer, wishing to withdraw an existing product, shall inform the Authority giving the details of the product and the reasons for withdrawal.

6. **GENERAL INSTRUCTIONS**

   a. Insurers shall only use the specified form for filing the products.

b. If an insurer wishes to offer riders/add-ons along with a basic health insurance product, he must furnish the information in respect of the riders/add-ons separately using the Form: IRDA- HEALTH INSURANCE PRODUCTS/RIDERS as the case may be and also the financial projections along with sensitivity analysis for each rider/add-on benefit. It is also clarified that it is not necessary to file the rider details more than once, but it would be necessary to furnish the item financial projections (i.e. item no.14 of the Form), when the same rider is offered along with other products.

Note: If an insurer offers rider A along with product X, product Y or product Z (e.g. Accident Benefit Rider), then the Form has to be furnished afresh along with each of the products under which the said rider is offered. This is because the financial projections for the rider may differ under that product. For instance, the financial projections submitted for a rider A under the product X need not be the same when the same rider A is offered along with product Y. As such the financial projections need to be furnished for the said rider along with product in the specified Forms. It may be noted that rider details need not be mentioned again but only the financial projections, when the same rider is offered along with the second of the third product.

c. All items in the Forms with the relevant details must be furnished. For instance, under Item 16 of the Form "Certification" the details such as Name of Appointed Actuary, Name of the product, Name of Insurer etc. must be furnished. This would avoid unnecessary delays.

d. Forms along with the necessary enclosures such as Specimen Policy Bond, Specimen Proposal Form, Specimen Sales Literature, and the Statement of Financial Projections, etc shall be furnished, but NOT in piecemeal.

e. Insurers shall not alter the contents of the products under the File & Use procedure later without prior approval of the Authority.

f. While submitting the Forms, reference to enclosures shall be avoided.

g. If an insurer wishes to modify materially an existing product which is already in use in the market, then he is required to comply with 'File & Use' procedure afresh, depending upon the nature of modification.

h. If an insurer wishes to withdraw an existing product in the market, he may do so. But he shall inform the Authority giving reasons for withdrawal, within 7 days from the date of withdrawal.

i. If an insurer does not launch the product within a period of 3 months, he will be required to comply with 'File & Use' procedure afresh.

j. The Appointed Actuary shall initial on all the pages of the File and Use application form and all the correspondence on products with the Authority shall be made only by the AA.

k. The insurer shall undertake to furnish the premium rates in their web-site so that if any member of public is interested to know the premium rate he can obtain the same by using the web-site. This applies to all products whether individual or group.

l. The insurer shall also furnish the name of the software used in the matter of designing and filing the products (for instance the software can be AXIS,

PROPHET etc). If the insurer is using his own software he must inform so. This is for the information of the Authority only.

II. File and Use Application form for 'health insurance products' offered by Life insurers and non-life insurers:

S No	Item	**Particulars (to be filled in by insurer)**
1	Name of Life/Health/Non-Life Insurer	
1.1	Registration No.alloted by IRDA	
2	Name of Appointed Actuary [Please note that his appointment should be in force as on the date of this application]	
3	Brand Name [Give the name of the product which will be printed in Sales Literature and known in the market. This name should not be altered/modified in any form after launching in the market. This name shall appear in all returns etc. which would be submitted to IRDA.]	
3.1	Unique ID no. (allotted by IRDA, if this application is for modification of an exisitng product)	
4	Date of introduction of the product (proposed in case of new products; actual date in case of existing products): [In case of new products being launched for the first time in the market, give the proposed date (However the date cannot be within 60 days from date of this application) from which Insurer wants to market. In case of existing products, the actual date from which product was launched in the product.]	
5	Date of modificiation/withdrawal (proposed in case of existing products, but not applicable for	

	new products): [(a)This must be filled as "Not Applicable" for all the new products. (b) Proposed date of modification of the features of the product, where such product is already in use in the market. (c) In case the Insurer wishes to withdraw the existing product from the market, the date of withdrawal must be furnished under this item.]		
6	**General Terms and Conditions [All the items should be filled in properly and carefully. No item must be left blank.]**		
6.1	**Whether the health product is offered to/through: [Answer YES/NO]**		
	6.1.1	Individuals	**YES / NO**
	6.1.2	Family Floater	**YES / NO**
	6.1.3	Groups	**YES / NO**
	6.1.4	Specific geographic locations in India [if YES, specify the locations.]	**YES / NO**
	6.1.5	All geographic locations in India	**YES / NO**
	6.1.6	Rural population	**YES / NO**
	6.1.7	Micro Insurance	**YES / NO**
	6.1.8	Government Schemes	**YES / NO**
	6.1.9	Indemnity basis	**YES / NO**
	6.1.10	Benefit basis	**YES / NO**
	6.1.11	Indemnity and benefit based both inclusive	**YES / NO**
6.2	**Specify the following:**		
	6.2.1	Target population [This section should discuss the target market for which the product is designed. Also please enclose separately the details of any market research conducted for this purpose.]	
	6.2.2	Grace period allowed for renewal—specify the number of days allowed	

		for renewal of the contract-minimum grace period shall be 30 days.		
	6.2.3	Grace period allowed for payment of premiums in installments—specify the number of days allowed for payment of premium when premiums are not paid on stiuplated dates.		
	6.2.4	Minimum Group Size (state the minimum membership of the group)		
	6.2.5	Maximum Group Size (state the maximum membership of the group)		
	6.2.5	**Basic Sum Insured (for groups, per member details to be furnished):**		
		6.2.5.1	Minimum offered	
		6.2.5.2	Maximum offered	
		6.2.5.3	Sum insured rebates /discounts offered, if any (please provide objective and transparent criteria to offer rebates and financial justifications by AA-no discretion allowed to the insurer in offering such rebates/discounts)	
	6.2.6	**Policy Period:**		
		6.2.6.1	Minimum	

			Policy period offered	
		6.2.6.2	Maximum Policy period offered	
		6.2.6.3	Premium paying terms, if different from policy term	
	6.2.7	**Modes of Premium Payment Offered:**		
		6.2.7.1	State the modes of premium payment allowed- (Single premium /annual/ halfy-yearly, etc.)	
		6.2.7.2	Rebates/charges for different modes offered, with justifications from AA:	
	6.2.8	**Annualised Premium (for group give the details per member)**		
		6.2.8.1	Minimum:	
		6.2.8.2	Maximum:	
		6.2.8.3	Premium rebates /discounts offered, if any (please provide objective and transparent criteria to offer rebates and financial justifications by AA-no discretion allowed to the insurer in	

			offering such rebates/discounts)	
	6.2.9	**Entry Age:**		
		6.2.9.1	Minimum:	
		6.2.9.2	Maximum:	
	6.2.10	Maximum renewal Age, for age specific products		
	6.2.11	Restrictions on travel outside India (If YES, specify the conditions]		**YES/NO**
	6.2.12	Any other restrictions [If there is restriction proposed, the same should be furnished, e.g. future occupation]		**YES/NO**
	6.2.13	Deductibles allowed		
	6.2.14	Co-pay allowed		
	6.2.15	Staff rebates or any other Rebates offered—(please provide objective and transparent criteria to offer rebates and financial justifications by AA-no discretion allowed to the insurer in offering such rebates/discounts)		
	6.2.16	Any other discounts offered—(please provide objective and transparent criteria to offer rebates and financial justifications by AA-no discretion allowed to the insurer in offering such rebates/discounts)		
	6.2.17	Any loadings proposed—(please provide objective and transparent criteria to offer rebates and financial justifications by AA-no discretion allowed to the insurer in offering such rebates/discounts)		

	6.2.18	Subrogation, if any				
6.3	**Product details:**					
	6.3.1 2	Is the Product filed for the first time?	**Yes/No**			
		6.3..1.1	**If no, furnish the date of first filing of the product. If yes, please go to item no 7 directly.**			
		6.3.1.2	**Please give the proposed modifications in tabular form**			
		S.no	**Existing Features / assumptions/premiums rates –which are proposed to modify**	**Proposed modifications**	**Justification for such modification**	**Any supporting data for such modification**
	6.3.2	Whether the product features/assumptions/premium rates have been modified from the date of clearance?	**Yes/No**			
		6.3.2.1	**If Yes, Please give the information of all the modifications carried out till date in tabular form:-History of modifications carried out till date:**			
			S No	**Date of modification filed with the Authority**	**Exisitng Features/Assumpitons/ premium rates as on date of clearance of the product i.e. before the modification**	**Features/Assumptions/premium rates modified from the first/subsequent filing i.e. after the clearance of the modification**	**Date of clearance of the modification from the Authority and the unique identification number allotted**
7	**Benefit Structure of the Product. [This section should describe the various contingencies under which the benfits would be payable and how these would be determined-please do not refer to any other document which is enclosed along with this]**					
	Event:		**Benefit Amount Insured:**			
7.1	On Hospitalization					

<table>
<tr><td>7.2</td><td colspan="2">On events other than (7.1) – (please furnish the complete details seperately for each benefit offered)</td><td colspan="4"></td></tr>
<tr><td>7.3</td><td colspan="2">On cancellation by the insured:</td><td colspan="4"></td></tr>
<tr><td>7.4</td><td colspan="2">On cancellation by the insurer- only allowed on grounds of misrepresentation, fraud, non-disclosure or non-cooperation of the insured</td><td colspan="4"></td></tr>
<tr><td>7.5</td><td colspan="2">Specify Non-forfeiture conditions [When the contract would be not null and void]</td><td colspan="4"></td></tr>
<tr><td>7.6</td><td colspan="2">Specify options available under the product. (e.g. to increase or decrease benefits, plan changes, etc.) [This section should specify the various options available under the product.The charges, if any, towards the cost of the option shall also be specified.]</td><td colspan="4"></td></tr>
<tr><td>7.7</td><td colspan="2">Procedure for renewal</td><td colspan="4"></td></tr>
<tr><td>7.8</td><td colspan="6">Riders / ADD-ons</td></tr>
<tr><td></td><td>7.8.1</td><td>Riders / Add-ons attached to the product</td><td>S.No</td><td>Rider/Add-on Name</td><td>UIN alloted by IRDA</td><td>Date of clearance</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td>7.8.2</td><td>Any other features that may be relevant for the product.</td><td colspan="4"></td></tr>
<tr><td></td><td>7.8.3</td><td>How the rider will benefit the insured if taken along with this product</td><td colspan="4"></td></tr>
<tr><td>8</td><td colspan="6">Underwriting –Selection of Risks [This section should discuss how the different segments of the population will be dealt with for the purpose of underwriting (to the extent they are relevant and a brief detail of procedure adopted for assessment of various risk classes may be given.)</td></tr>
<tr><td>8.1</td><td colspan="2">Specify Non-medical Limit [No medical examination asked for]</td><td colspan="4"></td></tr>
<tr><td>8.2</td><td colspan="2">Specify when and what classes of lives would be subject to medical examination</td><td colspan="4"></td></tr>
</table>

8.3	Specify the minimum participation of membership for groups.							
8.4	Exclusions: please specify time bound exclusions have been proposed for payment of benefits							
8.5	Exclusions: please specify permanent exclusions have been proposed for payment of benefits							
9	**Other Terms:**							
9.1	Nomination							
9.2	Conditions for revival of the contract, in case of installment/regular premiums:							
10	**Distribution Channels & New Business Strain.**							
10.1	**Distribution channels:**							
	10.1.1	Specify the various distribution channels to be used for distributing the product- [reply shall be specific and can not refer to the replies like "as approved by IRDA]						
	10.1.2	Commission scales to distribution channels—specify the rates which are to be paid-[reply shall be specific and can not refer to the replies like "as per the "Act"]						
10.2	Expected proportions of business to be procured by each channel shall be indicated for the next 5 years.		**Distribution Channel**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
			1.Individual Agents					
			2. Corporate Agents					
			3. Brokers					
			4. Others-specify					
			5. Total					
10.3	New Business Strain, if any		**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	

11	**Reinsurance arrangements:**		
11.1	Retention limit		
11..2	Name of the reinsurer (s)		
11.3	Terms of reinsurance(type of reinsurance, commissions, etc.).		
11.4	Any recapture provisions shall be described.		
11.5	Reinsurance rates provided		
11.6	Whether a copy of the reinsurance program and a copy of the Treaty is sumbitted to the Authority.		**Yes/NO**
	11.6.1	Whether reinsurance program and a copy of the treaty enclosed (required only if these are not filed with the Authority previously)	**Yes/No**
12	**Pricing: The pricing assumptions and the methodology may vary depending on the nature of product. Give details of the following**		
12.1	Give the actuarial formulae, if any, used; if not, state how premiums are arrived at giving briefly the methodology and details):		
12.2	Source of data (internal/industry/ reinsurance)		
12.3	Rate of morbidity [The tables whereever relevant shall be the prescribed one.]		
12.4	Rates of policy terminations, if any. [The rates used must be in accordance with insurer's experience, if such experience is not available, this can be from the industry/reinsurer's experience .]		
12.5	Rate of interest, if any. [The rate or rates must be consistent with the investment policy of the insurer.]		
12.6	Commission scales [Give rates of commission. These are explicit items.]		

12.7	**Expenses: Split into:- [Expense assumptions must be company specific. If such experience is not available, the Appointed Actuary might consider industry experience or make reasonable assumptions.]**				
	12.7.1	First year expenses by : sum assured related, premium related, per policy related			
	12.7.2	Renewal expenses, where relevant (including overhead expenses) by : sum assured related, premium related, per policy related			
	12.7.3	Claim expenses			
	12.7.4	Future inflationary increases, if any allowed in pricing			
12.8	Allowance for transfers to shareholder, if any: [Please see section 49 of the Insurance Act, 1938]				
12.9	Taxation. [Please see the relevant sections of the Income Tax Act, 1961]				
12.10	Any other parameter relevant to pricing of product –please specify				
12.11	Reserving assumptions (please specify all the relevant details)				
12.12	Base rate (risk premium)-furnish the rate table, if any				
12.13	Gross premium- furnish the rate table.				
12.14	Expected loss ratio (for the product) -to be furnished for each plans offered within the product separately				
12.15	Age-wise loss ratio- to be furnished for each plans offered within the product separately		**S.No**	**Age**	**Loss ratio**
12.16	Sum insured-wise- loss ratio to be furnished each plans offered within the product separately		**S.No**	**SA**	**Loss ratio**
12.17	Age and sum insured wise loss ratio - to be furnished for each plans offered within the product separately		**Table given below (SI band and age bands shall be increased depending on the minimum and maximum SI offered)**		

	S.NO	SI/Age bands	25000	50000	100000	150000	200000
	1	>=0<=2					
	2	>=3<=15					
	3	>=16<=25					
	4	>=26<=30					
	5	>=31<=35					
	6	>=36<=40					
	7	>=41<=45					
	8	>=46<=50					
	9	>=51<=55					
	10	>=56<=60					
	11	>=61<=65					
	12	>=66					
12.18	Expected combined ratio (for the product) -to be furnished for each plan separately						
12.19	Age-wise combined ratio- to be furnished for each plan separately						
12.20	Sum insured-wise- combined ratio to be furnished for each plan separately						
12.21	Age and sum insured wise combined ratio - to be furnished for each plan separately		**Table given below (SI band and age bands shall be increased depending on the minimum and maximum SI offered)**				
	S.NO	SI/Age bands	**25000**	**50000**	**100000**	**150000**	**200000**
	1	>=0<=2					
	2	>=3<=15					
	3	>=16<=25					
	4	>=26<=30					
	5	>=31<=35					
	6	>=36<=40					

	7	>=41<=45					
	8	>=46<=50					
	9	>=51<=55					
	10	>=56<=60					
	11	>=61<=65					
	12	>=66					

12.22	Expected cross-subsidy between age/sum insured/ plans etc	
12.23	Experience of similar products, if any	

	S.No	Exposure	Premium – Rs.	Number of claims	**Incurred claims-Rs.**	**Claim frequency**	**Average cost per claim**	**Burning cost-Rs.**	**Loss ratio**	**Combined ratio**
	2008-09									
	2007-08									
	2006-07									
	2005-06									
	2004-05									

	1. Exposure: earned life year (no of life earned during a particular financial year); **2. Premium: premium earned during the financial year;** **3.Number of claims: claims occurred during the financial year;** **4. Incurred claims: Incurred amount as of today for claims mentioned in "3";** **5. Claim frequency: No. of claims/ Exposure;** **6. Average cost per claim: Incurred claims / No. of claims;** **7. Burning cost: Claims frequency* Average cost per claim;** **8. Loss ratio: Incurred claims/ Premium;** **9. Combined ratio: Loss ratio + Expense ratio;**
13	**Revision in pricing for existing products**
13.1	Justification for change/ modification in premium
13.2	Experience of the product across plans / sum insured / age bands **In addition to the experience of similar products in Item 12.23, these tables to be furnished for the product for which revision**

		in pricing is requested		
13.3	How the pricing methodology differs between sum insured options, if any			
14	**Results of Financial Projections/Sensitivity Analysis: [The profit margins should be shown for various model points for base,optimistic and pessimistic scenarios in a tabular format below. The definition of profit margin should be taken as the present value of net profits to the p.v of premiums. Please specify assumptions made in each scenario. For terms less than or equal t oone year loss ratio may be used and for terms more than one year, profit margin may be used.]**			
14.1	Risk discount rate used in the profit margin			
14.2	Average Sum Insured Assumed			
14.3	Assumptions made under pessimistic scenario			
14.4	Assumptions made under optimistic scenario			
14.4	Age [PM: Profit Margin/Loss Ratio]	***PM (base scenario)***	***PM (pessimistic scenario)***	***PM (optimistic scenario)***
	>=0<=2			
	>=3<=15			
	>=16<=25			
	>=26<=30			
	>=31<=35			
	>=36<=40			
	>=41<=45			
	>=46<=50			
	>=51<=55			
	>=56<=60			
	>=61<=65			
	>=66			
15	**The following specimen documents shall be enclosed:**			
15.1	**Proposal Form:**			
15.2	**Sales Literature /Prospectus – the pamphlets made available to members of the public at the time of sale. This is the literature which is to be used by the various distribution channels for selling the produc in the market. This shall enumerate all the salient features of the product alongwith the exclusions applicable for the basic benefits and shall be incomplaince with the relevant circulars issued by the Authority at all times).**			
15.3	**Policy Document along with policy schedule**			

15.4	**Underwriting Manual**
15.5	**Claims Manual**
15.6	**Premium Table**
15.7	**Certificates –Form A, Form B and Form C**
15.8	**Customer information sheet**
15.9	**Database sheet**

16. Certification. The Insurer shall enclose a certificate from the Appointed Actuary, countersigned by the principal officer of the insurer, as per specimen given below: (The language of this should not be altered at all)

" I, (**name of the appointed actuary**), the appointed actuary, hereby solemnly declare that the information furnished above is true. I also certify that, in my opinion, the premium rates, advantages, terms and conditions of the above product are workable and sound, the assumptions are reasonable and premium rates are fair."

Place
Date:

Signature of the Appointed Actuary.

Name and Counter Signature of the principal officer along with name, and Company's seal.

Annexure-V
Form A

FILING OF GENERAL INSURANCE PRODUCT

Name of insurer:

Date of filing:

Class of insurance:

Name of product:

Certificate by Principal Officer Or Designated Officer

This is to confirm that:

1. The rates, terms and conditions of the above-mentioned product filed with this certificate have been determined in compliance with the IRDA Act, 1999, Insurance Act, 1938, and the Regulations and guidelines issued thereunder, including the File and Use guidelines.
2. The prospectus, sales literature, policy and endorsement documents, and the rates, terms and conditions of the product have been prepared on a technically sound basis and on terms that are fair between the insurer and the client and are set out in language that is clear and unambiguous.
3. These documents are also fully in compliance with the underwriting and rating policy approved by the Board of Directors of the insurer.
4. The statements made in the filing Form A are true and correct.
5. The requirements of the revised File and Use guidelines have been fully complied with in respect of this product.

Date:
Place:

Signature of *Principal* Officer or Designated Officer
Name and designation

Annexure-V
Form B

FILING OF GENERAL INSURANCE PRODUCT

Name of insurer:

Date of filing:

Class of insurance:

Name of product:

Certificate by Appointed Actuary

This is to confirm that:

1. I have carefully studied the requirements of the File and Use Guidelines in relation to the design and rating of insurance products.
2. The rates, terms and conditions of the above-mentioned product are determined on a technically sound basis and are sustainable on the basis of information and claims experience available in the records of the insurer.
3. An adequate system has been put in place for collection of data on premiums and claims based on every rating factor that will enable review of the rates and terms of cover from time to time. *It is planned to review the rates, terms and conditions of cover based on emerging experience (enter periodicity of review).*
4. The requirements of the revised File and Use guidelines have been fully complied with in respect of this product.

Date:
Place:

Signature of Appointed Actuary
Name and designation

Annexure-V
Form C

FILING OF GENERAL INSURANCE PRODUCT

Name of insurer:

Date of filing:

Class of insurance:

Name of product:

Certificate by the Lawyer of the insurer This is to confirm

that:

1. I have carefully studied the prospectus, sales literature, policy wordings and endorsement wordings relating to the above-mentioned product in the light of the IRDA (Protection of Policyholders' Interests) Regulations 2002, and the File and Use Guidelines.
2. The above mentioned documents are written in clear unambiguous language, and properly explain the nature and scope of cover, the exceptions and limitations, the duties and obligations of the insured and the effect of non-disclosure of material facts.
3. These documents are in compliance with the Policyholders' Protection Regulations and Insurance Advertisements and Disclosure Regulations.

Date:
Place:

Signature of Lawyer
Name and address

20.2.2013

Annexure - VI

INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY

DATABASE FORMAT

(DETAILS FOR FILE AND USE APPROVAL OF HEALTH INSURANCE PRODUCTS)

A. PRODUCT INDEX

Insurer Code:

Product Category (3-tier codes at annexure): | | | |

(The logic of Categorization is provided at Appendix 1. Accordingly, insurers have to provide the Categorization in the order of priority and the pricing impact)

Additional Category 1: | | | |

Additional Category 2: | | | |

Additional Category 3: | | | |

Number of Plans/ Variants within the product: . . . . . .

Nomenclature used for Plans/ Variants: . . . . . .

Product Commercial Name:

New or Revision: New (V00) / Revised Version (V01/V02/V03): . . . . . .

If Revision, give application/ approval dates of earlier version: . . . . . .

Unique ID no: . . . . . .
(Automatically generated field after product approval by Authority)

B. PROCESSING HISTORY (FOR INTERNAL USE ONLY)

IRDA Inward date:

IRDA Inward Number:

Nodal Officer processing the product:

IRDA File number:

Product Category: HEALTH

Last clarification received date (DDMMYY):

Approval communicated on (DDMMYY):

Text of any Major Policy Stand/ Observation by Chairman/Member on this product file:

. . . . . .

. . . . . .

C. PRODUCT DETAILS

C.a. Hospitalization : Contingencies covered:

Contingency	Covered (Y/N)	Sub-Limits in % of SI, if applicable	Sub limits in fixed rupee terms, if applicable
Room charges			
Boarding charges for patient			
Nursing charges for patient			
ICU charges			
Medical Practitioners Fees			
Operation Theatre charges			
Surgical Consumables			
Prescribed drugs			
Diagnostic tests			
Cost of blood			
Cost of transplantation			
Hospitalization expenses of donor			
Cost of artificial limbs			
Cost of pacemakers			
Parenteral Chemotherapy			
Radiotherapy			
Haemodialysis			
Domiciliary Hospitalization			
Ambulance charges			
Maternity expenses			
Neonatal expenses			
Funeral expenses			
Pre-hospitalization expenses			
Post-hospitalization expenses			
Cost of periodic health check-up for policies without claims			
Cost of periodic health check-up for policies with claims			
Day Care procedures covered			
Dental Procedures			
Hearing Aids			
Spectacles/ contact lens			
Any other contingency covered			

Whether any waiver of sub-limits is available in different plans or at different terms: Y/N
If yes, details of sub-limits which can be waived and terms for the same:

If any other contingency is covered, details of sub-limits which can be waived and terms for the same.

C.b. Waiting periods and sub limits for specified diseases:

Type of waiting period	Period in months (Mention '0' if no waiting period)	Any sub-limits in rupee terms	Any sub-limits in % of S.I. terms
General waiting period for new covers (except accidents)			
Pre-existing diseases			
Cataract			
Hernia or Hydrocele			
Benign Prostate Hypertrophy			
Hysterectomy (non-malignant)			
Fistula in Anus, Anal Fissure, Piles			
Sinusitis			
Gall Bladder Stones			
Joint replacement			
Gastric or Duodenal ulcer			
Tonsilitis or Adenoids			
Breast lumps			
Cysts, nodules or polyps			
Intervertebral disc prolapse			
Arthritis			
Varicose veins/ varicose ulcers			
Spondylosis/ Spondylitis			
Maternity cover			
Renal Failure (old product)			
Heart Disease (old product)			
Cancer (old product)			
Hypertension (old product)			
Diabetes (old product)			
Any other waiting period/ sub-limit.			

If any other waiting period/ sub-limits are applicable, details of the same.

C.c. Exclusions:

Type of exclusion	Applicable (Y/N)	Special conditions, if any
Pre-existing disease for non-indemnity or non-domestic policies		
War, invasion, war like operation		
Circumcision unless medically necessary		

Vaccination/inoculation except post-bite		
Venereal diseases and HIV/AIDS		
Pregnancy/ Maternity except ectopic pregnancy		
Voluntary termination of pregnancy		
Fertility or assisted conception		
Treatment of obesity		
Cosmetic or aesthetic procedures except for burns/ injuries etc.		
Change of life/ sex-change		
Spectacles or contact lens		
Hearing Aids		
Dental treatment except requiring hospitalization		
Convalescence/ debility		
Intentional self-injury/ suicide attempt		
Influence of intoxicating drugs or alcohol		
Expenses unlinked to active treatment in hospital		
Nuclear weapons/material		
OPD expenses except pre and post-hospitalization as covered under Scope		
Naturopathy or Yoga		
Ayurvedic Medicine		
Homeopathic Medicine		
Unani Medicine		
Unrecognized systems of medicine		
Speed contest, racing, adventure sports		
Durable or external medical equipment required post-operatively		
Personal comfort and convenience items		
Hormone replacement therapy		
Mental Illness		
Any other		

If any other exclusion applies, details of the same.

C.d. Age Limits

Minimum Age at Entry –Adult (Years)	
Maximum Age at Entry –Adult (Years)	
Maximum Age till which renewal is available –Adult (Years)	
Minimum Age at Entry –Child (Months)	
Maximum age up to which dependent children who are unmarried and unemployed can be covered (Years)	

C.e. Cost sharing:

Cost Sharing Details	Applicable (Y/N)	Details
Does the policy have compulsory deductibles		
Does the policy have voluntary deductibles		

Cost Sharing Details	Applicable (Y/N)	Percentage
Does the policy require any compulsory co-pay in network hospitals		
Does the policy have option for voluntary co-pay in network hospitals		
Does the policy require any compulsory co-pay in non-network hospitals		
Does the policy require any compulsory co-pay in hospitals outside a specified geographical area?		
Does the policy require any compulsory co-pay for pre-existing diseases?		
Does the policy require any compulsory co-pay for 'packaged' charges by hospitals?		
Any other sub-limits?		

If any other cost sharing applies, details of the same.

C.f. Loyalty Benefits

	Offered (Y/N)	At first renewal	At second renewal (cumulative)	Maximum
Cumulative No Claim Bonus				
Cumulative Loyalty Bonus (regardless of Claim history)				
Health Check up for claim-free policies				
Health check up regardless of claim history				
No Claim Discount				
Loyalty Discount (regardless of claim)				
Any Other				

If any other loyalty benefit applies, details of the same.

C.g. Other Terms and Conditions

Terms/Conditions	Applicable (Y/N)	Details as applicable
Whether the policy is only available to a restricted group (e.g. customers of a bank)		
Whether the policy is only intended for claims arising in a specified and limited network of medical providers?		
Whether change in risk is to be intimated on renewal		
Whether TPA being used for the product		
Whether there is a Premium Installment option		
Whether increase in sum insured permissible at renewal		
Whether change of options/plans within same product permissible at renewal		
Whether inward migration allowed from other products of same insurer		
Whether inward migration allowed from other/ similar products of any insurer		
Whether there are any restrictions on renewal of specific sections/ components before the maximum renewal age for the product		
Whether parents are covered under the policy?		
Whether cancellation at option of insurer is on pro-rata basis?		
Whether cancellation at option of insurer for fraudulent cases is on 'no refunds' basis		
Whether Free Look period option is provided under the policy?		
Others		

C.h. Sum Insured and Rate Structure for Primary Member:

Chart given below applicable for primary member alone: Y/N

If No, Chart applicable for: _____

Different Sums Insured (in Rs)	Sum Insured (Rs)	Premiums applicable at different ages (Rs. per annum)						
		For 25 years	For 30 years	For 40 years	For 50 years	For 60 years	For 65 years	For 70 years
Minimum sum insured available								
Premium charged for Rs. 2 lakhs sum insured where applicable	200,000							
Premium charged	300,000							

for Rs. 3 lakhs sum insured where applicable								
Maximum sum insured available								

C.i. Reinsurance Details:

Reinsurance Details	Y/N	Details
Any reinsurance other than obligatory cession		
If yes, whether pricing is linked to reinsurance rates		

C.j. Critical Illness Coverage:

C.j.1. Critical Illness	Covered (Y/N)	If yes, details thereof
If Critical Illness is an additional component of a wider health cover, whether sum insured for Critical Illness is different from that for the primary component		

C.j.2. Critical Illness	Covered (Y/N)	If yes, survival period required in number of days
Survival Period required		

C.j.3. Critical Illness	Covered (Y/N)	Period	If modified from Standard Definitions, details
Stroke resulting in permanent symptoms			
Cancer of specified severity			
Kidney Failure requiring regular dialysis			
Open Chest Coronary Artery Bypass Graft			
Major Organ/ Bone Marrow Transplant			
Coma of specified severity			
Multiple Sclerosis with persisting symptoms			
First Heart Attack of specified severity			
Open Heart repair or replacement of heart valves			
Motor Neuron Disease with permanent symptoms			
Permanent Paralysis of Limbs			
Major Injuries			
Major Burns			
Others			

If any other critical illness cover is applicable, details of the same.

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C.k. Hospital Cash Coverage:

C.k.1. Hospital Cash	Covered (Y/N)	If yes, details thereof
If Hospital Cash is an additional component of a wider health cover, whether the amount of hospital cash cover is linked to sum insured		

C.k.2. Hospital Cash	Minimum Stay required (days)	Deductible if any (days)	Maximum Period Covered (days)	Minimum Daily Payout option (Rs)	Maximum Daily Payout option (Rs)
Room					
ICU					
Accidental					
Any other					

C.l. High Deductible Coverage:

High Deductible Coverage	Amount (Rs.)
Minimum Deductible Option	
Minimum Sum Insured above the minimum deductible	
Maximum Deductible Option	
Maximum Sum Insured above the maximum deductible	

C.m. Outpatient Coverage:

C.m.1. Outpatient Coverage	Y/N	If yes, Fixed Premium (Rs.)
Is the policy modeled as fixed total premium and variable OPD sum insured?		

C.m.2. Outpatient Coverage	Y/N	Period (MM/YY)
Is there any restriction on period?		
If yes, the period till which IRDA approval was given for this component		

C.m.3. Outpatient Coverage	Sum Insured (Rs)	OPD Premiums applicable for different ages (Rs. per annum)						
		For 25 years	For 30 years	For 40 years	For 50 years	For 60 years	For 65 years	For 70 years
Minimum OPD Cover offered								
Maximum OPD cover offered								

C.n. Travel Coverage:

C.n.1. Travel Coverage	Applicable (Y/N)	If yes, days	Condition s/ Details
Minimum duration of travel specified			
Maximum duration of travel specified			
Coverage for emergency evacuation-ground			
Coverage for emergency evacuation-air ambulance			
Coverage for emergency hospitalization			
Coverage for emergency OPD expenses			
Coverage for emergency repatriation			
Coverage for repatriation of mortal remains			
Coverage for attendant travel			
Coverage for loss of baggage			
Coverage for loss of passport			
Coverage for emergency stabilization in case of pre-existing diseases			
Coverage beyond emergency stabilization in cases with pre-existing diseases			
TPA used for servicing policies			
Any Other Coverage			

C.n.2. Travel Coverage	Applicable (Y/N)	If yes, Code	Details
Geographical zones where policy covers travel (Refer Travel Code Master for codes)			
If any other zone is applicable, give details of the zone.			

C.o. Pricing and Underwriting Details:

C.o.1. Pricing Criteria	Applicable (Y/N)	Rank by Priority/ Weightage
Age		
Sum Insured		
Gender		
Size of Group		
Geographical location of insured		
Deductible or Co-pay opted		
Occupation		
Policy period		
Discount for number of sections/ components covered		
Extension or reduction in geographical jurisdiction of coverage		
Any other pricing criteria		

C.o.2. Expected Claim Ratio	Percentage
Expected incurred claim ratio in first completed year	
Expected incurred claim ratio in second completed year	
Expected incurred claim ratio in third completed year	

C.o.3. Underwriting Details	Applicable (Y/N)	If yes, Age after which required
Whether entirely pre-underwritten		
Pre Insurance Medical Examination requirement		
Whether required at an earlier age based on proposal form details		

C.o.4. Underwriting Details	Applicable (Y/N)	Criteria filed with IRDA (Y/N)	Maximum loading/ discount (%)
Health-status based loading applicable on new policies			
Health status based loading applicable on renewals			
Claim history based loading applicable on renewals			
Maximum loading for all variables taken together			
Maximum discount for all variables taken together.			
Any other underwriting criteria			

If any other underwriting criteria are applicable, details of the same.

Addl. Comments/ Remarks/ Notes:

INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY

DETAILS FOR FILE AND USE APPROVAL OF HEALTH INSURANCE PRODUCTS

1	A & B. PRODUCT INDEX & PROCESSING HISTORY
2	C. PRODUCT DETAILS C.a. Hospitalization : Contingencies covered
3	C.b. Waiting periods and sub limits for specified diseases
4	C.c. Exclusions
5	C.d. Age Limits & C.e. Cost sharing
6	C.f. Loyalty Benefits & C.g. Other Terms and Conditions
7	C.h. Sum Insured and Rate Structure for Primary Member & C.i. Reinsurance Details
8	C.j. Critical Illness Coverage & C.k. Hospital Cash Coverage
9	C.l. High Deductible Coverage & C.m. Outpatient Coverage
10	C.n. Travel Coverage
11	C.o. Pricing Criteria, Expected Claim Ratio & Underwriting Details

Customer Information Sheet

Description is illustrative and not exhaustive

S. NO	TITLE	DESCRIPTION	REFER TO POLICY CLAUSE NUMBER
1	**Product Name**	• Approved Brand Name	
2	**What am I covered for:**	• Hospital admission longer than xx hrs • Related medical expenses incurred xx days prior to hospitalisation / amounting to x% of claim • Related medical expenses incurred within xx days from date of discharge / amounting to x% of claim • Specified / Listed procedures requiring less than 24 hours hospitalisation (day care) • Cover for xx critical illnesses on undergoing specified procedure or on diagnosis of an illness of specified severity • Hospital daily cash benefit of Rs__ per day • OPD / Dental / Maternity coverage • Emergency or Travel Medical Assistance etc	
3	**What are the major exclusions in the policy:**	• Any hospital admission primarily for investigation / diagnostic purpose • Pregnancy, infertility, congenital/genetic conditions, • Non-allopathic medicine, • Domiciliary treatment, treatment outside India. • Circumcision, sex change surgery ,cosmetic surgery & plastic surgery, • refractive error correction, hearing impairment correction, corrective & cosmetic dental surgeries, • Organ donor expenses, • Substance abuse, self-inflicted injuries, STDs and HIV / AIDS, • Hazardous sports, war, terrorism, civil war or breach of law, • Any kind of service charge, surcharge, admission fees, registration fees levied by the hospital. (Note: the above is a partial listing of the policy exclusions. Please refer to the policy clauses for the full listing).	
4	**Waiting period**	• **Initial waiting period:** 30 days for all illnesses (not applicable on renewal or for accidents) • **Specific waiting periods :** o 12 months for xx diseases (clauses aa to bb) o 24 months for yy diseases (clauses cc to dd) o 36 months for zz diseases (clauses ee to ff) o 48 months for xx diseases (clauses gg to hh) • **Pre-existing diseases:** Covered after __ months/ Not covered	
5	**Payout basis**	• Reimbursement of covered expenses up to specified limits AND / OR • Fixed amount on the occurrence of a covered event	
6	**Cost sharing**	• In case of a claim, this policy requires you to share the following costs: o Expenses exceeding the following **Sub-limits** ▪ Room / ICU charges beyond _____ ▪ For the following specified diseases: ▪ _____ ▪ _____ o **Deductible** of Rs XXX per claim / per year / both o xx% of each claim as **Co-payment** (yy % in a non-network hospital)	
7	**Renewal Conditions**	• Your policy is ordinarily renewable (OR Guaranteed) up to age x (OR for x years) • After you attain the age of x years, the following features of your policy change: o ---------- o ---------- • Other terms and conditions of renewal	

(LEGAL DISCLAIMER) NOTE: The information must be read in conjunction with the product brochure and policy document. In case of any conflict between the KFD and the policy document the terms and conditions mentioned in the policy document shall prevail.

S. NO	TITLE	DESCRIPTION	REFER TO POLICY CLAUSE NUMBER
8.	**Renewal Benefits:**	• x% increase in your annual limit for every claim free year (or) x% discount on renewal premium, subject to a maximum of x%. • In case a claim is made during a policy year, the bonus proportion (or) discount would reduce by x% in the following year. • For every block of x claim free policy years, free health check up for the insured persons subject to maximum x% of sum insured.	
9.	**Cancellation**	• This policy would be cancelled, and no claim or refund would be due to you if: ○ you have not correctly disclosed details about your current and past health status OR ○ have otherwise encouraged or participated in any fraudulent claims under the policy.	

(LEGAL DISCLAIMER) NOTE: The information must be read in conjunction with the product brochure and policy document. In case of any conflict between the KFD and the policy document the terms and conditions mentioned in the policy document shall prevail.

20/02/2013

Annexure: VIII

Minimum Standard Clauses necessarily to be included in the Service Level Agreement between Insurer and the Third Party Administrator:

The services rendered by the TPA to the insurer shall be in accordance with the provisions of the Insurance Act, 1938, extant regulations, guidelines in this regard. The Authority may, from time to time, prescribe clauses to be included in the agreements which shall be entered into between insurers and TPAs and such agreements shall cover the following amongst others:

1. The specific services to be rendered by the TPA, the procedure, as prescribed by the insurer, to be followed by the TPA for providing each of such services as agreed to.
2. The fee payable to the TPA for each of the services rendered by the TPA as detailed below. The complete details on the basis on which payment becomes payable shall be documented.

Rate of Service Fee

Service Provided	Fee payable

3. Turnaround times for each of the services rendered by the TPA, the course of action in case of default of services.
4. The TPA / insurer responsibilities in enforcing the agreement.
5. Confidentiality requirements
6. Termination notice
7. Inspection, Audit and Access rights of the TPAs on regular and ad-hoc basis
8. Arbitration and Dispute resolution
9. The minimum details on the id-cards including photograph of the insured, name of the insurer, emergency contact number, logo of the insurer
10. Issue of ID cards, cost of issuing the ID cards and the course of action in case of default
11. Procedure for cashless facility as in Schedule-I
12. Procedure for de-empanelment of network providers as in Schedule-II
13. Customer services and relations
14. Services rendered by the TPA shall compliance with the extant laws.
15. Intimation of changes in the key positions in the office of the TPA.
16. Code of conduct.

Schedule-I

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., 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 the 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 immeidately.
3. In the 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 follwed, the clarification for the delay needs to be forwarded along with the request for authorization.
6. The RAL form shall be dully filled with clearly mentioning Yes or No and/or the details as required. The form shall not be sent with nil or blanks 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 i.e. non-medical items which are specifically excluded in the policy, like Telephone usage, food provided to relatives/attendants, Provider registration fees etc shall 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 event of the cost of treatment increasing, the 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 may require to provide valid reasons for the same. No enhancement of limit is possible after discharge of insured.
11. Further 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 insurer within 24 hours shall be construed as denial of the additional amount.

12. In case the insured has opted for a higher accommodation / facility than the one eligible under the polciy, the provider shall explain orally the effect of such option and also take a written consent from the insured 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 up gradation of room accommodation/facility. In all such cases the insuer shall pay for the expenses which are based on the eligibility limits of the insured. 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 48hours of receiving the RAL.
14. In case the ailment is not covered or given medical data is not sufficient for the medical team of authorization department to confirm the eligibility, insurer or its representative TPA shall seek further clarification/ information immeidately.
15. Authorisation 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 standar 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-authorised amount and actual bill, if any. Insurer, upon receipt of the complete bills and documents, shall make payments 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 the Provider shall return the amount to the insurer immediately.
19. All the payments in respect of pre-authorised amounts 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 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. Preauthorization Procedure – RTA / MLCs:

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 form.
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 does 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 leter 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 Authorization letter will 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 the room category, if any, is not 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-authorisation 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 investigation repots,

d. All original prescription & 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 insurer".
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 in the Provider.
4. Signature of the insured on final Provider bill shall be obtained.
5. In the event of death or incapacitation of the insured, the signature of the nominee or any of insured's of the family who represents the insured as such subject to reasonable satisfaction of Provider shall be sufficient for the insurer to consider the claim.
6. Standard Claim form duly filled in shall be presented to the insured for signing and identity of the insured shall be confirmed by the provider.

V. 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 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 provide; and.
   k. the insured's 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 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.

Schedule-II

PROCESS NOTE FOR DE-EMPANELMENT OF PROVIDERS

Process To Be Followed For De-Empanelment of Providers:

Step 1 – Putting the Provider on "Watch-list"

1. Based on the claims data analysis and/ or the Provider visits, if there is any doubt on the performance of a Provider, the Insurance Company can put that Provider on the watch list.
2. The data of such Provider shall be analysed very closely on a daily basis by the Insurance Company for patterns, trends and anomalies.

Step 2 – Suspension of the Provider

3. A Provider can be temporarily suspended in the following cases:
   a. For the Providers which are in the "Watch-list" if the Insurance Company observes continuous patterns or strong evidence of irregularity based on either claims data or field visit of Providers, the Provider shall be suspended from providing services to policyholders/insured patients and a formal investigation shall be instituted.
   b. If a Provider is not in the "Watch-list", but the insurance company observes at any stage that it has data/ evidence that suggests that the Provider is involved in any unethical practice/ is not adhering to the major clauses of the contract with the Insurance Company involved in financial fraud related to health insurance patients, it may immediately suspend the Provider from providing services to policyholders/insured patients and a formal investigation shall be instituted.
4. A formal letter shall be send to the Provider regarding its suspension with mentioning the timeframe within which the formal investigation will be completed.

Step 3 – Detailed Investigation

5. The Insurance Company can launch a detailed investigation into the activities of a Provider in the following conditions:
   a. For the Providers which have been suspended.
   b. Receipt of complaint of a serious nature from any of the stakeholders
6. The detailed investigation may include field visits to the Providers, examination of case papers, talking with the policyholders/insured (if needed), examination of Provider records etc.
7. If the investigation reveals that the report/ complaint/ allegation against the Provider is not substantiated, the Insurance Company would immediately revoke the suspension (in case it is suspended). A letter regarding revocation of suspension shall be sent to the Provider within 24 hours of that decision.

Step 4 – Action by the Insurance Company

8. If the investigation reveals that the complaint/allegation against the Provider is correct then following procedure shall be followed:
   a. The Provider must be issued a "show-cause" notice seeking an explanation for the aberration.
   b. After receipt of the explanation and its examination, the charges may be dropped or an action can be taken.

c. The action could entail one of the following based on the seriousness of the issue and other factors involved:
   i. A warning to the concerned Provider,
   ii. De-empanelment of the Provider.

9. The entire process should be completed within 30 days from the date of suspension.

Step 5 – Actions to be taken after De-empanelment

10. Once a Provider has been de-empanelled by insurer, following steps shall be taken:
   a. A letter shall be sent to the Provider regarding this decision.
   b. This information shall be sent to all the other Insurance Companies which are doing health insurance business.
   c. An FIR shall be lodged against the Provider by the insurer at the earliest in case the de-empanelment is on account of fraud or a fraudulent activity.
   d. The Insurance Company which had de-empanelled the Provider, may be advised to notify the same in the local media, informing all policyholders/insured about the de-empanelment, so that the beneficiaries do not utilize the services of that particular Provider.
   e. If the Provider appeals against the decision of the Insurance Company, the aforementioned actions shall be subject to the dispute resolution process agreed in the service level agreement.

Annexure - IX

Agreement between Insurers, Network Providers and/or TPAs

Insurance companies may offer policies providing cashless services to the policyholders provided the services are offered in network providers who have been enlisted to provide medical services either directly under an agreement with the insurer or by an agreement between health services provider, the TPA and the insurer. The provider empanelment shall be made based on the information furnished in the standard empanelment form as in Schedule-V. The Authority may, from time to time, prescribe clauses to be included in such agreements as stipulated in the Agreements which shall be entered into between insurers, network providers/TPAs and shall cover the following amongst others:

1. Scope of services provided by the network provider
2. the tariff applicable with respect to various kinds of healthcare services being provided by the network provider.
3. a clause empowering the insurer to cancel or otherwise modify the agreement in case of any fraud, misrepresentation, inadequacy of service or other non-compliance or default on the part of TPA or network provider; provided no such cancellation or modification shall be done by the insurer unless the concerned TPA/ network provider is given an opportunity of being heard.
4. a standard clause providing for continuance of services by a network provider to the insurance company if the TPA is changed or the agreement with TPA is terminated.
5. a clause providing for opting out of network provider from a given TPA for reasons of inadequacy of service rendered by the TPA to the network provider.
6. a clause specifically requiring only the insurance company the power to deny a claim.
7. a clause enabling insurer to inspect the premises of the network provider at any time without prior intimation.

8. Turnaround times for each of the services rendered by the parties, the course of action in case of default of services.
9. The responsibilities and obligations of each of the parties to the agreement in enforcing the agreement.
10. Display of information by the network provider at prominent location, preferably at the reception and admission counter and Casualty/Emergency departments.
11. Confidentiality requirements
12. Termination notice
13. Inspection, Audit and Access rights of the network providers and the TPAs involved on regular and ad-hoc basis
14. Arbitration and Dispute resolution
15. Procedure for cashless facility as in Schedule-I
16. Procedure for de-empanelment of network providers as in Schedule-II
17. Procedure to furnish the standard Discharge summary as in Schedule-III
18. Procedure to furnish the standard Billing Format as in Schedule-IV
19. Payments to be made through direct electronic fund transfer subject to deduction of tax at source as applicable under the relevant laws.
20. Payment Reconciliation process on a regular basis.
21. Customer services and relations
22. Services rendered by the TPA shall compliance with the extant laws.
23. Code of conduct.

STANDARD DISCHARGE SUMMARY:

1. Components of standardization:
    a. List of standard contents in the discharge summary
    b. Standard guidelines for preparing a discharge summary so that the interpretation of the terms in the document and the information provided is uniform.
2. Standard Contents of Discharge Summary Format:
    a. Patient's Name*:
    b. Telephone No / Mobile No*:
    c. IPD No:
    d. Admission No:
    e. Treating Consultant/s Name, contact numbers and Department/Specialty :
    f. Date of Admission with Time :
    g. Date of Discharge with Time :
    h. MLC No / FIR No*:
    i. Provisional Diagnosis at the time of Admission:
    j. Final Diagnosis at the time of Discharge:
    k. ICD-10 code(s) or any other codes, as recommended by the Authority, for Final diagnosis*:
    l. Presenting Complaints with Duration and Reason for Admission:
    m. Summary of Presenting Illness:
    n. Key findings, on physical examination at the time of admission:
    o. History of alcoholism, tobacco or substance abuse, if any:
    p. Significant Past Medical and Surgical History, if any*:
    q. Family History if significant/relevant to diagnosis or treatment :
    r. Summary of key investigations during Hospitalization*:
    s. Course in the Hospital including complications if any*:
    t. Advice on Discharge*:
    u. Name & Signature of treating Consultant/ Authorized Team Doctor:
    v. Name & Signature of Patient / Attendant*:

* refer to guide notes below:

3. GUIDE NOTES FOR FILLING DISCHARGE SUMMARY FORMAT:
    a. The patient's name shall be the official name as appearing in the insurance policy document and the attendants should be made aware that it cannot be changed subsequently, because in some cases the attendants give the nick names which are different from documented names. As a matter of abundant precaution, all personal information should be shown to the patient/attendant and validated with their signatures.
    b. The contact numbers shall be specifically those of the patient and if pertaining to attendant, the same should be mentioned.
    c. Where applicable, copy of MLC/FIR needs to be attached
    d. Desirable not mandatory
    e. Significant past medical and surgical history shall be relevant to present ailment and shall provide the summary of treatment previously taken, reports of relevant tests conducted during that period. In case history is not given by patient, it should be specified as to who provided the same.

f. Summary of key investigations shall appear chronologically consolidated for each type of investigation. If an investigation does not seem to be a logical requirement for the main disease/line of treatment, the admitting consultant should justify the reason for carrying out such test/investigation.

g. The course in the hospital shall specify the line of treatment, medications administered, operative procedure carried out and if any complications arise during course in the hospital, the same should be specified. If opinion from another doctor from outside hospital is obtained, reason for same should be mentioned and also who decided to take opinion i.e.whether the admitting and treating consultant wanted the opinion as additional expertise or the patient relatives wanted the opinion for their reassurance.

h. Discharge medication, precautions, diet regime, follow up consultation etc should be specified. If patient suffers from any allergy, the same shall be mentioned.

i. The signatures/Thumb impression in the Discharge Summary shall be that of the patient because generally the patient is discharged after having improved. In other cases like Death summary or transfer notes in case of terminal illness, the attendant can sign, the inability of the patient to sign should be recorded by the attending doctor.

STANDARD FORMAT FOR PROVIDER BILLS

1. **Components of standardization: Standardization involves three components:**
   i. Bill Format
   ii. Codes for billing items and nomenclature
   iii. Standard guidelines for preparing the bills.
2. Format Specified: The bill is expected to be in two formats.
   i. The summary bill and
   ii. The detailed breakup of the bills.
3. **Explanation and Guidelines – Summary Bill**
   i. The summary format is annexed in the Schedule-IV A
   ii. The Bill shall be generated on the letter head of the provider and in A4 size to aid scanning.
   iii. The summary bill shall not have any additional items (only 9)
   iv. The provider has to mention the service tax number in case they charge service tax to the insurance company.
   v. The payer mentioned in the bill has to be necessarily the insurance company and not the TPA.
   vi. In case of package charged for any procedure/treatment, the provider is expected to mention the amount in serial no 9 only. Items beyond the package are to be mentioned in serial numbers 1 to 8.
   vii. The patient/attendant signature is mandatory on the summary bill
   viii. The additional guidelines to fill the summary format shall be as below:

Field Name	**Remarks**
Provider Name	Legal entity name and not the trade name
Provider Registration Number	Registration number of the provider with local authorities. once the clinical establishments (registration and regulation) bill, 2007 is passed, then registration number under this act
Address	Address of the Facility where member is admitted. A provider can have more than one facility.
IP No	Unique number identifying the particular hospitalization of the member
Patient Name	Full name of the patient

Payer Name	Name of the Insurance company with whom the member is insured. In case of cash patient then the field is to be left blank. If the bill is raised to more than one insurer then the primary insurer who has given cashless is to be mentioned. The name of insurance company needs to be mentioned and not the TPA.
Member address	Full address of the member
Bill Number	Bill number of the provider
Bill Date	Date on which the bill is generated.
PAN Number	PAN Number – Mandatory
Service Tax Regn No	Registration number from service tax authorities. Mandatory in case service tax is charged in the bill
Date of admission	Date of admission of the member in case of IPD cases. In case of Day care procedures, this is the date of procedure
Date of discharge	Date of discharge of the member in case of IPD cases. In case of Day care procedures, this is the date of procedure(same as date of admission)
Bed Number	Bed number in which the patient is admitted. In case the member is admitted under more than one bed number, all the numbers have to be mentioned.
SL No 1 of billing Summary	All items under the primary head Rs. '100000' in the detailed bill have to be summarized into this. In case the procedure is packages, then only bills amount beyond the package needs to be mentioned here.
SL No 2 of billing Summary	All items under the primary head Rs.'200000' in the detailed bill have to be summarized into this. In case the procedure is packages, then only bills amount beyond the package needs to be

	mentioned here.
SL No 3 of billing Summary	All items under the primary head Rs. '300000' in the detailed bill have to be summarized into this. In case the procedure is packages, then only bills amount beyond the package needs to be mentioned here.
SL No 4 of billing Summary	All items under the primary head Rs.'400000' in the detailed bill have to be summarized into this. In case the procedure is packages, then only bills amount beyond the package needs to be mentioned here.
SL No 5 of billing Summary	All items under the primary head Rs.'500000' in the detailed bill have to be summarized into this. In case the procedure is packages, then only bills amount beyond the package needs to be mentioned here.
SL No 6 of billing Summary	All items under the primary head Rs.'600000' in the detailed bill have to be summarized into this. In case the procedure is packages, then only bills amount beyond the package needs to be mentioned here.
SL No 7 of billing Summary	All items under the primary head Rs.'700000' in the detailed bill have to be summarized into this. In case the procedure is packages, then only bills amount beyond the package needs to be mentioned here.
SL No 8 of billing Summary	All items under the primary head Rs.'800000' in the detailed bill have to be summarized into this. In case the procedure is packages, then only bills amount beyond the package needs to be mentioned here.
SL No 9 of billing Summary	All items under the primary head Rs.'900000' in the detailed bill have to be

	summarized into this. If more than one procedure is done, the total amount of the two procedures needs to be summarized
Total Bill amount	Sum total of all items 1 to 9 in the bill
Amount paid by the member	Amount of bill paid by the member including co-pay, deductible, non-medical items etc incl discount offered to member, if any.
Amount charged to Payer	Amount payable by Insurance company
Discount Amount	Amount offered as discount to the insurance company
Service tax	Service Tax chargeable to insurance company
Amount Payable	Total amount payable by insurance company including service tax
Amount in words	Above amount in words for the sake of clarity
Patients signature	Signature of the patient or the attendant of the patient needs to be mandatorily taken
Authorized signatory	The signature of the authorized signatory at the provider

4. Explanation and Guidelines – Detailed Breakup of the Bill

i. The summary format is annexed in Schedule-IV-B

ii. The Bill shall be generated on the letter head of the provider and in A4 size paper to aid scanning.

iii. The billing has to be done at level 2 or 3

iv. In case of medicines/consumables, the relevant level code has to be mentioned (40100, 401002) and the text should indicate the actual medicine used

v. If providers have outsourced the pharmacy to external vendors, in such cases the providers can attach the original bills separately. However, the summary of this original bill has to be mentioned in the summary bill.

vi. In case of pharmacy returns the same code originally used is to be used with a negative sign in the units.

vii. In case of cancellation of any service the same code originally used is to be used with a negative sign indicating reversal.

viii. The date on which the service is rendered is to be mentioned in the bill. This would be
   a. the date of requisition in case of investigations
   b. date of consultation for professional fees
   c. date of requisition in case of pharmacy/consumables irrespective of when they were used
   d. date of return of pharmacy items for pharmacy returns

ix. The additional guidelines to fill the summary format shall be as below, except that the first section of the bill is same as the bill summary referred in 3 above.

Field Name	**Remarks**
Date	Date on which service is rendered. For example, this is the date of investigation, date of procedure etc.
Code	Level 2 or 3 code of the billing item as per the codes(Part II)
Particulars	Text explanation of the item charged
Rate	Per unit price (per day room rent, per consultation charge)
Unit	No of units charged(hours, days, number as appropriate)
Amount	Rate*unit(s)

1. **Schedules:**

Schedule-IV A

SUMMARY BILL FORMAT

Provider Name	.....	Bill Number	.....
Provider registration No.		Bill Date	
Address		PAN Number	
IP No		Service Tax Regn No	
Patient Name		Date of admission	
Payer Name	XXXX Insurance Company Ltd	Date of Discharge	
Member Address		Bed Number	

Billing Summary

Sl No	Primary Code	Particulars	Amount
1	100000	Room & Nursing Charges	
2	200000	ICU Charges	
3	300000	OT Charges	
4	400000	Medicine & Consumables	
5	500000	Professional Fees'	
6	600000	Investigation Charges	
7	700000	Ambulance Charges	
8	800000	Miscellaneous Charges	
9	900000	Package Charges	

Total Bill Amount	0
Amount paid by member	0
Amount charged to Payer	0
Discount Amount	0
Service Tax	0
Amount Payable	0
Amount in Words	Rupees Zero Only

Patients Signature

Authorized Signatory

Schedule-IV B

DETAILED BREAKUP FORMAT

PART-I

Provider Name	....	Bill Number	....
Provider registration No.		Bill Date	
Address		PAN Number	
IP No		Service Tax Regn No	
Patient Name		Date of admission	
Payer Name		Date of Discharge	
Member Address		Bed Number	

Billing Details

Sl No	Date	Code	Particulars	Rate	Nos(Unit)	Amount
1		101001	General Ward Charges	500	1	500.00
2		401001	XXX medicine	50	2	100.00
3		401001	XXX Medicine – return	50	-1	-50.00

PART-II:

Level 1 Code	Level 1	Level 2 Code	Level 2	Level 3 Code	Level 3	Remarks
100000	Room & Nursing Charges					
100000	Room & Nursing Charges	101000	Room Charges			
100000	Room & Nursing Charges	101000	Room Charges	101001	General Ward charges	
100000	Room & Nursing Charges	101000	Room Charges	101002	Semi-private room charges	
100000	Room & Nursing Charges	101000	Room Charges	101003	Single Room charges	
100000	Room & Nursing Charges	101000	Room Charges	101004	Single Deluxe room charges	
100000	Room & Nursing Charges	101000	Room Charges	101005	Deluxe room charges	
100000	Room & Nursing Charges	101000	Room Charges	101006	Suite charges	
100000	Room & Nursing Charges	101000	Room Charges	101007	Electricity charges	
100000	Room & Nursing Charges	101000	Room Charges	101008	Bed sheet charges	
100000	Room & Nursing Charges	101000	Room Charges	101009	Hot water charges	
100000	Room & Nursing Charges	101000	Room Charges	101010	Establishment Charges	
100000	Room & Nursing Charges	101000	Room Charges	101011	Alpha/Water Bed Charges	
100000	Room & Nursing Charges	101000	Room Charges	101012	Attendant Bed Charges	
100000	Room & Nursing Charges	102000	Nursing charges			
100000	Room & Nursing Charges	102000	Nursing charges	102001	Nursing fees	
100000	Room & Nursing Charges	102000	Nursing charges	102002	Dressing	
100000	Room & Nursing Charges	102000	Nursing charges	102003	Nebulization	
100000	Room & Nursing Charges	102000	Nursing charges	102004	Injection charges	
100000	Room & Nursing Charges	102000	Nursing charges	102005	Infusion pump charges	
100000	Room & Nursing Charges	102000	Nursing charges	102006	Aya Charges	
100000	Room & Nursing Charges	102000	Nursing charges	102007	Blood Transfusion Charges	
100000	Room & Nursing Charges	103000	Duty Doctor fee			
100000	Room & Nursing Charges	103000	Duty Doctor fee	103001	Duty Doctor fee	
100000	Room & Nursing Charges	103000	Duty Doctor fee	103002	RMO Fees	
100000	Room & Nursing Charges	104000	Monitor charges			
100000	Room & Nursing Charges	104000	Monitor charges	104001	Pulse Oxymeter charges	If used in normal Room
200000	ICU Charges					
200000	ICU Charges	201000	ICU Charges			
200000	ICU Charges	201000	ICU Charges	201001	Burns Ward	
200000	ICU Charges	201000	ICU Charges	201002	HDU charges	
200000	ICU Charges	201000	ICU Charges	201003	ICCU charges	
200000	ICU Charges	201000	ICU Charges	201004	Isolation ward charges	
200000	ICU Charges	201000	ICU Charges	201005	Neuro ICU charges	
200000	ICU Charges	201000	ICU Charges	201006	Pediatric/neonatal ICU charges	
200000	ICU Charges	201000	ICU Charges	201007	Post Operative ICU	
200000	ICU Charges	201000	ICU Charges	201008	Recovery Room	
200000	ICU Charges	201000	ICU Charges	201009	Surgical ICU	
200000	ICU Charges	202000	ICU Nursing charges			If ICU nursing charged seperatel y

200000	ICU Charges	202000	ICU Nursing charges	202001	Nursing fees	If ICU nursing charged seperatel y
200000	ICU Charges	202000	ICU Nursing charges	202002	Dressing	If ICU nursing charged seperatel y
200000	ICU Charges	202000	ICU Nursing charges	202003	Nebulization	If ICU nursing charged seperatel y
200000	ICU Charges	202000	ICU Nursing charges	202004	Injection charges	If ICU nursing charged seperatel y
200000	ICU Charges	202000	ICU Nursing charges	202005	Infusion pump charges	
200000	ICU Charges	203000	Monitor charges			
200000	ICU Charges	203000	Monitor charges	203001	Monitor charges	
200000	ICU Charges	203000	Monitor charges	203002	Pulse Oxymeter charges	If used in ICU
200000	ICU Charges	203000	Monitor charges	203003	Cardiac Monitor charges	
200000	ICU Charges	204000	Monitor charges	203004	IABP charges	
200000	ICU Charges	204000	Monitor charges	203005	Phototherapy Charges	
200000	ICU Charges	204000	ICU Supplies & equipment			
200000	ICU Charges	204000	ICU Supplies & equipment	204001	Oxygen charges	
200000	ICU Charges	204000	ICU Supplies & equipment	204002	Ventilator charges	
200000	ICU Charges	204000	ICU Supplies & equipment	204003	Suction pump charges	
200000	ICU Charges	204000	ICU Supplies & equipment	204004	Bipap charges	
200000	ICU Charges	204000	ICU Supplies & equipment	204005	Pacing Charges	Tempora ry Pacemak er
200000	ICU Charges	204000	ICU Supplies & equipment	204006	Defibrillator Charges	
300000	OT Charges					
300000	OT Charges	301000	OT rent			
300000	OT Charges	301000	OT rent	301001	Major OT charge	
300000	OT Charges	301000	OT rent	301002	Minor OT Charge	
300000	OT Charges	301000	OT rent	301003	Cath Lab Charges	
300000	OT Charges	301000	OT rent	301004	Theatre charges	
300000	OT Charges	301000	OT rent	301005	Labour Room Charges	
300000	OT Charges	302000	OT Equipment charges			

300000	OT Charges	302000	OT Equipment charges	302001	C-arm charges	
300000	OT Charges	302000	OT Equipment charges	302002	Endoscopy charges	
300000	OT Charges	302000	OT Equipment charges	302003	Laproscope charges	
300000	OT Charges	302000	OT Equipment charges	302004	Equipment charges	If not specified
300000	OT Charges	302000	OT Equipment charges	302005	Monitor charges	for OT monitoring
300000	OT Charges	302000	OT Equipment charges	302006	Instrument charges	for OT instruments
300000	OT Charges	303000	OT Drugs & Consumables			
300000	OT Charges	303000	OT Drugs & Consumables	303001	OT Drugs	
300000	OT Charges	303000	OT Drugs & Consumables	303002	Implants	
300000	OT Charges	303000	OT Drugs & Consumables	303003	OT Consumables	includes guidewires, catheter etc
300000	OT Charges	303000	OT Drugs & Consumables	303004	OT Materials	
300000	OT Charges	303000	OT Drugs & Consumables	303005	OT Gases	
300000	OT Charges	303000	OT Drugs & Consumables	303006	Anaesthetic drugs	
300000	OT Charges	304000	OT Sterlization			
300000	OT Charges	304000	OT Sterlization	304001	CSSD Charges	
400000	Medicine & Consumables charges					
400000	Medicine & Consumables charges	401000	Medicine & Consumables charges			
400000	Medicine & Consumables charges	401000	Medicine & Consumables charges	401001	Ward Medicines	OT drugs under OT charges
400000	Medicine & Consumables charges	401000	Medicine & Consumables charges	401002	Ward Consumables	
400000	Medicine & Consumables charges	401000	Medicine & Consumables charges	401003	Ward disposables	
400000	Medicine & Consumables charges	401000	Medicine & Consumables charges	401004	Ward Materials	
400000	Medicine & Consumables charges	401000	Medicine & Consumables charges	401005	Vaccination drugs	
500000	Professional fees charges					
500000	Professional fees charges	501000	Visit charges			

500000	Professional fees charges	501000	Visit charges	501001	Consultation Charges	
500000	Professional fees charges	501000	Visit charges	501002	Medical Supervision Charges	
500000	Professional fees charges	501000	Visit charges	501003	Professional fees	
500000	Professional fees charges	502000	Surgery Charges			
500000	Professional fees charges	502000	Surgery Charges	502001	Surgeons Charges	
500000	Professional fees charges	502000	Surgery Charges	502002	Assisstant Surgeons Fee	Would also include Standby Surgeon
500000	Professional fees charges	503000	Anaesthetists fee			
500000	Professional fees charges	503000	Anaesthetists fee	503001	Anaesthetists fee	
500000	Professional fees charges	503000	Anaesthetists fee	503002	OT standby charges	Providers charge for standby anaesthetist
500000	Professional fees charges	504000	Intensivist Charges	504000		
500000	Professional fees charges	505000	Technician Charges	505000	OT /Cath Lab Technician	
500000	Professional fees charges	505000	Physiotherapy			
500000	Professional fees charges	504000	Procedure charges			
500000	Professional fees charges	504000	Procedure charges	504001	Bedside procedures	Catheterization, Central IV Line, Tracheostomy, Venesection
500000	Professional fees charges	504000	Procedure charges	504002	Suture charges	
600000	Investigation Charges					
600000	Investigation Charges	601000	Bio Chemistry			Serum Sodium, Ueres etc
600000	Investigation Charges	602000	Cardiology charges			for procedures like echo, ECG etc
600000	Investigation Charges	603000	Haemotology charges			cross matching etc
600000	Investigation Charges	604000	Microbiology charges			blood culture, C&S
600000	Investigation Charges	605000	Neurology			for EMG, EEG etc

600000	Investigation Charges	606000	Nuclear medicine			PET CT, Bone scan etc
600000	Investigation Charges	607000	Pathology charges			
600000	Investigation Charges	608000	Radiology services			X-ra, CT, MRI etc
600000	Investigation Charges	609000	Serology charges			
600000	Investigation Charges	610000	Medical Genetics			Chrosom al Analysis etc
600000	Investigation Charges	611000	Profiles			Profiles instead of individua l tests (Lipid profile, LFT etc)
700000	Ambulance Charges					
700000	Ambulance Charges	701000	Ambulance Charges			
800000	Miscellaneous charges					
800000	Miscellaneous charges	801000	Admission charges			
800000	Miscellaneous charges	802000	Attendant food charges			
800000	Miscellaneous charges	803000	Patient food charges			
800000	Miscellaneous charges	804000	Registration charges			
800000	Miscellaneous charges	805000	MRD Charges			
800000	Miscellaneous charges	806000	Documentation charges			
800000	Miscellaneous charges	807000	Telephone charges			
800000	Miscellaneous charges	808000	Bio Medical Waste Charges			
800000	Miscellaneous charges	809000	Taxes		Luxury Tax/Surcharge/Service Charge	Excluding VAT & Service Tax
900000	Package Charges					To be used only in case of packages
900000	Package Charges	901000	Cardiac Surgery	ICD-10-PCS	CABG	To be used only in case of packages

900000	Package Charges	902000	CardiologyPackages	ICD-10-PCS	PTCA	To be used only in case of packages
900000	Package Charges	903000	Cath Lab	ICD-10-PCS	CAG	To be used only in case of packages
900000	Package Charges	904000	Dental Procedures	ICD-10-PCS	Root Canal Treatment	To be used only in case of packages
900000	Package Charges	905000	ENT	ICD-10-PCS	FESS	To be used only in case of packages
900000	Package Charges	906000	Gastroenterology	ICD-10-PCS	Gastrectomy - Partial	To be used only in case of packages
900000	Package Charges	907000	General Surgery	ICD-10-PCS	Inguinal hernia	To be used only in case of packages
900000	Package Charges	908000	Gynaecology	ICD-10-PCS	LSCS	To be used only in case of packages
900000	Package Charges	909000	Nephrology	ICD-10-PCS	Nephrectomy	To be used only in case of packages
900000	Package Charges	910000	Neuro Surgery	ICD-10-PCS	Craniotomy	To be used only in case of packages
900000	Package Charges	911000	Oncology Procedures	ICD-10-PCS	IMRT	To be used only in case of packages
900000	Package Charges	912000	Opthalmology procedures	ICD-10-PCS	Cataract	To be used only in case of packages

900000	Package Charges	913000	Orthopaedic Surgery	ICD-10-PCS	Bilateral TKR	To be used only in case of packages
900000	Package Charges	914000	Plastic Surgery	ICD-10-PCS	Skin Grafting	To be used only in case of packages
900000	Package Charges	915000	Pulmonology Packages	ICD-10-PCS	Pleural Tapping	To be used only in case of packages
900000	Package Charges	916000	Urology	ICD-10-PCS	ERCP	To be used only in case of packages
900000	Package Charges	917000	Vascular Surgery	ICD-10-PCS	Embolectomy	To be used only in case of packages