HDFC ERGO General Insurance Company Limited

REQUEST FOR CASHLESS HOSPITALISATION FOR HEALTH INSURANCE POLICY PART - C

DETAILS OF THE THIRD PARTY ADMINISTRATOR/ INSURER/ HOSPITAL (All fields are mandatory and fill in CAPITALS only)

a) Name of the TPA/ Insurance Company: **HDFC ERGO General Insurance Company Limited**

b) Customer service no: 022 - 6234 6234 / 0120 - 6234 6234

c) Name of Hospital: _____

i. Address _____

ii. Rohini ID _____

iii. E-mail id _____

TO BE FILLED BY INSURED/ PATIENT

a) Name of the Patient: (First Name) (Middle Name) (Last Name)

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

e) Contact Number: f) Contact number of attending relative:

g) Insured Member ID card No: h) Policy No./Name of Corporate:

I) Employee ID

j) Currently do you have any Mediclaim/Health Insurance: ☐ Yes ☐ No

i) Company Name:

ii) Give details:

k) Do you have a family physician: ☐ Yes ☐ No l) Name of the family physician:

m) Contact No, if any

n) Current Address of Insured Patient

o) Occupation of Insured Patient

(PLEASE COMPLETE DECLARATION OF THIS FORM)

TO BE FILLED BY 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 present ailment: ☐☐☐ Days i) Date of first consultation: D D M M Y Y Y Y ii) Past history of present ailment, if any

f) Provisional Diagnosis i) ICD Code:

g) Proposed line of treatment ☐ i) Medical Management ☐ ii) Surgical Management ☐ iii) Intensive Care ☐ iv) Investigation ☐ v) Non allopathic treatment

h) If investigational &/or Medical Management provide details i) Route of drug administration

I) If surgical name of surgery i) ICD 10 PCS code

j) If other treatment provide details k) How did injury occur

l) In case of Accident: i. Is it RTA: ☐ Yes ☐ No ii. Date of injury: D D M M Y Y Y Y iii. Reported to 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 report)

m) In case of Maternity ☐ G ☐ P ☐ L ☐ A

i) Expected date of Delivery D D M M Y Y Y Y

Details of patient admitted

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

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

e) Expected No. of days stay in hospital: ☐☐☐ Days

f) Days in ICU: ☐☐☐ Days g) Room Type

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

I) Expected cost for investigation + diagnostics Rs.

j) ICU Charges Rs.

k) OT Charges Rs.

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

m) Medicines + Consumables + Cost of Implants (if applicable please specify). Rs.

n) Other hospital expenses if any Rs.

o) All inclusive package charges if any applicable Rs.

p) Sum Total expected cost of hospitalization Rs.

d) Mandatory Past history of any chronic illness If yes, since (month/year)

- ☐ i) Diabetes D D M M
- ☐ ii) Heart Disease D D M M
- ☐ iii) Hypertension D D M M
- ☐ iv) Hyperlipidemias D D M M
- ☐ v) Osteoarthritis D D M M
- ☐ vi) Asthma/ COPD/ Bronchitis D D M M
- ☐ vii) Cancer D D M M
- ☐ viii) Alcohol or drug abuse D D M M
- ☐ ix) Any HIV or STD / Related ailments D D M M

x) Any other Ailment give details:

DECLARATION (Please read carefully)

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

a) Name of the treating doctor :

b) Qualification :

c) Registration No. with state code:

Hospital Seal (Must include Hospital ID)

Patient/ Insured Name & Signature

DECLARATION BY THE PATIENT / REPRESENTATIVE

a. 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.
b. Payment to hospital is governed by the terms and conditions of the policy. In case the Insurer /TPA is not liable to settle the hospital bill, I undertake to settle the bill as per the terms and conditions of the policy.
c. All non-medical expenses and expenses not relevant to current hospitalization and the amounts over & above the limit authorized by the Insurer/T.P.A not governed by the terms and conditions of the policy will be paid by me.
d. I hereby declare to abide by the terms and conditions of the policy and if at any time the facts disclosed by me are found to be false or incorrect I forfeit my claim and agree to indemnify the Insurer / T.P.A
e. 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.
f. I hereby warrant the truth of the forgoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppression or concealment with respect to the claim, my right to claim reimbursement of the said expenses shall be absolutely forfeited.
g. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer / TPA.
h. "I/We authorize Insurance Company/TPA to contact me/us through mobile/email for any update on this claim".

Patient's/ Insured's Name:_____

Contact No.:_____ E-mail Id (optional): _____

Patient's/ Insured's Signature:_____

Date:_____ Time: _____

HOSPITAL DECLARATION

a. We have no objection to any authorized TPA / Insurance Company official verifying documents pertaining to hospitalization.
b. All valid original documents duly countersigned by the insured/patient as per the checklist below will be sent to TPA / Insurance Company within 7 days of the patient's discharge.
c. We agree that TPA /Insurance Company will not be liable to make the payment in the between the facts in this form and discharge summary or other documents
d. The patient declaration has been signed by the patient or by his representative in our presence.
e. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications
f. We will abide by the terms and conditions agreed in the MOU.
g. We confirm that no additional amount would be collected from the insured in excess of Agreed Package Rates except costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility/choosing separate line of treatment which is not envisaged/considered in package).
h. We confirm that no recoveries would be made from the deposit amount collected from the Insured except for costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility/ choosing separate line of treatment which is not envisaged/considered in package).
I. In the event of unauthorized recovery of any additional amount from the Insured in excess of Agreed Package Rates, the authorized TPA / Insurance Company reserves the right to recover the same from us (the Network Provider) and/or take necessary action, as provided under the MOU or applicable laws.

Hospital Seal

Doctor's Signature

Date:_____ Time: _____

CENTRAL KYC REGISTRY | Know Your Customer (KYC) Application Form | Individual

Instructions:
A) Fields marked with '*'are mandatory fields.
B) Please Fill the form in English and in BLOCK Letters.
C) Please read guidelines / detailed instructions overleaf
D) List of Two character ISO-3166 country codes are available overleaf

Application Type : ❑ New ❑ Update
Account Type* : ❑ Normal ❑ Small
KYC Number :

❑ PERSONAL DETAILS

❑ PHOTO

Signature / Thumb Impression

Name* *(Same as ID proof)* : Prefix First Name Middle Name Last Name
Maiden Name (If any*) : Prefix First Name Middle Name Last Name
Father / Spouse Name* : Prefix First Name Middle Name Last Name
Mother Name* : Prefix First Name Middle Name Last Name
Date of Birth* : D D - M M - Y Y Y Y Gender* : ❑ Male ❑ Female ❑ Transgender
Marital Status* : ❑ Married ❑ Unmarried Nationality* : ❑ Indian ❑ Others Country Name
Residential Status* : ❑ Resident Individual ❑ Non Resident Indian ❑ Foreign National ❑ Person of Indian Origin
Occupation* : ❑ Private Sector Service ❑ Public Sector ❑ Government Sector ❑ Business ❑ Professional
❑ Self Employed ❑Retired ❑Housewife ❑ Student❑ Other Please Specify
Tick if applicable : ❑ Residence for Tax purposes in jurisdiction(s) outside India

ADDITIONAL DETAILS REQUIRED* *(If Applicant is resident outside India for Tax purposes)*
(Please read guidelines / details for 'Jurisdiction of Residence' and 'Tax Identification Number')
ISO -3166 Country Code of Jurisdiction of Residence* :
Tax Identification Number or equivalent (If issued by jurisdiction)* :
Place / City of Birth* : ISO -3166 Country Code of Birth* :

❑ PROOF OF IDENTITY (PoI)* *(One Certified Copy of any one of the following Proof of Identity[PoI] needs to be submitted)*

❑ PAN : ❑ UID (Aadhaar) :
❑ Voter ID Card : ❑ NREGA Job Card :
❑ Passport Number : Passport Expiry Date : D D - M M - Y Y Y Y
❑ Driving License : Driving License Expiry Date : D D - M M - Y Y Y Y
❑ Others (any document notified by the central government) :

❑ PROOF OF ADDRESS (PoA)

CURRENT / PERMANENT / OVERSEAS ADDRESS DETAILS *(One Certified Copy of any one of the following Proof of Address [PoA] needs to be submitted)*
Line 1* :
Line 2 :
Line 3 : City / Town / Village :
State/U.T* : Pin / Post code : ISO -3166 Country Code :
Proof of Address* : ❑ Passport ❑ Driving License ❑ Aadhaar Card ❑ Voter Identity Card ❑ NREGA CARD ❑ Others Please Specify

CORRESPONDENCE / LOCAL ADDRESS DETAILS *(In case the PoA is not the local address or address where the customer is currently residing. To be declared only and no PoA is required)*
❑ Same as Current / Permanent / Overseas Address details *(In case of multiple correspondence / local addresses, Please fill 'Annexure A1')*
Line 1* :
Line 2 :
Line 3 : City / Town / Village :
State/U.T* : Pin / Post code : ISO -3166 Country Code :

ADDRESS IN THE JURISDICTION DETAILS WHERE APPLICANT IS RESIDENT * *(If Applicant is resident outside India for Tax purposes)*
❑ Same as Current / Permanent / Overseas Address details ❑ Same as Correspondence / Local Address details
Line 1* :
Line 2 :
Line 3 : City / Town / Village :
State/U.T* : Pin / Post code : ISO -3166 Country Code :

❑ CONTACT DETAILS *(Communications will be done on provided Mobile no. and Email-ID)*

Tel. (Off) : STD CODE Tel. (Res) : STD CODE Mobile :
FAX : STD CODE Email ID :

❑ DETAILS OF RELATED PERSON *(In case of additional related persons, Please fill 'Annexure B1' form)*

❑ Addition of Related Person ❑ Deletion of Related Person KYC Number (if available) :
Related Person Type: ❑Guardian Of Minor ❑Nominee ❑Assignee ❑Authorized Representative ❑Beneficial Owner ❑Beneficiary
Name*: Prefix First Name Middle Name Last Name

PROOF OF IDENTITY (PoI)* *(Mandatory if KYC number is not available. One Certified Copy of any one of the following Proof of Identity[PoI] needs to be submitted)*

❑ PAN : ❑ UID (Aadhaar) :
❑ Voter ID Card : ❑ NREGA Job Card :
❑ Passport Number : Passport Expiry Date : D D - M M - Y Y Y Y
❑ Driving License : Driving License Expiry Date : D D - M M - Y Y Y Y
❑ Others (any document notified by the central government) :

❑ OTHER DETAILS

Income Range : ❑ Below 1 Lac ❑ 5 Lac to 10 Lac ❑ 10 Lac to 15 Lac ❑ 15 Lac to 25 Lac❑ 25 Lac and above
Net Worth (In INR) : As on : D D - M M - Y Y Y Y
Educational Qualification : ❑Below SSC ❑SSC ❑HSC ❑Graduate ❑ Masters ❑Professional (CA, CS, CMA, Others)
Please Tick If Applicable : ❑Politically Exposed Person ❑Related to Politically Exposed Person
AnyOther Information :

APPLICANT DECLARATION

I hereby declare that the details furnished above are true and correct to the best of my/our knowledge and belief and I undertake to inform you of any changes therein, immediately. In case any of the above information is found to be false or untrue or misleading or misrepresenting, I am/we are aware that I/we may be held liable for it.

I would like to share my personal / KYC details with Central KYC Registry.

[Signature / Thumb Impression]

❑ Signature / thumb Impression of Applicant

Place :
Date :

ATTESTATION / FOR OFFICE USE ONLY

Documents Received : ❑Self-Certified ❑True Copies ❑Notary
Risk Category : ❑High ❑Medium ❑Low

IN PERSON VERIFICATON DETAILS

Identity Verification : ❑ Done
Date : D D - M M - Y Y Y Y
Emp. Name :
Emp. Code :
Emp. Designation :
Emp. Branch :
Signature :

[Employee Signature]

INSTITUTION DETAILS

Name :
Code :
Stamp :

[Institution Stamp]

INSTRUCTIONS

Important Points

a) Application should be completed in **ENGLISH** and in **BLOCK** letters
b) **KYC Number** is Mandatory for UPDATE Application.
c) Tick '✓' wherever applicable.
d) Tick '✓' in the respective section heading for updation
e) Please fill the form in **legible handwriting** so as to avoid errors in your application processing. Please do not overwrite. Corrections should be made by cancelling and re-writing and such corrections should be countersigned by the client.
f) You are required to submit a **Proof of Identity** and **Proof of Address** for Current/Permanent/Overseas address provided by you.
g) **Name**: Please state your name as Prefix (Mr/Mrs/Ms/Dr/etc.), First, Middle and Last Name in the space provided. This should match the name as mentioned in the Proof of Identity submitted failing which the application is liable to be rejected.
h) **Pin/Post Code** is not mandatory if country is other than India
i) Please provide additional details wherever required if **Applicant resident outside India or Tax Purposes**
j) For Individuals:
   a. Please fill 'Annexure A1' for **multiple addresses** Details.
   b. Please fill 'Annexure B1' for **Related Person** Details.

ISO 3166 Two Digit Country Code

Country	Country Code	Country	Country Code	Country	Country Code	Country	Country Code
Afghanistan	AF	Dominican Republic	DO	Libya	LY	Saint Pierre and Miquelon	PM
Aland Islands	AX	Ecuador	EC	Liechtenstein	LI	Saint Vincent and the Grenadines	VC
Albania	AL	Egypt	EG	Lithuania	LT	Samoa	WS
Algeria	DZ	El Salvador	SV	Luxembourg	LU	San Marino	SM
American Samoa	AS	Equatorial Guinea	GQ	Macao	MO	Sao Tome and Principe	ST
Andorra	AD	Eritrea	ER	Macedonia, the former Yugoslav Republic of	MK	Saudi Arabia	SA
Angola	AO	Estonia	EE	Madagascar	MG	Senegal	SN
Anguilla	AI	Ethiopia	ET	Malawi	MW	Serbia	RS
Antarctica	AQ	Falkland Islands (Malvinas)	FK	Malaysia	MY	Seychelles	SC
Antigua and Barbuda	AG	Faroe Islands	FO	Maldives	MV	Sierra Leone	SL
Argentina	AR	Fiji	FJ	Mali	ML	Singapore	SG
Armenia	AM	Finland	FI	Malta	MT	Sint Maarten (Dutch part)	SX
Aruba	AW	France	FR	Marshall Islands	MH	Slovakia	SK
Australia	AU	French Guiana	GF	Martinique	MQ	Slovenia	SI
Austria	AT	French Polynesia	PF	Mauritania	MR	Solomon Islands	SB
Azerbaijan	AZ	French Southern Territories	TF	Mauritius	MU	Somalia	SO
Bahamas	BS	Gabon	GA	Mayotte	YT	South Africa	ZA
Bahrain	BH	Gambia	GM	Mexico	MX	South Georgia and the South Sandwich Islands	GS
Bangladesh	BD	Georgia	GE	Micronesia, Federated States of	FM	South Sudan	SS
Barbados	BB	Germany	DE	Moldova, Republic of	MD	Spain	ES
Belarus	BY	Ghana	GH	Monaco	MC	Sri Lanka	LK
Belgium	BE	Gibraltar	GI	Mongolia	MN	Sudan	SD
Belize	BZ	Greece	GR	Montenegro	ME	Suriname	SR
Benin	BJ	Greenland	GL	Montserrat	MS	Svalbard and Jan Mayen	SJ
Bermuda	BM	Grenada	GD	Morocco	MA	Swaziland	SZ
Bhutan	BT	Guadeloupe	GP	Mozambique	MZ	Sweden	SE
Bolivia, Plurinational State of	BO	Guam	GU	Myanmar	MM	Switzerland	CH
Bonaire, Sint Eustatius and Saba	BQ	Guatemala	GT	Namibia	NA	Syrian Arab Republic	SY
Bosnia and Herzegovina	BA	Guernsey	GG	Nauru	NR	Taiwan, Province of China	TW
Botswana	BW	Guinea	GN	Nepal	NP	Tajikistan	TJ
Bouvet Island	BV	Guinea-Bissau	GW	Netherlands	NL	Tanzania, United Republic of	TZ
Brazil	BR	Guyana	GY	New Caledonia	NC	Thailand	TH
British Indian Ocean Territory	IO	Haiti	HT	New Zealand	NZ	Timor-Leste	TL
Brunei Darussalam	BN	Heard Island and McDonald Islands	HM	Nicaragua	NI	Togo	TG
Bulgaria	BG	Holy See (Vatican City State)	VA	Niger	NE	Tokelau	TK
Burkina Faso	BF	Honduras	HN	Nigeria	NG	Tonga	TO
Burundi	BI	Hong Kong	HK	Niue	NU	Trinidad and Tobago	TT
Cabo Verde	CV	Hungary	HU	Norfolk Island	NF	Tunisia	TN
Cambodia	KH	Iceland	IS	Northern Mariana Islands	MP	Turkey	TR
Cameroon	CM	India	IN	Norway	NO	Turkmenistan	TM
Canada	CA	Indonesia	ID	Oman	OM	Turks and Caicos Islands	TC
Cayman Islands	KY	Iran, Islamic Republic of	IR	Pakistan	PK	Tuvalu	TV
Central African Republic	CF	Iraq	IQ	Palau	PW	Uganda	UG
Chad	TD	Ireland	IE	Palestine, State of	PS	Ukraine	UA
Chile	CL	Isle of Man	IM	Panama	PA	United Arab Emirates	AE
China	CN	Israel	IL	Papua New Guinea	PG	United Kingdom	GB
Christmas Island	CX	Italy	IT	Paraguay	PY	United States	US
Cocos (Keeling) Islands	CC	Jamaica	JM	Peru	PE	United States Minor Outlying Islands	UM
Colombia	CO	Japan	JP	Philippines	PH	Uruguay	UY
Comoros	KM	Jersey	JE	Pitcairn	PN	Uzbekistan	UZ
Congo	CG	Jordan	JO	Poland	PL	Vanuatu	VU
Congo, the Democratic Republic of the	CD	Kazakhstan	KZ	Portugal	PT	Venezuela, Bolivarian Republic of	VE
Cook Islands	CK	Kenya	KE	Puerto Rico	PR	Viet Nam	VN
Costa Rica	CR	Kiribati	KI	Qatar	QA	Virgin Islands, British	VG
Cote d'Ivoire !Côte d'Ivoire	CI	Korea, Democratic People's Republic of	KP	Reunion !Réunion	RE	Virgin Islands, U.S.	VI
Croatia	HR	Korea, Republic of	KR	Romania	RO	Wallis and Futuna	WF
Cuba	CU	Kuwait	KW	Russian Federation	RU	Western Sahara	EH
Curacao !Curaçao	CW	Kyrgyzstan	KG	Rwanda	RW	Yemen	YE
Cyprus	CY	Lao People's Democratic Republic	LA	Saint Barthelemy !Saint Barthélemy	BL	Zambia	ZM
Czech Republic	CZ	Latvia	LV	Saint Helena, Ascension and Tristan da Cunha	SH	Zimbabwe	ZW
Denmark	DK	Lebanon	LB	Saint Kitts and Nevis	KN		
Djibouti	DJ	Lesotho	LS	Saint Lucia	LC		
Dominica	DM	Liberia	LR	Saint Martin (French part)	MF		

Foot Notes

(A) **Jurisdiction (s) of Residence:** It may be mentioned that since US taxes the global income of its citizen, every US citizen if whatever nationality, is also a resident for tax purpose in USA.
(B) **Tax identification Number (TIN):** In the footnote it may be mentioned that TIN need not be reported if it has not been issued by the jurisdiction. However, if the said jurisdiction has issued by high integrity number with an equivalent level of identification (a "Functional equivalent"), the same may be reported. Examples of that type of number for individual include, a social security/insurance number, citizen/personal identification/services code/number, and resident registration number)

BREACH CANDY HOSPITAL TRUST

Cashless Consent Form – Third Party Administrator (TPA)

- I have been explained in details about the cashless facilities at Breach Candy Hospital Trust. I undertake not to hold the hospital responsible for any delay in getting approval or extensions from TPA.

- I have understood that such approvals are my responsibility and the hospital renders this service as a value addition only.

- I will be admitted on the basis of authorization letter received from the insurance Co / TPA which is only a provisional authorization.

- In the absence of an authorization letter, I would be admitted as a "Cash" patient. I would be required to pay the requisite deposit on admission & subsequently clear all hospital bills.

- In case of emergency admission, if the authorization is not received from the insurance Co. / TPA, then I would undertake to clear the bills of the hospital.

- I would have to clear all bills related to exclusions as stated by the Insurance Co. / TPA

- I am aware that subsequent to the pre-authorization and admission a request for confirmation of claim payable is sent to TPA. Only on confirmation from TPA, I will be treated as TPA (Cashless Facility)

- In case I undergo treatment for which the Insurance Co / TPA withdraws authorization or rejects the claim, then I would clear all hospital bills of the hospital.

- I would be required to pay security deposit 48 hrs before the admission. The same will be refunded on settlement from the Insurance Co/ TPA.

- The hospital is not responsible for refusal on part of TPA for reimbursement of my claims.

- I am aware that the original reports and original discharge card are handed over to the Insurance Co/ TPA.

- I am aware that I have to show the copy of the pre-authorization form at the reception on the day of admission to get the cashless benefit.

- I am aware that in planned admission I have to submit the pre-authorization form one week prior to admission and in emergency within 24 hrs. of admission.

- I agree to pay the over and above bill of the approval amount and that I will not seek reimbursement for the same.

Signature of the Patient _____ Signature of the Relative _____

Name of the Patient _____ Name the of Relative _____