Process to avail Cashless Anywhere

1. Insured/ Hospital must share the Preauthorization Form to SBIG team 48 hours before an elective procedure and within 48 hours for an Emergency Treatment.
2. Pre-authorization request must be sent at cashlessforall.health@sbigeneral.in

   Intimation must also be provided at our toll free 1800 210 3366 / 1800 210 6366.
3. Pre-authorization not received **48 hours before admission for elective procedures** OR after **48 hours after admission for emergency procedures** shall not be considered under the "cashless anywhere" process.
4. On receipt of the Preauthorization Form, SBIG claims team will review the Pre-authorization Form and notify the Customer and the Hospital of our approval, denial or requirement of additional information for Cashless Facility.
5. If the Hospital is Non-Network or affiliated with another insurer, the SBIG Team will request for a mutual agreement with Hospital to extent the cashless facility. Acceptance of the terms of the agreement by the hospital is mandatory for cashless facility being allowed.

Letter on consent from Hospital (Non-Network) to extend cashless

LETTER OF CONSENT

Ref No: - **Date: -**

Hospital Name:
Hospital Address:

Sub: Letter of Consent for extending Cashless to the beneficiaries of "Insurance Company Name"

"**Insurance Company Name**" (hereinafter referred to as "the company ") has agreed to enter into a business arrangement with **"Provider Name"** for providing cashless to beneficiaries of "**Insurance Company Name"** Health Policy. This letter contemplates that both the company and **Provider agrees** to abide by the terms as mentioned below

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

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

3. The Hospital shall allow "**Insurance Company Name**" to conduct audits of the bills as and when necessary, by deemed "**Insurance Company Name**". Such audits shall be conducted by "**Insurance Company Name** "audit team without prior intimation to the Hospital.

4. Hospital will submit all the documents within 15 days from the date of the discharge of the patient/Insured Beneficiary and **Insurance Company Name** will make payment of eligible bills within 30 days from the date of receipt of such submission. However, if required, Insurance Company Name "can call for further document related to treatment to process the case, in which case the payment may be delayed beyond 30 days as contemplated herein (Depending on the query response received from the Hospital)
5. The Hospital also hereby indemnify and keep <**Insurer name**> Indemnified for its breach of any representations and warranties, or for its not obtaining license or registration under local, state or National Laws, and also registered with such agency/authority as prescribed IRIDAI, from time to time, as may be applicable and also for the doctors who treat the Members in Hospital are not duly qualified holding required Degree/qualifications from the authority competent to issue such Degree/qualifications or for any inadequate or deficiency of services/Health Checkup services, or for breach of confidentiality or for acts, commissions

and omissions of the Hospital, its employees, Doctors, Nurses or other staff/persons who are involved in the process of providing the Cashless Medical Treatment or healthcare services to the Members/Beneficiaries or for acts, commissions and omissions of Hospital, its staff, employees, doctors, agents etc., or for breach of this Agreement, resulting in any claims, damages, actions, proceedings suits [including the advocate fees incurred by our company, if any etc.,] against <**Insurer** name>. For all these obligations and indemnities, the Hospital shall also be liable to the Members who suffer due to various aspects mentioned in this clause".

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

7. Each party shall maintain confidentiality relating to all matters and issues dealt with by the partiesin the course of the business contemplated by and relating to this agreement. The Hospital shall not disclose to any third party and shall use its best efforts to ensure that its, officers, employees, keep secret all information disclosed, including without limitation, document marked confidential,medical reports, personal information relating to insured, and other unpublished information except as maybe authorized in writing by "Insurance Company Name". "Insurance Company Name" shall not disclose to any third party and shall use its best efforts to ensure that its directors,officers, employees, sub-contractors and affiliates keep secret all information relating to the hospital including without limitation to the hospital's proprietary information, process flows, and other required details.

8. All the claim documents shall be dispatched at the following address of Insurance

   Company Address:

This letter is being entered into to confirm the understanding of principal terms and our willingness to provide Cashless services in mutual good faith.

Provider name" to provide the documents as listed below along with this Letter of Consent for the payment of case

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

In case you are agreeable to the foregoing terms, please sign this Letter of Consent.

For Insurance Company

Authorized Signatory
Name:
Designation:

For "Provider Name"

Authorized Signatory
Name:
Designation:

REQUESTFORCASHLESS HOSPITALISATION
PART C (Revised)

SBI general INSURANCE
SURAKSHA AUR BHAROSA DONO

Hospital ID :

TO BE FILLED IN BLOCK LETTERS ONLY

Name of the hospital:

Hospital Location: Hospital ID:

Hospital Email ID: ROHINIID:

DETAILS OF CLAIMS ADMINISTRATOR

a)Nameof Insurer: SBI General Insurance Company Limited

b) Toll Free no.: 1800 210 3366 / 1800 210 6366

TO BE FILLED BY INSURED/PATIENT

a) Name of the patient:

b) Gender: Male Female Third Gender C) Contact no.: d) Alternate Contact

e) Age: Years Y Y Months M M f) Date of Birth: D D M M Y Y Y Y g) Insurer ID Card No.:

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

j) Currently do you have any other medical claim / health insurance: Yes No j1) Insurer name:

j2) Give details:

k) Do you have family physician, if yes: Name: k1) contact No.:

l) Occupation of insured patient :

m) Address of insured patient :

TO BE FILLED BY THE TREATING DOCTOR / HOSPITAL

a) Name of the treating doctor : b) contact No.:

c) Name of illness / disease with presenting complaints: d) Relevant clinical findings:

e) Duration of the present ailment: Days e.1) Date of first consultation: D D M M Y Y Y Y

e.2) Duration of the present ailment:

f) Provisional diagnosis: f.1) ICD 10 Code:

g) Proposed line of treatment: Medical Management Surgical Management Intensive Care Investigation Non-allopathic treatment

h) If investigation and/or medical management, provide details: h.1) Route of drug administration IV Oral Other

i) If surgical, name of surgery: i.1) ICD 10 PCS Code:

j) If other treatments, provide details: k) How did injury occur:

REQUESTFORCASHLESS HOSPITALISATION

PART C (Revised)

SBI general INSURANCE
SURAKSHA AUR BHAROSA DONO

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 Policy: Yes No iv) FIR No.:

v) Injury / disease caused due to substance abuse/alcohol consumption: Yes No vi) Test conducted to establish this, if yes attach report: Yes No

m) In case of Maternity: G P L A n) Expected date of delivery: D D M M Y Y Y Y

REQUESTFORCASHLESS HOSPITALISATION

PART C (Revised)

SBI general INSURANCE
SURAKSHA AUR BHAROSA DONO

TO BE FILLED IN BLOCK LETTERS ONLY

DETAILS OF PATIENT ADMITTED

A) Date of admission: D D M M Y Y Y Y b) Time of admission: H H M M c) This is an ☐ An emergency / ☐ A planned hospitalization event

d) Date of admission: Days e) Days in ICU: Days f) Room Type:

g) PerDayRoom Rent+Nursing & Servicecharges+Patient's Diet : Rs

h) Expected cost for investigation + diagnostics: Rs

i) ICU Charges: Rs

J) OT Charges: Rs

k) Professional fees Surgeon + Anesthetist fees + Consultation charges: Rs

l) Medicines + Consumables cost of Implants: (specify if applicable): Rs

m) Other hospital expenses if any Rs

n) All inclusive package charges if any applicable : Rs

o) Sum Total expected cost of hospitalization Rs

p. Mandatory past history of any chronic illness. If yes (since month/ year)

1. Diabetes M M Y Y
2. Heart Disease M M Y Y
3. Hypertension M M Y Y
4. Hyperlipidemias M M Y Y
5. Osteoarthritis M M Y Y
6. Asthma / COPD / Bronchitis M M Y Y
7. Cancer M M Y Y
8. Alcohol or drug abuse M M Y Y
9. Any HIV or STD / Related Ailments M M Y Y

DECLARATION (PLEASE READ VERY CAREFULLY)

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

a. Name of the treating doctor

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

DECLARATION BY THE PATIENT / REPRESENTATIVE

a. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Insurer/TPA 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 condi- tions 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/TPA 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 / TPA

e. I agree and understand that TPA 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"

a. Patient's / Insured's Name:

b. Contact Number: c) Email ID: (Optional)

c. Patient's / Insured's Signature Date: D D M M Y Y Y Y Time: H H M M

REQUESTFORCASHLESS HOSPITALISATION

PART C (Revised)

SBI general INSURANCE
SURAKSHA AUR BHAROSA DONO

TO BE FILLED IN BLOCK LETTERS ONLY

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 event of any discrepancy 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.

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.

HospitalSeal:

Doctor's Signature:

Date: D D M M Y Y Y Y

Time: H H M M