**BHARAT ELECTRONICS LIMITED**
**CORPORATE OFFICE**
**HUMAN RESOURCES & EMPLOYEE RELATIONS**

**No. 17556/821/CO-HR** **Date: 29.03.2024**

# MEMO

**Sub: BEL Retired Employees Contributory Health Scheme (Revised)**
**Ref: Office Order No. HO/821/027 dated 19.06.1996 (as amended)**

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1.0 The Group Mediclaim Policy for hospitalization of BEL Retired Employees' has been awarded to **M/s. United India Insurance Company Limited (UIICL), Divisional Office II, No.2, Narasimharaja Square, Bengaluru - 560002, for a period of One year from 01.04.2024 to 31.03.2025.**

2.0 This Policy covers pre-hospitalization expenses incurred 30 days prior to hospitalization and post hospitalization expenses up to 60 days and will be part of Inpatient treatment, if it is towards the same treatment and subject to admissibility by the Insurance Company. Procedures which require day care will be covered under Inpatient treatment as per the terms and conditions of the Insurance.

3.0 Further, the United India Insurance Company Ltd., has appointed Third Party claim administrator viz., **M/s Medi Assist Insurance TPA Pvt. Ltd.** for providing necessary service and settling all hospitalization claims. Members can login to Medi Assist Portal i.e. https://portal.mediassist.in to check Panel Hospital list, Claim status, etc. The **User ID** is **Staff Number@BEL.COM** and **Default Password** is **BEL@1234**. Members can login and change the password immediately.

4.0 The Claim Form (Part A & B), Checklist and Cashless procedure is enclosed for reference. In case of reimbursement claims, members have to send the claims to the following address:

**Medi Assist TPA,**
**Bangalore claims receiving center,**
**58/1A, Singasandra Village,**
**Hosur Main Road, Begur Hobli,**
**Bangalore South Taluk.**
**Karnataka – 560068**

Further, in case of general queries, BERECHS members can contact the following:

| Contact Points | Name | Contact no. | e-mail Id |
|---|---|---|---|
| Level – 1 | Dedicated number | 040-68172637 | info@mediassist.in |
| Level – 2 only for escalation | Srinivasa S | 9379188983 | srinivas.s@mediassist.in |

For cashless request, the Hospital will have to send the pre-authorisation to cashless@mediassist.com (operational 24 x 7).

5.0 In case of emergency hospitalization, the intimation should be sent within 24 hours of hospitalization. The bills for non-cashless treatment undergone by members / spouses should be submitted within 15 days from the date of discharge.

6.0 Further, in case of Pre and post-hospitalization expenditure, the timeline for submitting claims shall be 7 days from the date of completion of treatment or 60 days post-hospitalization, whichever is earlier.

7.0 **BERECHS Helpdesk facility:** Full-fledged onsite Helpdesk facility has been established in Bangalore Complex and Ghaziabad Unit which will be operational from **01.04.2024**. The details are brought out below:

| SOUTHER UNITS | NORTHERN UNITS |
|---|---|
| **ADDRESS:**<br>BERECHS Helpdesk,<br>BEL Smart Township Integrated Command & Control Centre,<br>Jallahalli, Bengaluru - 560013<br>E-mail ID: bgberechs@bel.co.in | **ADDRESS:**<br>BERECHS Helpdesk<br>Bharat Electronics Limited,<br>Site IV, Sahidabad Industrial Area,<br>Bharat Nagar Post,<br>Ghaziabad - 201010<br>E-mail ID: gadberechs@bel.co.in |

Additional details will be issued seperately by the concerned Units where Helpdesk is established.

8.0 **Super Top-up Medicare Policy:** The Top-up Medicare Policy i.e., additional coverage over and above the base sum insured is being offered by M/s. UIICL at retail premium rates. The policy may be availed on individual / floater basis. Accordingly, members who wish to avail the top-up policy for In-Patient treatment may pay the premium directly to the Insurer i.e., M/s. United India Insurance Co. Ltd.

Enrolment process and contact details will be made available on www.bel-india.in under the tab ***'Retired Employees Medical Scheme'*** during the first week of April 2024.

9.0 All other provisions contained in the above referred Office Order remain unaltered. Units / Offices may note the above and widely disseminate the same to the Retired Employees Association / Members of the scheme.

**GENERAL MANAGER (HR)**
29.03-24

**UNIT HR HEADS**
**RO / MC HEADS**

Medi Assist
Medi Assist Insurance TPA Pvt. Ltd.

# 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

SECTION A

## DETAILS OF PRIMARY INSURED:

(To be filled in block letters)

a) Policy No:
b) SI. 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:

SECTION B

## DETAILS OF INSURANCE HISTORY:

a) Currently covered by any other Mediclaim / Health Insurance: ☐ Yes ☐ No
b) Date of commencement of first Insurance without break : DD MM YY
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: MM YY
Diagnosis :
e) Previously covered by any other Mediclaim / Health insurance: ☐ Yes ☐ No
f) If yes, Company Name

SECTION C

## DETAILS OF INSURED PERSON HOSPITALIZED:

a) Name: (SURNAME / FIRST NAME / MIDDLE NAME)
b) Gender: Male ☐ Female ☐
c) Age: years YY Months MM
Date of Birth: DD MM YY
e) Relationship to Primary insured: Self ☐ Spouse ☐ Child ☐ Father ☐ Mother ☐ Other (Please Specify)
f) Occupation: Service ☐ Self Employed ☐ Homemaker ☐ Student ☐ Retired ☐ Other ☐ (Please Specify)
e) Address(if different from above)
City:
State:
Pin Code:
Phone No:
Email ID:

SECTION D

## 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: DD MM YY
e) Dated Admission: DD MM YY
f) Time: HH : MM
g) Date of Discharge: DD MM YY
h) Time: HH : MM
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:

SECTION E

## 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

SECTION F

## DETAILS OF BILLS ENCLOSED:

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

SECTION G

## 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:**

SECTION H

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.

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) SI. 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 Health Insurance? | Indicate whether previously covered by another Mediclaim / | 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. | | |

## 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 indude the original preauthorization request form in lieu of PART A

### DETAILS OF HOSPITAL

(To be filled in block letters)

SECTION A

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

SECTION B

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

b) IP Registration Number c) Gender: Male Female d) Age: Years Months 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)

SECTION C

| a) | ICD10 Codes | Description | b) | ICD 10 PCS | Description |
|---|---|---|---|---|---|
| i. Primary Diagnosis: | | | i. Procedure1: | | |
| ii. Additional Diagnosis: | | | ii. Procedure2: | | |
| iii. Co-morbidities: | | | iii. Procedure3: | | |
| iv. Co-morbidities: | | | iv. Details of Procedure: | | |

c) Pre-authorization obtained: Yes No d) Pre-authorization Number:

e) if authorization by network hospital not obtained, give reason:

f) 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

SECTION D

- Claim Form duly signed
- Original Pre-authorization request
- Copy of the Pre-authorization approval letter
- Copy of photo ID card of patient verified by hospital
- Hospital Discharge summary
- Operation Theater 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)

SECTION E

a) Address of the hospital:

City: State:

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

d) Hospital PAN: e) No 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)

SECTION F

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 |
| 1) 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 | | |

**IPD-CHECKLIST FOR CLAIM SUBMISSION**

**Employee Name:** ______________________________

**Company Name:** ______________________________

**Mobile No.:**______________________ **Alternate Contact No.:** ______________________

**Email ID:** ______________________________

| DOCUMENTS REQUIRED FOR CLAIMING HOSPITALIZATION EXPENSES | | |
|---|---|---|
| **1)** | **Claim Form – Part A: Duly completed by the insured on the prescribed format / MS claim form** | |
| **2)** | **Claim Form – Part B: Duly completed and signed by the hospital authorities** | |
| **3)** | **PPN Declaration Form ( GIPSA PPN hospital only )- Original** | |
| **4)** | **Medi Assist TPA ID Card – Photocopy** | |
| **5)** | **Photo ID proof (Employee ID card, Aadhar card etc.) – Photocopy** | |
| **6)** | **Cancelled Cheque of Employee's Bank Account – Original** | |
| | (Cancelled Cheque, with Employee name printed under place of signature) | |
| **7)** | **Delay Letter in case of late submission of claim** | |
| **8)** | **Discharge Card/Summary – Original** | |
| | (Gives the summary of diagnosis and treatment in hospital) | |
| **9)** | **Death Summary (Instead of Discharge Summary) – Original** | |
| | (Only in case of death of patient during Hospital stay) | |
| **10)** | **Indoor Case Papers (ICP)** | |
| **11)** | **Police FIR/Medico Legal Certificate (MLC)** | |
| | (Mandatory for All Road traffic accidents – Duly attested by Police) | |
| **12)** | **Hospital Main Bill with bill no. & break up – Original** | |
| | (With detailed break up of various heads like Room Rent/OT charges/Nursing etc.) | |
| **13)** | **Hospital Payment receipt with receipt number – Original** | |
| | (With seal & signature of hospital) | |
| **14)** | **All Payment Receipts with receipt number – Original** | |
| | (For consultation/surgeon charges, if charged outside the main hospital bill) | |
| **15)** | **Investigation bills cum receipt – Original** | |
| **16)** | **Prescriptions – Original** | |
| | (On Doctor's letterhead, mentioning duration and dosage for medicines and advice for | |
| | diagnostic tests) | |
| **17)** | **Pharmacy bills cum receipt/Cash Memo – Original** | |
| **18)** | **Investigation Reports – Original** | |
| | (Reports for all tests done along with images like USG, X-Ray, ECG, etc. and Blood reports) | |
| **19)** | **Sticker for the Implants used, along with supporting invoice – Original** | |
| | (For Implants used in Cataract, Heart Valve, CABG, Abdominal, Knee replacement surgeries) | |
| Document Available | | ✓ |
| Document Not Available | | X |
| Not Applicable | | NA |

**Signature of Employee:** ______________________

## CASHLESS TREATMENT:

### Steps to be followed for availing cashless - Planned

- Please notify the hospital that your TPA is **Medi Assist TPA**
- Produce your Third-Party Administrator (TPA) ID-card (E-card) along with a valid Govt. ID Proof at Hospital Reception Counter/TPA Desk. Till such time your e-cards are available, please quote your employee ID to the TPA call center.
- All Cashless request to be sent to Medi Assist TPA cashless@mediassist.in by the Network Hospitals
- The network hospital will ask for some nominal deposit which is refundable.
- **Medi Assist TPA** will assess the pre-authorization request based on sum insured, clinical eligibility. Query if any, will be faxed to hospital. Hospital will be given an authorization based on eligibility.
- If you are not getting response within 2 to 3 hours of sending cashless request to TPA.
- Employee pays the expenses if hospitalization not covered under policy conditions & non-medical expenses such as registration fees, telephone bills, non-covered treatments, energy/soft drinks, chocolates, attendant's rooms, etc.
- Employee/Dependent to verify and sign hospital bill. Employee should sign a claim form and leave all original documents at hospital.
- Collect all original receipts of all payments/deposits done to hospital, medicines purchased from outside the hospital along with the relevant prescriptions.
- Employee can represent a claim as reimbursement if denied at the cashless stage.

    - Entire list of our Network Hospitals is available online i.e. **https://www.medibuddy.in/networkHospitals or login to https://portal.mediassist.in/Home.aspx** and enter your login credentials.

Steps to be followed after login:

1. Click on "Hospital Network"
2. Select Insurance company as "**United India Insurance Company Limited**"
3. Enter either City, Hospital Name, Pin code, and click on Search.

### Steps to be followed for availing cashless in - Emergency

- Step I Admission - In cases of emergency, the member should get admitted in the nearest network hospital by showing their ID card.
- Step II Pre-authorization Process - Relatives of admitted member should approach Hospital Insurance/TPA Desk & seek preauthorization.
- All Cashless request to be sent to Mediassist TPA cashless@mediassist.in by the Network Hospitals
- The preauthorization letter would be directly given to the hospital by **Medi Assist TPA**. In case of denial, member would be informed directly.
- If you are not getting response within 2 to 3 hours of sending cashless request to TPA,
- Step III Treatment & Discharge - After the hospitalization has been pre-authorized the employee is not required to pay the hospitalization bill in case of a network hospital except for the non-medical expenses. The bill will be sent directly to Medi Assist TPA and will be settled by Insurer,

**Reimbursement Claim Process Flow**

**Document Checklist**

**The checklists for submission of claim are as under:**

- Duly filled original Claim Form signed by you including NEFT form for Electronic Funds Transfer
- Original Discharge Summary / Card (with details of complaints and treatment availed)
- Original Death Summary (only in case of death of patient during Hospital stay)
- Original Final Hospital Bill with itemized break-up
- Numbered Paid Receipt from the hospital (Advance & Final)
- Pharmacy bills with supporting prescription
- Original Investigation Bills/Receipts with Reports in original / attested by Hospital)
- Photocopies of Indoor Case Sheet (wherever applicable) etc. attested by the hospital
- ID proof of the patient / claimant with self-attestation
- PAN Card and Aadhar card copy of the employee
- Cancelled cheque (The cheque should have your name printed. In case your name is not printed, it should be Accompanied by your Bank Passbook / Bank Statement front page where Account Holder name and account details / IFSC code is specified)

**Note: In case of Accidents / Road Traffic Accident / Poisoning cases – Copy of MLC (Medico Legal Certificate) / FIR would essentially be required, but employee should not be under the influence of alcohol during the accident / situation.**

**IMPORTANT POINTS TO NOTE:**

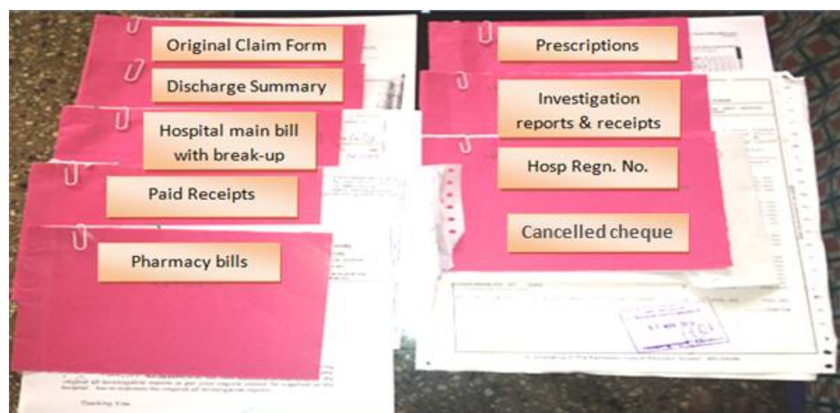
- Please retain copies of all the documents submitted to us for future reference.
- Please retain a POD copy of the courier for tracking your consignment in case of any delay etc.
- For Implants used in Cataract, Heart Valve surgeries, CABG, Abdominal Surgeries, Knee replacement surgeries, please submit the bill from the vendor for the prosthetic device used along with Sticker.
- The above list of documents is indicative. In case of any other document requirement as specified by the Insurance Company, our Document recovery Team will contact you on receipt of your claim documents by us.
- Please refer to the auto-mailers acknowledging receipt of claim, intimation of shortfall documents, settlement, etc. received from Medi Assist TPA and can also track the status of claim online in Medi Assist link i.e. https://mediassisttpa.in/

**Please courier the claim documents within 15 days from date of discharge, in a sealed envelope to:**

**To,**

**Medi Assist TPA Pvt. Ltd.**
**Bangalore claims receiving centre 58/1A,**
**Singasandra Village, Hosur Main Road,**
**Begur Hobli, Bangalore South Taluk,**
**Karnataka – 560 068**

Below is the snapshot of how the bills need to be sorted. Topmost document should be a Claim Form followed by documents as mentioned in above list:




You are requested to arrange the claim docket in the order listed below. The numbering of each page of the claim docket should be as follows: for e.g. If total documents in this claim are 20, then the numbering should follow the pattern 1 of 20, 2 of 20………………..20 of 20. This will enable you and the TPA to connect with the right pages on the claim documents.

**Summary**

| Document Type | Range | Pattern of Page nos. |
|---|---|---|
| Claim form | 1 | 1 of 20 |
| Discharge summary (2 pages) | 2-3 | 2 of 20<br>3 of 20 |
| Hospital main bill (2 pages) | 4-5 | 4 of 20<br>5 of 20 |
| Paid receipts (numbered) (3) | 6-8 | 6 of 20<br>7 of 20<br>8 of 20 |
| Pharmacy bills (2) | 9-10 | 9 of 20<br>10 of 20 |
| Pharmacy prescriptions (3) | 11-13 | 11 of 20<br>12 of 20<br>13 of 20 |
| Investigation reports (4) | 14-17 | 14 of 20<br>15 of 20<br>16 of 20<br>17 of 20 |
| Investigation receipts (1) | 18-20 | 18 of 20 |
| Hospital Regn. No. (1) | 19-20 | 19 of 20 |
| Cancelled cheque (1) | 20-20 | 20 of 20 |