भारत इलेक्ट्रॉनिक्स
BHARAT ELECTRONICS
QUALITY, TECHNOLOGY, INNOVATION

BHARAT ELECTRONICS LIMITED
CORPORATE OFFICE
OUTER RING ROAD, NAGAWARA, BENGALURU

सं.No. 17556/821/CO-HR दिनांक / **Date: 31.03.2025**

ज्ञापन / MEMO

विषय - बीईएल सेवानिवृत्त कर्मचारी अंशदायी स्वास्थ्य योजना (परिशोधित) – के संबंध में
Sub: BEL Retired Employees Contributory Health Scheme (Revised) – reg.
संदर्भ - कार्यालय आदेश सं. प्रका/821/027 दिनांक 19.06.1996 (यथा संशोधित)
Ref: Office Order No. HO/821/027 dated 19.06.1996 (as amended)

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1.0 बीईएल के सेवानिवृत्त कर्मचारियों को अस्पताल में भर्ती होने की सामूहिक मेडीक्लेम पालिसी मैसर्स यूनाइटेड इंडिया इंश्योरेंस कंपनी लिमिटेड (यूआईआईसीएल), मंडल कार्यालय-II, सं. 2, नरसिम्हाराजा स्क्वेयर, बेंगलूरु-560002 को दिनांक 01.04.2025 से 31.03.2026 तक एक वर्ष की अवधि के लिए प्रदान की गई है।

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 01.04.2025 to 31.03.2026.**

2.0 इस पॉलिसी में अस्पताल में भर्ती होने से पहले के 30 दिन और अस्पताल में भर्ती होने के 60 दिन बाद के खर्च शामिल हैं और यह अंतःरोगी उपचार का हिस्सा होगा, यदि यह उसी उपचार के लिए हो और बीमा कंपनी द्वारा स्वीकार किया जाता हो। ऐसी प्रक्रियाएं जिनके लिए दिन भर की देखभाल की आवश्यकता होती है, बीमा के निबंधन व शर्तों के अनुसार अंतःरोगी उपचार के तहत शामिल होंगे।

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 इसके अलावा, यूनाइटेड इंडिया इंश्योरेंस कंपनी लिमिटेड ने आवश्यक सेवा प्रदान करने और अस्पताल में भर्ती होने संबंधी सभी दावों को निपटाने के लिए तृतीय पक्षकार दावा प्रशासक यानी मेसर्स मेडी असिस्ट इंश्योरेंस टीपीए प्राइवेट लिमिटेड को नियुक्त किया है। सदस्य पैनल अस्पताल सूची, दावा की स्थिति आदि की जांच करने के लिए मेडी असिस्ट पोर्टल https://portal.mediassist.in पर लॉग इन कर सकते हैं। यूज़र आईडी **Staff Number@BEL.COM** है और डिफॉल्ट पासवर्ड **BEL@1234** है। सदस्य लॉग इन कर सकते हैं और पासवर्ड को तुरंत बदल सकते हैं।

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 दावा प्रपत्र (भाग ए और बी), जाँच सूची और नकदरहित प्रक्रिया संदर्भ के लिए संलग्न है। मूल दावा मेडी असिस्ट के कार्यालय को भेजा जाना चाहिए और देरी/हानि/भविष्य के संदर्भ के लिए परेषण की निगरानी के लिए कूरियर का संदर्भ संख्या संभालकर रखी जानी चाहिए। प्रतिपूर्ति के दावों के मामले में, सदस्य निम्नलिखित पते पर दावा भेजें -

The Claim Form (Part A & B), Checklist and Cashless procedure is enclosed for reference. The original claim must be sent to Medi Assist Office and the reference number of the courier shall be retained for tracking the consignment in case of delay / loss / future reference. In case of reimbursement claims, members have to send the claims to the following address:

मेडी असिस्ट टीपीए,
बेंगलूर दावा प्राप्तकर्ता केंद्र,
58/1ए, सिंगसंद्रा ग्राम,
होसुर मेन रोड, बेगूर होबली,
बेंगलूर दक्षिण तालुक,
कर्नाटक - 560068
Medi Assist TPA,
Bangalore claims receiving Center,
58/1A, Singasandra Village,
Hosur Main Road, Begur Hobli,
Bangalore South Taluk,
Karnataka – 560068

इसके अलावा, सामान्य प्रश्नों के मामले में, बीईआरईसीएचएस के सदस्य निम्नलिखित से संपर्क कर सकते हैं -

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

संपर्क बिंदु **Contact Points**	नाम **Name**	संपर्क सं. **Contact no.**	ई-मेल आईडी **E-mail ID**
Level – 1	Dedicated number	040-68172637	info@mediassist.in
Level – 2 only for escalation (Southern units)	Srinivasa S	9379188983	srinivas.s@mediassist.in
Level – 2 only for escalation (remaining locations)	Charu Saini	7618791817	charu.saini@mediassist.in

नकदरहित अनुरोध के लिए, अस्पताल को cashless@mediassist.com (24 x 7 चालू) पर पूर्व-प्राधिकार भेजना होगा।

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

5.0 आपात स्थिति में अस्पताल में भर्ती होने के मामले में, सूचना अस्पताल में भर्ती होने के 24 घंटों के भीतर भेजी जानी चाहिए। सदस्यों/पति-पत्नी द्वारा किए गए गैर-नकदरहित उपचार के बिल अस्पताल से छुट्टी मिलने के 15 दिनों के भीतर प्रस्तुत किए जाने चाहिए। 15 दिनों के बाद प्रस्तुत करने में यदि कोई देरी होती है, तो देरी के कारण का औचित्य-स्थापन किया जाएगा और दावे के साथ संलग्न किया जाएगा।

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. For any delay in submission beyond 15 days, the reason for delay has to be justified and attached along with the claim.

6.0 इसके अलावा, अस्पताल में भर्ती होने से पहले और बाद के खर्च के मामले में, उपचार पूरा होने की तारीख से 7 दिन या अस्पताल में भर्ती होने के 60 दिन बाद, इनमें से जो भी पहले हो, दावा करने की समय सीमा होगी।

Further, in case of Pre & 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 **01.04.2025 से 31.03.2026** की अवधि के लिए, बीईआरईसीएच योजना के सदस्य <u>अपोलो फार्मेसी आउटलेट</u> से दवाइयां खरीदना जारी रख सकते हैं। इस अवधि के दौरान, सदस्य अपोलो फार्मेसी के आउटलेट से परिवार (यानी, सेवानिवृत्त और उनकी पत्नी/उनके पति) के मामले में **प्रति वर्ष रु. 40,000** की सीमा तक और दवाइयों की लागत के 10% (एमआरपी पर 18.75% सहमत छूट की अनुमति देने के बाद) का भुगतान करके (एकल सदस्य के मामले में) **रु. 30,000 प्रति वर्ष** की सीमा तक दवाइयां खरीदने के पात्र होंगे ।

For the period **01.04.2025** to **31.03.2026,** Members of the BERECH Scheme can continue to purchase medicines from **<u>Apollo Pharmacy outlets</u>**. During this period, members will be eligible to purchase medicines to the extent of **Rs. 40,000 per annum** in case of family (i.e., retiree and spouse) and to the extent of **Rs. 30,000 per annum** (in case of single member) by paying 10% of the cost of medicines (after allowing agreed discount of 18.75% on MRP) at Apollo Pharmacy Outlets.

8.0 यूनिट/कार्यालय उपर्युक्त को नोट करें और सेवानिवृत्त कर्मचारी संघ/योजना के सदस्यों में इसका व्यापक प्रचार-प्रसार करें।

Units / Offices may note the above and widely disseminate the same to the Retired Employees Association / Members of the Scheme.

A. रामकुमार
Manj

महाप्रबंधक (मानव संसाधन)
GENERAL MANAGER (HR)
31.03.25

यूनिट एचआर प्रमुख / UNIT HR HEADS
आरओ / एमसी प्रमुख / 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

DETAILS OF PRIMARY INSURED:

(To be filled in block letters)

SECTION A

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:

DETAILS OF INSURANCE HISTORY:

SECTION B

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:

SECTION C

a) Name: SURNAME FIRST NAME MIDDLE NAME

b) Gender: Male Female c)Age: years Y Y Months M M 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)

e)Address(if different from above)

City: State:

Pin Code: Phone No: Email ID:

DETAILS OF HOSPITALIZATION:

SECTION D

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) Dated Admission: D D M M Y Y f) Time: H M : 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:

SECTION E

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:

SECTION F

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:	
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:

SECTION G

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.

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

SECTION H

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

Medi Assist
Medi Assist Insurance TPA Pvt. Ltd.

SECTION A

DETAILS OF HOSPITAL

(To be filled in block letters)

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.

SECTION B

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 Months e) Date of birth: D D M M Y Y

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

j) Type of Admission: Emergency Planned Day Care Maternity k) If Maternity i. Date of Delivery: D D M M Y Y ii. Gravida Status:

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

SECTION C

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a)	ICD10 Codes	Description
i. Primary Diagnosis:		
ii. Additional Diagnosis:		
iii. Co-morbidities:		
iv. Co-morbidities:		

b)	ICD 10 PCS	Description
i. Procedure1:		
ii. Procedure2:		
iii. Procedure3:		
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:

SECTION D

CLAIM DOCUMENTS SUBMITTED - CHECK LIST

- 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

SECTION E

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) No of Inpatient beds f) Facilities available in the hospital: i.OT: Yes No ii. ICU: Yes No

iii. Others:

SECTION F

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: D D M M Y Y

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-General Checklist for the claim Submission

Employee Name:_____

EmployeeNo.:_____ Work location_____

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 (GIPSAPPN hospital only) -Original	
4)	TPA ID Card – Photocopy	
5)	Photo ID proof (Employee IDcard, Aadhar card etc.) –Photo copy for KYC verification	
6)	Salary 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. & breakup –Original	
	(With detailed breakup 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 letter head, 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
*NotApplicable		NA

Points to remember:

1) Do not forget to attach this checklist with the Claim file.
2) Arrange the documents in the same order as in the checklist.
3) Please retain copies of all the documents submitted to us for future reference.
4) Please send original claim to MediAssist office and retain the POD of the courier for tracking your consignment in case of any delay /loss.
5) 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 send an email to you on the receipt of your claim documents.
6) You will receive email communication from TPA at different stages of claim processing: Receipt of your claim, deficiency if any, claim statusetc. Kindly submit the deficiency documents within 25days of getting email to avoid repudiation of your claim by the Insurer.
7) Please enter your Salary Bank Account details and KYC documents online for Electronic Fund Transfer of your medicalClaim directly into your bank account. Please ensure that you mention the correct accountnumber for the fund transfer since the claim credit will be processed solely based on the account number provided by you.
8) Please visit **https://portal.mediassist.in/home.aspx** for more details
9) For any assistance with any of the above formats, please contact at **bel@mediassist.in** and call to your dedicated number **040-68172637**

Signature of Employee:_____

Date of online claim submission ……

Steps to be followed for availing Cashless – Planned Hospitalization:

- 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 Mediassist 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.

  - The Network Hospital list is available online at **https://portal.mediassist.in/Home.aspx** Click on "Hospital Network"

1. Select Insurance company as "**United India Insurance Company Limited**"
2. 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 Medi Assist 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,
- **You may reach at Dedicated Number: 040 – 68172637 for cashless status update.**
- 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 Aadhaar 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.

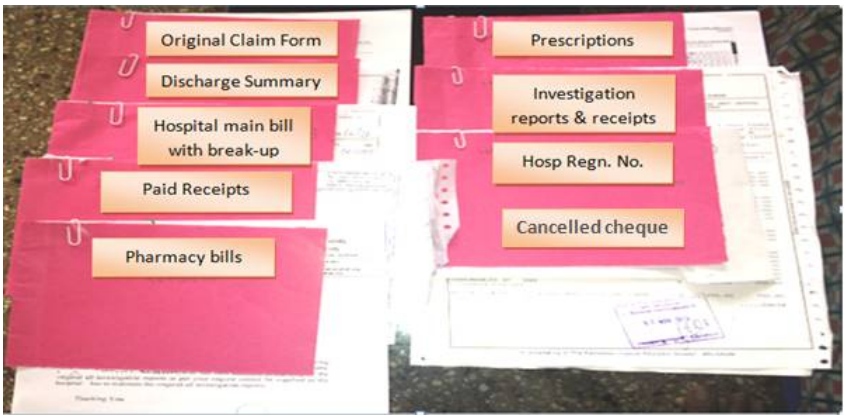
IMPORTANT POINTS TO NOTE:

- 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,
BegurHobli, 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:



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

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 pager)	2-3	2 of 20 3 of 20
Hospital main bill (2 pager)	4-5	4 of 20 5 of 20
Paid receipts (numbered) (3)	6-8	6 of 20 7 of 20 8 of 20
Pharmacy bills (2)	9-10	9 of 20 10 of 20
Pharmacy prescriptions (3)	11-13	11 of 20 12 of 20 13 of 20
Investigation reports (4)	14-17	14 of 20 15 of 20 16 of 20 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