

Request for Cashless Hospitalisation for Health Insurance Policy (PART $\,$ C)

Email ID: healthserve@universalsompo.com		Cashless Re	quest Form	Toll Free Helpline: 1800 200 4030			
Name of the Insurance Company: UNIVERSAL SOMPO GENERAL INSURANCE COMPANY LIMITED							
		T0 05 5U	LED BY THE HOSPITAL				
		TO BE FIL	LED BY THE HOSPITAL				
a) Name of the Hospital:							
b) Address:							
c) ROHINI ID:		d) E	mail ID:				
TO BE FILLED BY THE INSURED / PATIENT							
a) Name of the Patient:							
b) Gender :	Male Female Third Ger	nder c) Age: years	months	d) Date of Birth:			
e) Contact number:			f) Contact number of attending re	elative:			
g) Insured card ID number:							
h) Policy number / Name of corporate:			i) Em	nployee ID:			
j) Currently do you have any oth	ner Mediclaim / Helath Insurance:	Yes No	i. Company Name:				
ii. Give details:							
k) Do you have a family physicia	n? Yes No I) Name o	of the family physician:		m) Contact number, if an	y:		
n) Current Address of Insured I	Patient:	<u>'</u>		o) Occupation Insured Patier			
				(PLEASE CO	MPLETE DECLARATION OF THIS FORM)		
		TO BE FILLED BY THE	TREATING DOCTOR / HOSPITAL		,		
 a) Name of the treating doctor; 			b) Contact number:				
c) Nature of illness/ disease with presenting complaints:			d) Relevant clinical findings:				
e) Duration of the present ailment:	Days i. Date of first consultation:		ii. Past history of present ailment, if any:				
f) Provisional diagnosis:			i. ICD 10 Code:				
g) Proposed line of treatment:	Medical Management Surgi	ical Management Inte	nsive Care Investigation	Non allopathic Treatm	ent		
h) If investigation & / 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 the injury occur?				
I) In case of accident: i. Is it RTA? Yes No ii. Date of injury: iii. Report to Police: Yes No iv. FIR No.:							
v. Injury /Disease caused due to substance abuse /alcohol consumption: Yes No vi. Test conducted to extablish this? Yes No (If yes attach reports)							
m) In case of maternity: (IMPORTANT: PLEASE TURN OVER)	G P L	A	i. Expected Date of Delivery:				
(Init OKIANI, FELASE TURN OVER)							

- Universal Commo							
Universal Sompo General Insurance Suraksha, Hamesha Aapke Saath							
	DETAILS OF PATIENT ADMITTED						
a) Date of admission:	b) Time:	d) Mandatory: Past history of If Yes, since(month /year) any chronic illness					
c) Is this an emergency / a planned hospitalization event	:? Emergency Planned	Diabetes					
e) Expected no. of days/ Stay in hospital:	Days f) Days in ICU: Days	Heart Disease					
g) Room Type	:	Hypertension					
h) Per Day Room Rent + Nursing & Service Charges + Pati	ient's Diet : ₹	Hyperlipidemias					
i) Expected cost of investigation + diagnostic	: ₹	Osteoarthritis					
j) ICU Charges	: ₹	Asthma / COPD / Bronchitis					
k) OT Charges	: ₹	Cancer					
l) Professional fees Surgeon + Anesthetist Fees + consultation charges	:₹	Alcohol/ Drug abuse					
m) Medicines + Consumables + Cost of implants (if applic	:able, : ₹	Any HIV/ or STD Related ailments					
please specify), other hospital expenses, if any n) Other hospital expenses if any	: ₹	Any other Ailment, give details:					
o) All inclusive package charges, if any applicable	: ₹						
p) Sum Total expected cost of hospitalization	: ₹						
	DECLARATION						
We confirm having read understood and agreed to the Do a) Name of the treating Doctor:	eclarations of this form b) Qualification:						
a) Name of the treating poetor.	b) Qualification.						
c) Registration number with state code:							
Hospital Seal (must include hospital ID)		Patient / Insured Name & Signature					
DECLARATION BY THE PATIENT / REPRESENTATIVE	E						
1. I agree to allow the hospital to submit all origina on the Final Bill & the Discharge Summary, before n		ompo General Insurance Company Ltd after the discharge. I agree to sign					
2. Payment to hospital is governed by the terms and conditions of the policy. In case the Universal Sompo General Insurance Company Ltd is not liable to settle the hospital bill, I							
undertake to settle the bill as per the terms and conditions of the policy. 3. All non-medical expenses and expenses not relevant to current hospitalization and the amounts over & above the limit authorized by the Universal Sompo General Insurance Company							
Ltd not governed by the terms and conditions of the policy will be paid by me. In case any clarification is needed on admissibility of a particular item I shall contact Insurance Company at the Toll Free Number on the reverse of this form.							
4. I hereby declare to abide by the terms and conditions of the policy and if at any time the facts disclosed by me are found to be false or incorrect I forfeit my claim and agree to indemnify the Universal Sompo General Insurance Company Ltd.							
5. I agree and understand that Insurer is in no way warranting the service of the hospital & that the Universal Sompo General Insurance Company Ltd is in no way guaranteeing that the services provided by the hospital will be of a particular quality or standard.							
6. I hereby warrant the truth of the forgoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppression or concealment, my right to claim reimbursement of the said expenses shall be absolutely forfeited. I further declare that, in respect of the above treatment, no benefits are admissible under any other Medical Scheme or Insurance.							
7. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Universal Sompo General Insurance Company Ltd.							
8. I/We authorize Universal Sompo General Insurance Company Ltd 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):						
d) Patient's / Insured's Signature:	e) Date	Time: :					
(IMPORTANT: PLEASE TURN OVER)							



HOSPITAL DECLARATION

- 1. We have no objection to any authorized Insurance Company official verifying documents pertaining to hospitalization.
- 2. All valid original documents duly countersigned by the insured / patient as per the checklist below will be sent to Universal Sompo General Insurance Company Ltd Company within 7 days of the patient's discharge.
- 3. All non-medical expenses, OR expenses not relevant to hospitalization or illness, OR expenses disallowed in the Authorization Letter of the Universal Sompo General Insurance Company Ltd, OR arising out of incorrect information in the pre-authorisation form will be collected from the patient.
- 4. WE AGREE THAT INSURANCE COMPANY WILL NOT BE LIABLE TO MAKE THE PAYMENT IN THE EVENT OF ANY DISCREPANCY BETWEEN THE FACTS IN THIS FORM AND DISCHARGE SUMMARY or other documents.
- 5. The patient declaration has been signed by the patient or by his representative in our presence.
- 6. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications.
- 7. We will abide by the terms and conditions agreed in the MOU.
- 8. 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).
- 9. 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).
- 10. In the event of unauthorized recovery of any additional amount from the Insured in excess of Agreed Package Rates, Universal Sompo General Insurance Company Ltd reserves the right to recover the same from us (the Network Provider) and, for take necessary action, as provided under the MOU or applicable laws.

Hospital Seal	Doctor's Signature	
Date	Time: : :	

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.
- $5. \ \ Certificates \ from \ attending \ Medical \ Practitioner \ / \ Surgeon \ that \ the \ patient \ is \ fully \ cured.$

*As per IRDA circular Ref: IRDA/SDD/GDL/CIR/020/02/2013 Anti-Money Laundering /Counter Financing of Terrorism (AML/CFT)-Guidelines for General Insurers. All general insurance companies are required to carry out KYC norms at the settlement stage where claim payout crosses a threshold of `One lakh per claim. In cases where payments are made to third party service providers such as hospitals, the KYC norms shall apply on the customers on whose behalf service providers act.

Registered Office: Universal Sompo General Insurance Co Ltd,8th Floor and 9th Floor (part - south side),Commerz, International Business park, Oberoi Garden City, Off Western Express Highway,
Goregaon East, Mumbai- 400063

Health Claims Management: Universal Sompo General Insurance Co Ltd, 1st Floor, Plot No.- C 56 A/13, Sector - 62, Noida, Uttar Pradesh -201309
Toll Free Helpline No: 1800 200 4030; Email ID: healthserve@universalsompo.com