

DECLARATION BY THE PATIENT / REPRESENTATIVE

1. 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.
2. 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.
3. 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. In case any clarification is needed on admissibility of a particular item I shall contact T.P.A 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 Insurer / T.P.A
5. 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.
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 Insurer / TPA.

a) Patient's / Insured's Name: _____

b) Contact number: _____ d) Patient's / Insured's Signature: _____

HOSPITAL DECLARATION

1. We have no objection to any authorized TPA / 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 TPA / Insurance 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 TPA / Insurance Co, OR arising out of incorrect information in the pre-authorisation form will be collected from the patient.
4. 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.
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, the authorized TPA / Insurance Company reserves the right to recover from 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:

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.
6. Original Final Bills has to be signed by the Patient / Insured.

DOCUMENTS TO BE PROVIDED BY THE PATIENT / INSURED IN SUPPORT OF THE CLAIM

1. Aadhar card copy.
2. Pan card copy.
3. In case of Non availability of PAN CARD – FORM 60 as per the annexure need to be provided.

FORM NO. 60

[See second proviso to rule 114B]

Form for declaration to be filed by an individual or a person (not being a company or firm)
who does not have a permanent account number and who enters into any transaction specified in rule 114B

First Name	:								
Middle Name	:								
Surname	:								
Date of Birth / Incorporation of declarant	:	D	D	M	M	Y	Y	Y	Y
Father's Name (in case of individual)	:								
First Name	:								
Middle Name	:								
Surname	:								
Flat/ Room No.	:				Floor No.	:			
Name of premises	:				Block Name/No.	:			
Road/ Street/ Lane					Area/ Locality				
Town/ City					District				
State					Pin code				
Telephone Number (with STD code)					Mobile Number				
Amount of transaction (Rs.)									
Date of transaction		D	D	M	M	Y	Y	Y	Y
In case of transaction in joint names, number of persons involved in the transaction									
Mode of transaction:		<input type="checkbox"/> Cash,	<input type="checkbox"/> Cheque,	<input type="checkbox"/> Card,	<input type="checkbox"/> Draft/Banker's Cheque,	<input type="checkbox"/> Online transfer,	<input type="checkbox"/> Other		
Aadhaar Number issued by UIDAI (if available)									
If applied for PAN and it is not yet generated enter date of application and acknowledgement number		D	D	M	M	Y	Y	Y	Y
If PAN not applied, fill estimated total income (including income of spouse, minor child etc. as per section 64 of Income-tax Act, 1961) for the financial year in which the above transaction is held									
a. Agricultural income (Rs.)									
b. Other than agricultural income (Rs.)									
Details of document being produced in support of identify in Column 1 (Refer Instruction overleaf)	Document code	Document identification number	Name and address of the authority issuing the document						
Details of document being produced in support of address in Columns 4 to 13 (Refer Instruction overleaf)	Document code	Document identification number	Name and address of the authority issuing the document						

Verification

I, _____ do hereby declare that what is stated above is true to the best of my knowledge and belief. I further declare that I do not have a Permanent Account Number and my/ our estimated total income (including income of spouse, minor child etc. as per section 64 of Income-tax Act, 1961) computed in accordance with the provisions of Income-tax Act, 1961 for the financial year in which the above transaction is held will be less than maximum amount not chargeable to tax.

Verified today, the _____ day of _____ 20_____

Place: _____

(Signature of declarant)