MASTER CIRCULAR

Master Circular as per the provisions of IRDAI (Third Party Administrators – Health Services) Regulations, 2016 and subsequent amendments thereof, applicable to all applicant TPAs, registered TPAs and insurers carrying out health insurance business.

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Circular Reference No. IRDAI/TPA/REG/CIR/130/06/2020, dated 03.06.2020

Issued on: 03.06.2020

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1. OBJECTIVE:

IRDAI (TPA – Health Services) Regulations, 2016 were notified on 14th March 2016 and subsequently amendment Regulations were notified on 4th December 2019. Vide various provisions of the said regulations the Authority is empowered to specify the Regulatory Norms, Forms, Formats, and Check list etc., for compliance by all TPAs and other regulated entities, as may be applicable.

The objective of this master circular is to consolidate all the regulatory requirements stipulated under various circulars referred hereunder and to enable the concerned applicant or registered entity, as the case may be, comply with.

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2. APPLICABILITY:

This circular is applicable to all applicant TPAs, registered TPAs and the insurers wherever applicable.

3. LEGAL AND OTHER PROVISIONS:

3.1 This Master Circular is issued under the provisions of Section 14 (1) of IRDA Act, 1999 and under the powers vested under the provisions of various regulations of IRDAI (TPA – Health Services) Regulations, 2016 as amended from time to time.

3.2 "Key Managerial Person referred in this circular includes the Chief Executive Officer, Chief Administrative Officer, Chief Operating Officer, Chief Finance Officer or Chief Accounts Officer and Chief Medical Officer."

3.3 In this circular where name and details of CEO or CAO are sought in case both these officers are in existence details of both officials shall be submitted.

3.4 Where shareholders are referred in these forms information shall be submitted in respect of those shareholders who are having 5% and above stake in the TPA Company.

3.5 The periodicity of the reports shall be as mentioned under respective annexure in this circular.

4. Standard Pre-Authorization and Claims Forms;
   The Insurers, TPAs and Network Providers, as the case may be shall use the following forms specified at Annexure – 30, while rendering health services;

   4.1 Claims Form Part – A: Claim Form Is Applicable For Health Insurance Policies Other Than Travel And Personal Accident Policies.
   4.2 Claim Form Part – B: Claim Form To Be Filled In by the Hospital
   4.3 Pre-Authorization Form Part – C: Request for Cashless Hospitalization for Health Insurance Policy.
   4.4 Cashless Authorization Letter Part - D

5. This master circular supersedes the following circulars:
   5.1 Circular Reference no: IRDA/TPA/REG/CIR/059/03/2016 dated 28-03-2016: (First Circular).
   5.2 Circular Reference no: IRDAI/HLT/REG/CIR/015/02/2018 dated 02-02-2018: (Second Circular).
   5.3 Circular Reference no: IRDA/HLT/REG/CIR/86/05/2019 dated 27-05-2019: (Third Circular).

6. Effective date:

   The provisions of this circular shall be applicable with immediate effect or as specified in the respective provisions of this circular.

D V S Ramesh,
General Manager (Health)

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Annexure – 1

As per Regulations 7 (1) of IRDAI (TPA – Health Services) Regulations, 2016

FORM TPA – 1

APPLICATION FOR GRANT OF CERTIFICATE OF REGISTRATION TO TPA

Instructions for filling up the form:

1. It is important that before this application form is filled in, the regulations made by the Authority are studied carefully.
2. Applicant must submit a duly completed application form together with all appropriate, supporting documents to the Authority.
3. Application for registration will be considered only if it is complete in all respects.
4. A separate Fit & Proper criteria form shall be submitted in respect of Directors, Promoters, Shareholders and Key Managerial Personnelappointed by the applicant Company,. Where any of the Key Managerial Persons referred herein is appointed subsequent to receipt of Certificate of Registration, form shall be submitted subsequently as specified in TPA – 2 or TPA – 3.
5. Application for grant of Certificate of Registration (CoR) to the TPA shall be signed by at least two directors of Applicant Company.
6. Information which needs to be supplied in more details may be given on separate sheets which should be attached to the application form.

1	**PARTICULARS OF THE APPLICANT:**		
1.1		Name of the Applicant / TPA :	
1.2	(A)	Address - Registered Office:	 Pin code: _____ Landline No: _____ E-mail:_____ Fax No: ----------
1.3	(B)	Address for Correspondence: Principal Place of business or Corporate Office	 Pin code: _____ Landline No: _____ E-mail:_____ Fax No: ----------
1.4	(c)	Name of Chief Executive Officer or Chief Administrative Officer.	
1.5	(d)	Name of Chief Medical Officer	

2	**ORGANISATION STRUCTURE OF APPLICANT TPA COMPANY:**		
2.1		Date of Incorporation	Day _____ Month _____ Year _____ Place _____
2.2		RoC Registration /CIN details	
2.3		Scope of business as described in the Memorandum of Association (To be given in brief along with copy of Memorandum and Articles of Association registered with the RoC).	
2.4		List of major shareholders (holding 5% and above of applicant directly or along with associates companies)	

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Shareholding as on:___(dd/mm/yyyy)___

Sr. No.	Name of shareholder	No. of Shares held	% age of total paid up capital of the company	Foreign Direct / Indirect Investment Yes or No
1				
2				

2.5		Name of Promoters	

Sr. No	Complete Name of Promoter (only initials shall not be provided)	Complete Address,	Landline and Mobile numbers	e-mail id	No. of Shares held in applicant TPA Company	Percentage of shares held in applicant TPA Co.
1						
2						

2.6		Particulars of all Directors	

Sr. No.	Complete Name of Director (only initials shall not be provided) and DIN No.	Complete Address,	Landline and Mobile numbers	e-mail id	No. of Shares held in applicant TPA Company (if any)	Percentage of shares held in applicant TPA Co. (if any)
1						
2						

2.7	Details of Director having Medical Qualification		
	A	Name	
	B	Address	
	C	Qualification	

Name of Course Undergone	Name of the Institute	University Affiliation	Registration particulars with MCI	Duration of the Course	Year of Passing	Degree Certificate No.

(Attach proof of valid registration with MCI)

2.8	Details of Chief Medical Officer (CMO) (other than Director having Medical Qualification)		
	A	Complete Name	
	B	Address	
	C	Qualification	

Name of Course Undergone	Name of the Institute	University Affiliation	Registration particulars with MCI	Duration of the Course	Year of Passing	Degree Certificate No.

(Attach proof of valid registration with MCI)

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2.9	Details of CEO / CAO (in case if both are appointed by applicant Company details to be furnished separately)		
	A	Complete Name	
	B	Details of Academic Qualification	

Name of the Institute	University Affiliation	Reg. No. / Degree Particulars	Programme Details	Name of Course Undergone	Duration of the Course	Year of Passing	Marks / Grade Obtained

	C	Details of Associate / Fellow Ship examination passed as conducted by Insurance Institute of India (III) or equivalent:	

Name of the Institute	Registration Particulars	Diploma No.	Marks / Grade Obtained	Associate / Fellow Ship Certificate No. issued by III

	D	Details of practical training undergone in the field of Health Administration as approved by Authority;	

Name of the Institute	Registration Particulars	Duration of Training	Year of training	Certificate issued.

2.10	Name and activities of associate companies or subsidiary companies or joint venture companies of the Applicant TPA Company	

Sr. No.	Name of Company	Address with telephone no., Mobile no., e-mail	Nature of Business and the Type of activity	Names of Promoters and Directors	Stake of TPA / applicant company	Remarks if any
1						
2						

2.11		Whether any one or more promoters or directors of the associate or subsidiary or joint venture companies are interested in the TPA / applicant's business?	
2.12		Name and Address of the Principal bankers of the applicant, if any.	

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2.13		Name and address of the statutory auditors, if any	
2.14		Whether your company and / or any of your present promoter(s) / shareholder(s) / director(s) under the name of any other Company had applied earlier with the Authority or now applied with any of the insurers for grant of Individual or Composite Insurance Agency registration, Intermediary or Insurance Intermediary registration.	
2.15		If yes, please give details of applicant(s) and status of that application.	

3	**Business Information**		
3.1		Three years business plan document with projected business volume in terms of servicing of policies, insured members and income of the applicant company.	
3.2		Organization Chart showing functional responsibilities	(to be enclosed separately)
3.3		Particulars of Key Managerial Personnel	

Sr. No.	Name of Key Managerial Person and Designation	Date of appointment	Previous Work Experience. And experience with particular reference to TPA activities, if any	Functional areas
1				
2				

3.4		Details of infrastructure like office space, equipment and manpower available with the applicant TPA Company. (specify whether existing or proposed)	
3.5		Details of experience in TPA – Health Services and other services. (History, major events and present activities. Experience including outside India of the promoting Companies, if any, may also be indicated)	

4	**FINANCIAL INFORMATION**	
4.1		Capital Structure in case of Promoter(s) is / are Firm / Company etc.

(Amount INR in Lakhs)

Sr. No.	Particulars	Year prior to the preceding Financial Year (FY) of current FY	Preceding Financial Year	Current Financial Year
		Please specify relevant FY		
1	Authorized Capital			
2	Issued capital			
3	Paid-up capital			
4	Gross Revenue			

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5	Aggregate of Current Assets			
6	Aggregate of Current Liabilities			
7	Net Profit / (Loss)			
8	Free reserves (excluding re-valuation reserves)			

(Attach copies of audited financials and statement of net worth certified by a practising Chartered Accountant for respective three years)

4.2		Capital Structure in case of Promoter(s) is / are individuals,financial net worth certificate containing details of assets and liabilities, duly certified by the practicing chartered accountants for all the individuals for the preceding three Financial years.

				(Amount INR in Lakhs)
Sr. No.	Name of Individual promoter (s)	Year prior to the preceding Financial Year (FY) of current FY	Preceding Financial Year	Current Financial Year
		Please specify relevant FY		
1				
2				

(Attach proof of net worth duly certified by a practicing Chartered Accountant)

5		Schedule of proposed fees and costs to be charged by the applicant company for the various services offered (Please furnish details).	
6		The Authority may call for further information based on the information furnished in this form.	
7		Details of Fee Payment	Amount _____
			DD/UTR No.
			Favouring:
			Dated
			Drawn On
		Note: A non-refundable fee.	

8	Declaration	**THIS DECLARATION CUM UNDERTAKING IS TO BE SIGNED BY ANYTWO OF THE DIRECTORS OF APPLICANT COMPANY**
	a)	None of the Directors is a minor.
	b)	None of the Directors and the promoters is found to be of unsound mind by a court of competent jurisdiction.
	c)	None of the Directors and the promoters is found guilty of criminal misappropriation or criminal breach of trust or cheating or forgery or an abetment of or attempt to commit any offence by a court of competent jurisdiction.
	d)	None of the Directors and the promoters is found guilty of or knowingly participated in or connived with for any fraud, dishonestly or misrepresentation against an insured or an insurer.
	e)	CEO or CAO and CMO possesses the requisite qualifications and practical training as specified by Insurance Regulatory and Development Authority of India. The CEO, CAO and CMO of the company is / are also fit and proper as per Regulation 11of the TPA Regulations.
	f)	The Applicant Company did not violate the code of conduct specified by Insurance Regulatory and Development Authority of India.
	g)	We warrant that we have truthfully and fully answered the questions above and provided all the information which might reasonably be considered relevant for the purposes of granting or renewing the Certificate of Registration.
	h)	I declare that the information supplied in the application form is complete and correct.
	i)	The promoters and the directors of the Applicant Company are not engaged in any business apart from the proposed TPA activity as defined in the TPA regulations. The stake / the shares held by the applicant company in any of the other Companies are duly disclosed to the Authority. (Note:

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		Where it is to be determined whether officials referred herein are involved in any other insurance or insurance related activities or not, TPA Company shall furnish the detailed information separately along with the form)
	j)	The TPA Company has not committed any breach of the provisions of the applicable Acts, Regulations and / or circulars issued by the Authority from time to time.
	k)	None of the director(s) / promoter(s) / shareholder(s) Key managerial person(s) of our company is directlyorindirectly engaged in any other insurance or insurance related activity(s).
	l)	We, the promoters and directors of this Company have gone through Corporate Governance guidelines for TPAs issued by the Authority and this application is submitted in compliance of the same.
	m)	We confirm that all information furnished is correct in the event if it is proved that any information submitted is wrong or incorrect we undertake that the Certificate of Registration granted is subject to the provisions of the Act and Regulations notified by the Authority.

Date:	For and on behalf of (Name of Applicant Company)	
Place:	(Name of Director)	(Name of Director)

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Annexure – 2

As per Regulations 7 (1) of IRDAI (TPA – Health Services) Regulations, 2016

Check-list for Documentation to be submitted along with Form TPA - 1 and Procedural requirements for obtaining Fresh TPA Registration.

1. Submission of Completed Application along with attachment wherever necessary;

a) Submission of relevant information as required in the FORM TPA – 1. This form shall be filled in completely and signed by two directors of the applicant Company.
b) Remittance of requisite fee by demand draft / NEFT payable at Hyderabad, as specified under Regulation 3 (6) of IRDAI (TPA – Health Services) Regulations, 2016.
c) Submission of printed copy of applicant's Memorandum and Articles of Association registered with the RoC. The main objects of the Memorandum and Articles of Association shall be in line with Regulations.
d) Ensure that Director having Medical Qualification has effective and valid registration with Medical Council of India.
e) Ensure compliance to the qualification, training and passing of examination requirement as specified in Regulation 11 of IRDAI (TPA – Health Services) Regulations, 2016. This is a requirement to be complied with before any application could be considered for grant of registration.
f) Information pertaining to the CEO/CAO is to be submitted. Refer to Regulation 11 for details.
g) Details of Directors, Shareholders, Promoters, and Key Managerial Personnel are to be provided in the prescribed format.
h) Details of statutory auditors and Principal Bankers along with the Bank Account Number of applicant.
i) Details of existing or proposed infrastructure with regard to office space/ trained manpower, etc. for the registered office / corporate office.
j) Organization chart giving a complete picture of the company's activities like IT, claims settlement, marketing, accounts, back office etc.
k) Format for fit and proper criteria for Directors, Promoters, Shareholders, and Key Managerial Personnel of applicant TPA Company in the prescribed Form TPA – 2 at Annexure – 4, as mentioned in this circular.
l) Bring on record any other information, which is relevant to the nature of services rendered by the applicant for the growth and promotion of insurance business.
m) An undertaking to the above effect shall be furnished with the Authority;
n) Any other requirements as deemed necessary by the Authority.

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Annexure – 3.

As per Regulations 9 (1) of IRDAI (TPA – Health Services) Regulations, 2016

FORM TPA – 1A

Certificate of Registration

1. In exercise of the powers conferred by sub-section (1) of section 42D of the Insurance Act, 1938 (4 of 1938),the Authority hereby grants the Certificate of Registration to _____ to act as Third Party Administrator under that Act.

2. Registration Number for the Third Party Administrator is _____

3. This Registration shall be valid from _____ to _____

4. This Registration is subject to the Act, Insurance Regulatory and Development Authority Act, 1999 (4 of 1999) and Insurance Regulatory and Development Authority of India (Third Party Administrator – Health Services) Regulation, 2016 as amended from time to time and shall not be construed to be in compliance with or in conformity to any other Act, rules or regulations.

Place :
Date:

For and on behalf of
Insurance Regulatory and Development Authority of India

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Annexure - 4

As per Regulation 11 (3) of IRDAI (TPA – Health Services) Regulations, 2016

Declaration and Undertaking Form to be filled in by each of the Directors, Promoters, Shareholders, and Key Managerial Personnel of the TPA Company.

Form TPA - 2

Instructions for filling up the form:

a. Declaration and Undertaking' prescribed for the purpose of conducting due diligence to determine the 'fit and proper' status.
b. A separate form needs to be submitted by each individual i.e. Directors, Promoters, Shareholders, Key Managerial Personnel of the TPA Company or applicant TPA Company.
c. A separate form needs to be submitted in cases where both CEO & CAO are appointed by the TPA Company.
d. This form is to be submitted with the Authority at the time of fresh application for grant of TPA registration, in case of change in any of the Directors, Shareholders, Key Managerial Personnel of TPA Company or change (in any of the information already furnished in respect of the promoters or officials referred herein.

1	**PARTICULARS OF THE APPLICANT OR REGISTERED TPA COMPANY:**		
1.1		Name of the TPA :	
1.2	(A)	Address - Registered Office:	
			Pin code: _____ Landline No: _____
			E-mail:_____ Fax No: ----------

2. Personal Details of **Director or Promoter or Shareholder or Key Managerial Personnel as the case may be**;

Sr. No.	**Particulars of Information**	
a.	Complete name	
b.	Complete name of Father	
c.	Complete name of Spouse (if any)	
d.	Date of Birth	
e.	Nationality	
f.	Permanent Address	
g.	Present Address	
h.	Phone No (Business Direct)	
i.	Cell No.	
j.	Fax No.	
k.	e-mail id	
l.	web address:	
m.	PAN under the Income Tax Act and Name and address of Income Tax Circle	
n.	Passport No. (if any)	
o.	Position in the TPA Company and current position held from	
p.	Relevant knowledge and experience in insurance (if any)	

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q.	Description DCAof duties and responsibilities	
r.	Any other information relevant to position	

3. Academic Qualifications:

Sr. No.	Name of Institute	Country	Qualification	Year of study / Graduation

4. Professional Qualification / Training:

Sr. No.	Name of Institute	Country	Qualification	Year of study / Graduation

Sr. No.	Name of Professional Body (s) with whom membership / affiliation is in existence, if any.	Date of first grant of Membership / Affiliation	Date for validity of Membership / Affiliation	Membership / Affiliation No.	Remarks, if any

5. Present Shareholding in this company (if any). Status as on: _____ (dd/mm/yyyy)

Sr. No.	No. of shares held	% of shares held

6. Equity Interest in other Companies / Shareholding held in other companies (if any) as on dd/mm/yyyy:

Sr. No.	Name of the Company	No. of shares held	% of shares held

7. Directorship / Partnership / Proprietor positions held in other companies (if any) as on dd/mm/yyyy:

Sr. No.	Name of the Company	Position held in the Company	Period (Fromdd/mm/yyyy – Todd/mm/yyyy)

8. Working Experience (if any) in the preceding Eight Financial Years:

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Sr. No.	Name of the employer	Nature of Business	Designation	Description of duties	Period (From dd/mm/yyyy – To dd/mm/yyyy)

9. Relevant FIT & Proper Criteria; (If answer is YES to any of the questions relating to Directors, promoters, shareholders and the Key Managerial Personnel of TPA Company), please give full details, separate sheet may be attached for the same);

Sr. No.	Particulars of Information	Yes / No.
a.	Have you of ever registered or obtained license or registration from any of the regulatory authorities under any law such as SEBI, RBI, IRDAI, PFRDA, etc.	
b.	Is there any other business carried out under any name other than the TPA Company / Applicant Company.	
c.	Have you ever been refused or restricted by any regulatory authority to carry on any business, trade or profession for which a specific license or registration or other authorization is required by law.	
d.	Have you been ever censured or disciplined or suspended or refused permission or license or registration by any regulatory authority to carry on any business activity.	
e.	Have you been subject to any investigations or disciplinary proceeding or have been issued warning or reprimand by any regulatory authority	
f.	Have you been convicted of any offence or subject to any pending proceedings under any law	
g.	Have you been banned from entry at any profession / occupation at any time.	
h.	Details of prosecution, if any, pending or commenced or resulting in conviction in the past for violation of economic laws and regulations	
i.	Details of criminal prosecution, if any, pending or commenced or resulting in conviction in the past against you	
j.	Do you attract any of the disqualifications envisaged under Section 164 of the Companies' Act 2013?	
k.	Have you been subject to any investigation at the instance of Government department or agency?	
l.	Have you at any time been found guilty of violation of rules / regulations / legislative requirements by customs / excise / income tax / foreign exchange / other revenue authorities, if so give particulars	
m.	Have you at any time come to the adverse notice of a regulator such as RBI, SEBI, IRDAI, DCA. (Though it shall not be necessary for a candidate to mention in the column about orders and findings made by regulators which have been later on reversed / set aside in toto, it would be necessary to make a mention of the same, in case the reversal / setting aside is on technical reasons like limitation or lack of jurisdiction, etc, and not on merit. If the order of the regulator is temporarily stayed and the appellate / court proceedings are pending, the same also should be mentioned).	
n.	Any other explanation / information in regard to items I and II and other information considered relevant for judging fit and proper	

10. Undertaking: I, confirm that the above information is, to the best of my knowledge and belief, true and complete. I, undertake to keep the Authority fully informed, as soon as possible, of all events, which take place subsequent to my appointment, which are relevant to the information provided above.

Place:	Signature:

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Date:	Name:

Undertaking from the Applicant or Registered TPA Company.

It is hereby declared that the particulars furnished by the officials in Form TPA – 2 are examined. The Company also carried out the due diligence with regard to the appropriateness of the persons in appointing them to the said positions and found that the persons so appointed are fit to hold the said positions and comply with relevant regulatory provisions governing the management and administration of the TPA Company.

Date:	For and on behalf of (Name of Applicant or Registered TPA Company)	
Place:	(Name of Director)	(Name of Director or CEO / CAO)

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Annexure – 5

As per Regulations 11 (3) of IRDAI (TPA – Health Services) Regulations, 2016

FORM TPA –3

Form for Intimation of appointment or termination or change in Director and or Key Managerial Personnel if any.
(Note: Form to be submitted within 15 days of appointment or termination or change)

1	Details

Sr. No.	Name	Address with telephone no., Mobile no., e-mail id	Cessation or termination or Appointment	Date of cessation or termination / Appointment
1				
2				

	In case of Appointment of Director having Medical Qualification or Chief Medical Officer, furnish the following additional information;		
1.1			
	A	Name	
	B	Address	
	C	Qualification	

Name of Medicine Course Undergone	Name of the Institute	University Affiliation	Registration particulars with MCI	Duration of the Course	Year of Passing	Registration no. issued by MCI

2	In case of Appointment of other than Medical Director and CMO		
2.1			
	A	Name& Designation	

3	Declaration and Undertaking' prescribed for the purpose of conducting due diligence at the time of appointment to determine the 'fit and proper' status shall be furnished in prescribed format i.e. Form TPA – 2 at Annexure – 4 of this circular in all cases of appointment.

4. Any other relevant information to be declared with respect to official appointed.

Date:	For and on behalf of (Name of TPA Company)	
Place:	(Name of Director)	(Name of Director or CEO / CAO)

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Annexure – 6

As per Regulations 12 (1) of IRDAI (TPA – Health Services) Regulations, 2016

FORM TPA - 4

Application for issue of Duplicate Certificate of Registration

1	**PARTICULARS OF THE TPA COMPANY:**		
1.1		Name of the TPA :	
1.2	(A)	Address - Registered Office:	
			Pin code: _____ Landline No: _____
			E-mail:_____ Fax No: ----------
1.3	(B)	Address for Correspondence: Principal Place of business or Corporate Office	
			Pin code: _____ Landline No: _____
			E-mail:_____ Fax No: ----------
1.4	(c)	Name and Designation of Chief Executive Officer or Chief Administrative Officer.	

2	Details of Certificate of Registration		
	A	TPA Registration No.	
	B	Date of Registration or renewal of Registration (DD/MM/YYYY)	
	C	Date of Expiry for Current Certificate of Registration (DD/MM/YYYY)	
	D	Reason for loss / Mutilation of Original Certificate of Registration.	

3	Fee Payment; A non-refundable fee of as specified in the Regulations need to be paid to IRDAI		
		Payment Details	UTR No._____ Date _____
			Name of Bank

4	Declaration	**THIS DECLARATION IS TO BE SIGNED BY ANY TWO OF THE DIRECTORS OF TPA COMPANY**
	a)	I / We hereby apply for duplicate CoR in accordance to the provisions of regulation 12.
	b)	I/we therefore request the Authority to kindly issue a duplicate CoR in light of the circumstances explained above.
	c)	I / We -------(Name(s) of Director/s)---------- solemnly declare and confirm that the particulars given above are true to the best of our knowledge and belief.

Date:	For and on behalf of (Name of TPA Company)	
Place:	(Name of Director)	(Name of Director or CEO / CAO)

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Annexure – 7

As per Regulations 12 (3) of IRDAI (TPA – Health Services) Regulations, 2016

FORM TPA –4A

DUPLICATE CERTIFICATE OF REGISTRATION

1. In exercise of the powers conferred by sub-section (1) of section 42D of the Insurance Act, 1938 (4 of 1938)the Authority hereby grants the Certificate of Registration to _____ to act as Third Party Administrator under that Act.

2. Registration Number for the Third Party Administrator is _____

3. This Registration shall be valid from _____ to _____

4. This Registration is subject to the Act, Insurance Regulatory and Development Authority Act, 1999 (4 of 1999) and Insurance Regulatory and Development Authority of India (Third Party Administrator – Health Services) Regulation, 2016 as amended from time to time and shall not be construed to be in compliance with or in conformity to any other Act, rules or regulations.

Place :
Date:

For and on behalf of
Insurance Regulatory and Development Authority of India

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Annexure - 8

As per Regulations 13 (2) of IRDAI (TPA – Health Services) Regulations, 2016

FORM TPA – 5

APPLICATION SEEKING APPROVAL FOR CHANGE IN SHAREHOLDING PATTERN

1	**PARTICULARS OF THE TPA COMPANY:**		
1.1		Name of the TPA :	
1.2	(A)	Address - Registered Office:	
		Pin code: _____ Landline No: _____	
		E-mail:_____ Fax No: ----------	
1.3	(B)	Address for Correspondence: Principal Place of business or Corporate Office	
		Pin code: _____ Landline No: _____	
		E-mail:_____ Fax No: ----------	

2	**FINANCIAL INFORMATION**		
2.1		Capital Structure	

		(Amt in INR)
Sr. No.	Particulars	Amount
1	Authorized Capital	
2	issued capital	
3	Paid-up capital	
4	Free reserves (excluding re-valuation reserves)	

2.2		FDI Details	

#	Shareholder Name	Total Equity Share Capital	% Holding
Column Code	**a**	**b**	**c**
1	Indian		
2	Foreign Direct		
3	Foreign Indirect		

3	Details of change in Shareholding		
3.1		Date of change in Shareholding effected, if any (DD/MM/YYYY)	
3.2		Reasons for change in shareholding pattern. (Applicant TPA may attached separate sheet wherever necessary)	
3.3		Details for proposed change in shareholding	

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3.4		Effect of Change in shareholding pattern on the FDI	

#	Category of Shareholder (Foreign Direct/Foreign Indirect / Indian)	Particulars of changes in shareholding (Purchase / Sale / Fresh Issue)	Name and Address of the shareholder	Business or Profession	Shareholding as at end of DD/MM/YYYY (Number)	Shareholding as at end of (DD/MM/YYYY) (Amount in INR)	Percentage of change in shareholding
Column Code	***a***	**b**	**c**	**d**	**e**	**f**	**g**
1							
2							
3							
4							
5							

	Type of Share holding	Total Equity Share Capital	% Holding
Column Code	**a**	**b**	**c**
1	Indian		
2	Foreign Direct		
3	Foreign Indirect		

3.5		Details of proposed shareholding pattern;	

Sr. No.	Name of the Share holder	Prior to transfer of shares (1)		After the transfer of shares (2)		Remarks (if any)
		No. of shares held	Percentage of Paid up share capital	No. of shares held	Percentage of Paid up share capital held	

4	Declaration	**THIS DECLARATION IS TO BE SIGNED BY ANY TWO OF THE DIRECTORS OF APPLICANT COMPANY**
	a)	I/we therefore request the Authority to kindly approve change in shareholding pattern.
	b)	I / We -------(Name(s) of Director/s)---------- solemnly declare and confirm that the particulars given above are true to the best of my knowledge and belief.

Date:	For and on behalf of (Name of TPA Company)	
Place:	(Name of Director)	(Name of Director or CEO / CAO)

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Annexure – 9

As per Regulations 13 (2) of IRDAI (TPA – Health Services) Regulations, 2016

List of documents to be submitted for consideration of application for transfer of ownership when the transfer is exceeding 5% of the total paid up capital

If the proposed transferee is a corporate entity:

1. A certified copy of resolution of the Board of Directors of TPA Company approving the proposed change in shareholding.
2. The shareholding pattern after effecting the transfer, as per the format mentioned at Table – 1 hereunder, duly certified by a practicing Chartered Accountant or Company Secretary
3. A certified copy of the Board Resolution of the transferee approving the acquisition of the shares of TPA Company.
4. The details of the monetary consideration for transfer of shares.
5. A certified copy of the structure and shareholding pattern of the transferee Company.
6. Detailed Information, if any of the proposed shareholders are FII, NRI, PIOs or Foreign Nationals.
7. Detailed Information if any of the present directors of the TPA Company are already associated with the transferee.
8. The audited accounts of the transferee for the past three years, along with the certified copies of IT return.
9. A certificate from the practicing Chartered Accountant to the effect that the transferee is not an NBFC, if applicable. No Objection Certificate obtained from RBI, wherever necessary, for acquisition of these shares if transferee is a Non-banking financial company. A declaration that NoC is not required as the case may be.
10. The detailed list and activities of subsidiary or joint venture or associate companies/ firms of the transferee.
11. An undertaking from the transferee that; None of the director(s) / promoter(s) / shareholder(s) / Key managerial personnel of transferee company is / are engaged in any other insurance or insurance related activity(s).(Note: Where it is to be determined whether officials referred herein are involved in any other insurance or insurance related activities or not, TPA Company shall furnish the detailed information separately along with the form)
12. The details of any other proposed changes in the TPA Company, if any.
13. Format for fit and proper criteria for Directors, Promoters, Shareholders, and Key Managerial Personnel of TPA Company in the prescribed Form TPA – 2at Annexure – 4 as specified in this circular.
14. Any other documents, data, information, clarification as may be required by the Authority.

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If the proposed transferee is an Individual:

1. The shareholding pattern (as per Table - 1) prior and after effecting the transfer duly certified by a practicing Chartered Accountant or Company Secretary.
2. The net worth certificate containing details of assets and liabilities duly certified by practicing Chartered Accountant andcopies of Income Tax returns as filed with Income Tax Authorities, for the precedingthree financial years of the transferee.
3. The details of the monetary consideration for the transfer of shares
4. A certified copy of resolution of the Board of Directors of TPA Company approving the proposed change in shareholding.
5. Certificate from practicing Chartered Accountant about sources of funds to be invested in the Company by the transferee/s.
6. Complete particulars if the transferee is engaged in any other insurance or insurance related activities OR where the transferee is not engaged in any other insurance or insurance related activities, an undertaking from the transferee that; he / she is / are not engaged in any other insurance or insurance related activity(s).
7. Format for fit and proper criteria for Directors, Promoters, Shareholders, and the Key Managerial Personnel of TPA Company in the prescribed Form TPA – 2 at Annexure – 4, as specified in this circular
8. Any other documents, data, information, clarification as may be required by the Authority.

Format to be furnished about Share holding Pattern prior and after effecting the proposed share transfer;

TABLE - 1

Sr. No.	Name of the Share holder	Prior to transfer of shares (1)		After the transfer of shares (2)		Remarks (if any)
		No. of shares held	Percentage of Paid up share capital	No. of shares held	Percentage of Paid up share capital held	

Note:

1. If the current shareholding pattern is not the same as the shareholding pattern at the time of registration/ last renewal (whichever is later), the details of the same should also be provided
2. The names of the shareholders who do not hold/never held more than 5% should be shown in ‘Others’ unless they are associated or part of Promoter share holders

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Annexure – 10

As per Regulations 13 (3) and 13(4) of IRDAI (TPA – Health Services) Regulations, 2016

FORM TPA – 6A

STATUS OF SHAREHOLDING PATTERN OF A TPA COMPANY
(To be furnished whenever there is a change in the Shareholding pattern)

1	Name of the TPA :	
2	Financial Year	
3	Details of Share holding pattern.	**(To be furnished separately both prior to effecting the Change and after effecting the change in the shareholding pattern)**

Sr. No.	Name of Shareholder	Address	Category of Shareholder (Foreign Direct/Foreign Indirect / Indian)	Number of Shares Hold	Percentage of shareholding	Date of acquiring share of TPA	Remarks
Column Code	**a**	**b**	**c**	**d**	**e**	**f**	**g**
1							
2							
3							
4							
5							

Date:	For and on behalf of (Name of TPA Company)	
Place:	(Name of Director)	(Name of Director or CEO / CAO)

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Annexure – 11

As per Regulations 14 of IRDAI (TPA – Health Services) Regulations, 2016

Minimum Business Requirements of TPAs

The following Minimum Business Requirements to be fulfilled by every TPA registered with the Authority during each financial year.

TABLE- A

Number of Financial Years Completed since 01-04-2016 ordate of granting the Certificate of Registration, whichever is later	Number of policies serviced Parameter - 1	Number of lives serviced Parameter – 2
Second Year	2500	5000
Third Year	5000	10000
Fourth Year to Sixth Year	10000	25000
From Seventh Year onwards	15000	50000

Where TPAs are exclusively servicing Group Health Insurance Policies, they shall fulfill twice the number of policies prescribed under Parameter – 1 as an additional number of lives in the respective years in addition to those prescribed under Parameter – 2. For such TPAs the norms prescribed under Parameter – 1 are not applicable. Those TPAs who wish to exclusively service Group Policies shall inform the Authority at the commencement of the Financial Year.

Every TPA shall endeavor to enter into Health Services Agreement with at least two insurers during second and third years of business, a minimum of three insurers during fourth to sixth year of business and a minimum of four insurers from seventh year onwards. Provided the agreements to be entered with the number of insurers stipulated herein may be fulfilled at any time during the course of the applicable Financial Year.

The TPAs that received the Certificate of Registration on or after 01st October of the Financial Year shall consider the subsequent financial year as the first financial year for fulfillment of the minimum business norms stipulated at *Table – A*.

In respect of the applications received for the renewal of the certificate of registration, the business procured in the applicable preceding Financial Years shall be taken into consideration while determining the fulfillment of minimum business requirements in accordance to the provisions of Regulation 15 (C) (6). Where a TPA Company has completed more than six months business in a financial year and due for renewal, such TPA Company shall fulfill the proportionate business in respect of the completed number of months in that incomplete financial year. In case if a TPA Company has completed less than six months in a financial year and due for renewal, that period may be ignored.

These Minimum Business Requirements shall be applicable for all the TPAs registered with the Authority from 01st April, 2016 and the existing TPA Companies shall comply with the minimum business requirements from 01st April, 2016 onwards.

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Annexure – 12

As per Regulations 15 of IRDAI (TPA – Health Services) Regulations, 2016

FORM TPA – 7

APPLICATION FOR RENEWAL OF CERTIFICATE OF REGISTRATION

Instructions for filling up the form:

1. It is important that before this application form is filled in, the regulations made by the Authority are studied carefully.
2. Applicant must submit a duly completed application form together with all appropriate, supporting documents to the Authority.
3. Application for renewal of registration will be considered only if it is complete in all respects.
4. Application for renewal of Certificate of Registration (CoR), shall be signed by at least two directors of Applicant Company.
5. Information which needs to be supplied in more details may be given on separate sheets which should be attached to the application form.

1	**PARTICULARS OF THE TPA COMPANY:**		
1.1		Name of the TPA :	
1.2	(A)	Address - Registered Office:	
			Pin code: _____ Landline No: _____
			E-mail:_____ Fax No: ----------
1.3	(B)	Address for Correspondence: Principal Place of business or Corporate Office	
			Pin code: _____ Landline No: _____
			E-mail:_____ Fax No: ----------

2	Details of Certificate of Registration		
	A	TPA Registration No.	
	B	Date of First grant of Registration (DD/MM/YYYY)	
	C	Date of Renewal of Registration (DD/MM/YYYY) (if applicable)	
	D	Date of Expiry of Current Certificate of Registration (DD/MM/YYYY)	

3	**Details of Promoters, Directors, Shareholders, and Key Managerial Persons of the TPA Company.**					
Sr. No.	**Complete Name (only initials shall not be provided)**	**Relationship with TPA Company i.e. (Promoter, Directors, Shareholders, Key Managerial Persons)**	**Director having Medical Qualification (Yes / No)**	**No. of Shares held in TPA Company (if any)**	**Percentage of shares held in TPA Co. (if any)**	**Remarks (if any)**
1						
2						
3						

4	**Details about change, if any in respect of the following.**

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	A	Information about the change of shareholding pattern, if any, since the date of intimation to the Authority:	
	B	Change of the Directors, if any, since the date of intimation to the Authority:	
	C	Change in the Key Managerial Personnel, if any, since the date intimation to the Authority:	

Note: Wherever there is a change in respect of (A), (B) and (C) referred above furnish information as per the applicable format specified under this circular.

5	**Details of business done by TPA Company. (To be reported as per provisions of Regulations or Circular as issued by the Authority)**	
	A	Completed years of functioning as a registered TPA
	B	Business details

Sr. No.	**Years since granting the Certificate of Registration** (e.g. Second Year / Third Year / Forth Year)	1st applicable Financial Year (FY)	2nd applicable Financial Year	3rd applicable Financial Year
		Please specify relevant FY		
1	Number of policies serviced (as per Parameter – 1 of Authority Circular)			
2	Number of lives serviced (as per Parameter – 2 of Authority Circular)			
3	No. of service level agreements entered into with insurers.			

6	Fee Payment; A non-refundable fee as specified in the Regulations need to be paid to IRDAI		
		Payment Details	UTR No. _____ Date _____
			Name of Bank

7	**Particulars of Joint Venture Companies, Subsidiary Companies Incorporated by the TPA Company, changes effected thereon if any, subsequent to grant of Certificate of Registration.**

Sr. No.	Name of Company	Date of Incorporation	Address with telephone no., Mobile no., e-mail	Nature of Business and the Type of activity	Names of Promoters and Directors	Stake of TPA / applicant company	Remarks if any
1							
2							

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8	Declaration	**THIS DECLARATION CUM UNDERTAKING IS TO BE SIGNED BY ANY TWO OF THEDIRECTORS OFAPPLICANT COMPANY**
	a)	None of the Directors is a minor
	b)	None of the Directors and the promoters is found to be of unsound mind by a court of competent jurisdiction.
	c)	None of the Directors and the promoters is found guilty of criminal misappropriation or criminal breach of trust or cheating or forgery or an abetment of or attempt to commit any offence by a court of competent jurisdiction.
	d)	None of the Directors and the promoters is found guilty of or knowingly participated in or connived with for any fraud, dishonestly or misrepresentation against an insured or an insurer.The director of TPA Company having Medical Qualifications, has the approved medical qualification and has valid registration with the Medical Council of India.
	e)	CEO or CAO possesses the requisite qualifications and practical training as specified by Insurance Regulatory and Development Authority of India. The CEO, CAO of the company is / are also fit and proper as per Regulation 11of the TPA Regulations.
	f)	TPA Company is not engaged in any other business apart from TPA activity as defined in the TPA regulations. The TPA Company has not committed any breach of the provisions of the applicable Acts, Regulations and / or circulars issued by the Authority time to time.The Company did not violate the code of conduct specified by Insurance Regulatory and Development Authority of India.
	g)	We declarethat we have truthfully and fully answered the questions above and provided all the information which might reasonably be considered relevant for the purposes of renewing the Certificate of Registration.
	h)	We declare that the information supplied in the application form is complete and correct.
	i)	The TPA Company has not committed any breach of the provisions of the applicable Acts, Regulations and / or circulars issued by the Authority from time to time.
	j)	It is hereby declared that the TPA Company during the time of the registration with the Authority from ___ (date of granting the CoR / Date of Renewal of the Registration)__ has complied with the minimum business norms as specified by the Authority. (Note: Furnish the substantiating reasons, if any, separately where the minimum business norms were not fulfilled as specified in each of the relevant Financial Year)
	k)	None of the director(s) or promoter(s) or shareholder(s) or Key managerial personnel of the TPA Company are engaged directly or indirectly in any other insurance or insurance related activity(s).(Note: Where it is to be determined whether officials referred herein are involved in any other insurance or insurance related activities or not, TPA Company shall furnish the detailed information separately along with the form.)

Date:	For and on behalf of (Name of Applicant Company)	
Place:	(Name of Director)	(Name of Director or CEO / CAO)

(Seal of the Company)

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Annexure – 13

As per Regulations 15 of IRDAI (TPA – Health Services) Regulations, 2016

List of documents to be attached with the Application for Renewal of TPA Registration.

1. Form TPA-7 (Application form) duly filled in.
2. NEFT towards renewal fee and other taxes as may be applicable, if any.
3. Shareholding pattern of the company as on date of submission of the Application, if there is any change, subsequent to the intimation to the Authority in terms of the relevant provisions of the Regulation duly certified by a practicing Chartered Accountant or a practicing Company Secretary in format TPA-6A.
4. Net Worth certificate duly certified by the Statutory Auditors of the company in the format TPA-6C
5. Certified (by Practicing Chartered Accountant or Practicing Company Secretary) copy of Memorandum and Articles of Association issued by Registrar of Companies (to submit the certified copies only in case of changes from the earlier MoA/AoA submitted to the Authority)
6. Any other document, data, information, clarification as may be required by the Authority.

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Annexure – 14

As per Regulations 15 (F) (9) of IRDAI (TPA – Health Services) Regulations, 2016

FORM TPA – 7A

CERTIFICATE OF RENEWAL OF REGISTRATION

Certificate of Registration No. _____

1. The registration of M/s. _____ is hereby renewed as per provisions of Act, Insurance Regulatory and Development Authority Act, 1999 (4 of 1999) and IRDAI (TPA – Health Services) Regulations, 2016 to act as Third Party Administrator.

2. This Registration shall be valid from (DD/MM/YYYY) to (DD/MM/YYYY).

3. This Registration is renewed subject to the condition that the TPA shall comply with all the provisions of the Act, Insurance Regulatory and Development Authority, Act 1999 (4 of 1999), and Insurance Regulatory and Development Authority of India (Third Party Administrator – Health Services) Regulations, 2016 as amended from time to time, the rules or regulations made there under and the Guidelines, Circulars & Directions issued by the Authority from time to time.

Place :
Date:

For and on behalf of
Insurance Regulatory and Development Authority of India

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Annexure – 15

As per Regulations 17 (1) of IRDAI (TPA – Health Services) Regulations, 2016

List of documents to be submitted along with application for Voluntary Surrender of TPA Registration.

1. Application by TPA for surrender of Certificate of Registration of TPA mentioning the reason for surrender and to be signed by any two of the Directors of TPA.
2. A certified copy (Certified by two directors of TPA Company) of resolution of the Board of Directors recording reasons for surrender of the registration of the TPA Company.
3. A confirmation from the CEO or CAO that no fresh business is accepted from the date of the resolution of the Board seeking surrender of the registration of the TPA Company.
4. Original Certificate of Registration / Renewed Certificate of Registration issued by the Authority. (or Duplicate Certificate of Registration as the case may be)
5. An undertaking from any two Directors of the TPA Company that the company shall comply with the provisions of the Regulation 18 of IRDAI (TPA – Health Services) Regulations, 2016.
6. Particulars of the notification made to the Registrar of Companies and compliance with their requirements under Companies Act for deletion of Main Objects of MOA/AOA or produce proof of steps taken to de-register the company with Registrar of Companies.
7. To submit the statistics on claims in Form TPA – 6Bfrom the date of last submission to the Authority till the date of the last transaction.
8. Any other documents, data, information, clarification as may be required by the Authority.

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Annexure – 16

As per Regulations 19 (9) of IRDAI (TPA – Health Services) Regulations, 2016

Annual Report by Third Party Administrator

FORM TPA – 8

1	**PARTICULARS OF THE TPA:**		
1.1		Name of the TPA :	
1.2	(A)	Address - Registered Office:	
			Pin code: _____ Landline No: _____
			E-mail:_____ Fax No: ----------

1.3		Financial year	
1.4		Board of directors as on.....(end of concerned FY).....and changes in the board since the date of statement of the preceding year.	

Sr. No.	Name of Director and DIN No.	Age	Address with telephone no., Mobile no., e-mail	Details of Directorship in other Companies	Particulars of Change in Board (Cession / Appointment)	Date of Change in Board
1						
2						

1.5		Details of Chief Executive Officer (CEO)	

Sr. No.	Name of CEO	Age	Address with telephone no., Mobile no., e-mail	Qualifications	Details of Directorship in other Companies	Date of joining with TPA Company as a CEO

1.6		Details of Chief Administrative Officer (CAO)	

Sr. No.	Name of CAO	Age	Address with telephone no., Mobile no., e-mail	Qualifications	Details of Directorship in other Companies	Date of joining with TPA Company as a CAO

1.7		Details of Chief Medical Officer (CMO)	

Sr. No.	Name of CMO	Age	Address with telephone no., Mobile no., e-mail	Qualifications	Details of Directorship in other Companies	Date of joining with TPA Company

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1.8		Name and Address of Auditors	

1.9		Enumeration of TPA services provided :	

1.10		Enumeration of standing arrangements with hospitals and with doctors : Number of agreements with Network Providers Number of agreements with Doctors	

1.11		Summary of TPA Business:	
	a.	No. of insurers with whom agreements entered with.	
	b.	Lives covered under Health Policies (to be reported as per provisions of Reg. 14 of TPA Regulations and Circular in the matter issued by the Authority)	
	c.	Policies Served (to be reported as per provisions of Reg. 14 of TPA Regulations and Circular in the matter issued by the Authority)	
	d.	Number of Hospitals tied up by the TPA (beginning of concerned FY)	
	e.	Hospitals tied up during (for the concerned FY)	
	f.	Total Hospitals terminated or removed during (concerned FY)	
	g.	Total Hospitals tied up as on (end of concerned FY)	

1.12		Summary of TPA services:	

Sr. No.	Particulars of Services	No. of Policies Serviced	No. of lives Serviced	Amount of Premium Serviced wherever available. (INR in Lakh)
1	Individual / Retail Health Insurance Policies			
2	Group Health Insurance Policies (other than RSBY or other similar policies issued by insurers)			
3	Policies issued under RSBY or other similar policies issued by insurers			
4	Pre-Insurance Medical Examination			
5	Foreign Travel Policies issued by Indian insurer			
6	Foreign Travel Policies issued by Foreign insurer			
7	Non-insurance healthcare schemes sponsored by Central / State Government.			

Schedule – 1, FORM TPA – 8-RA

Revenue Account for the year ending 31st March _____

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Expenses	Income
I. Directors' remuneration **II. Staff expenses** (*a*) salaries, provident fund (*b*) other benefits **III. Office expenses** (*a*) Rent, rates and taxes (*b*) Electricity, water (*c*) House-keeping and Cleaning (*d*) Others (e) Travel (f) Entertainment (g) Lease rent of equipments (h) Post, telecommunication and similar expenses (i) Audit fees (j) Legal Expenses (k) Repairs and maintenance (l) Depreciation (m) Motor Vehicle Expenses (n) Other expenses (Please specify) (o) Loss on sale of investments or assets (p) Profit/Loss for the year **IV. Operating Expenses**	**I. Income** (a) Income from insurers (Indian & foreign) (b) From others (please specify) (c) Investment income (d) Profit on sale of investments or assets

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Schedule – 2, FORM TPA – 8-PL

Profit and Loss Appropriation Account for the year ending 31st March.....

Particulars	Amount (Rs.)	Particulars	Amount (Rs.)
Loss Brought Forward		Profit Brought Forward	
Loss for the year		Profit for the year	
Dividend for the year		Transfer from reserves	
Tax on Dividend		Loss Carried forward	
Transfer of Reserves		Deferred tax credit	
Other allocations from profit			
Provision for taxation			
Differed tax liability			
Taxation of earlier year			
Profit carried forward			

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Schedule – 3, FORM TPA – 8-BS

Balance Sheet as at 31st March .....

Liabilities	Amount (Rs.)	Amount (Rs.)	Assets	Amount (Rs.)	Amount (Rs.)
Authorized Capital			Building / Properties Cost		
Issued Capital			Less Depreciation		
Paid up Capital					
Reserves & Surplus			Furniture & Fixtures		
Amounts Due to			Less Depreciation		
a) Insurers					
b) Hospitals			Air Conditioners		
c) Doctors			Less Depreciation		
d) Others					
			Electrical Installation		
Secured Loan			Less Depreciation		
			Office Equipments		
Unsecured Loan			Less Depreciation		
			Computer Software		
Deferred Tax Liability			Less Depreciation		
Bank Overdraft			Motor Vehicles		
			Less Depreciation		
Current Liability					
Sundry Creditors			Investments		
Provisions			Government Securities (Market Value)		
Others			Loan & Debenture (Market Value)		
			Other Investments (Market Value)		
			Receivables		
			From Insurers		
			Others		
			Cash & Bank Balances		
TOTAL			**TOTAL**		

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Schedule – 4

Schedule of the income received towards various activities during the FY _____

Sr No	Description	Income / fees received during the FY (Amt. INR in Lakhs)
1	Towards Health Services of the Individual policies issued by Indian Insurers	
2	Towards Health Services of the Group Insurance policies issued by Indian Insurers	
3	Pre-insurance medical examination	
4	Towards Health Services in the foreign jurisdiction in respect of the policies issued by Indian Insurers	
5	Towards Non Insurance Services rendered	
6	Towards Servicing of policies issued by foreign Insurers	
7	Other income (please specify accounting head wise other income received)	
	TOTAL	

Schedule – 5

Schedule of apportionment of Expenses to various activities during the FY _____

Sl No	Description	Expenses incurred during the FY (Amt. INR in Lakhs)
1	Health Services of the policies issued by Indian Insurers	
2	Health Services in the foreign jurisdiction in respect of the policies issued by Indian Insurers	
3	Non Insurance Services rendered	
4	Servicing of policies issued by foreign Insurers	
5	Other Expenses Incurred (to specify)	

Schedule – 6

1. Data of claims received during the year .....

Benefit Based Policies		Cashless Claims		Reimbursement Claims		Total	
Number of Claims	Amount of Claims	Number of Claims	Amount of Claims	Number of Claims	Amount of Claims	No of claims	Amount of claims

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2. Data of Settled Claims in respect of Individual Policies;

Description (to be reckoned from the date of receipt of Claim)	Benefit Based Claims		Cashless Claims		Reimbursement Claims		Total	
	Number of Claims	Amount of Claims	Number of Claims	Amount of Claims	Number of Claims	Amount of Claims	No of claims	Amount of claims
within 1 months from date of receipt of claim								
Between 1 – 3 Months								
Between 3 to 6 Months								
More than 6 months								

3. Data of settled Claims in respect of Group Policies;

Description (to be reckoned from the date of receipt of Claim)	Benefit Based Claims		Cashless Claims		Reimbursement Claims		Total	
	Number of Claims	Amount of Claims	Number of Claims	Amount of Claims	Number of Claims	Amount of Claims	No of claims	Amount of claims
within 1 months from date of receipt of claim								
Between 1 – 3 Months								
Between 3 to 6 Months								
More than 6 months								

4. Data of settled Claims in respect of Total (Individual Policies+Group Policies);

Description (to be reckoned from the date of receipt of Claim)	Benefit Based Claims		Cashless Claims		Reimbursement Claims		Total	
	Number of Claims	Amount of Claims	Number of Claims	Amount of Claims	Number of Claims	Amount of Claims	No of claims	Amount of claims
within 1 months from date of receipt of claim								
Between 1 – 3 Months								
Between 3 to 6 Months								
More than 6 months								

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5. Data of Claims in respect of Individual Policies recommended for repudiation

Description (to be reckoned from the date of receipt of Claim)	Benefit Based Claims		Cashless Claims		Reimbursement Claims		Total	
	Number of Claims	Amount of Claims	Number of Claims	Amount of Claims	Number of Claims	Amount of Claims	No of claims	Amount of claims
within 1 months from date of receipt of claim								
Between 1 – 3 Months								
Between 3 to 6 Months								
More than 6 months								

6. Data of Claims in respect of Group Policies recommended for repudiation

Description (to be reckoned from the date of receipt of Claim)	Benefit Based Claims		Cashless Claims		Reimbursement Claims		Total	
	Number of Claims	Amount of Claims	Number of Claims	Amount of Claims	Number of Claims	Amount of Claims	No of claims	Amount of claims
within 1 months from date of receipt of claim								
Between 1 – 3 Months								
Between 3 to 6 Months								
More than 6 months								

7. Data of Claims in respect of Total Policies (Individual+Group Policies) recommended for repudiation;

Description (to be reckoned from the date of receipt of Claim)	Benefit Based Claims		Cashless Claims		Reimbursement Claims		Total	
	Number of Claims	Amount of Claims	Number of Claims	Amount of Claims	Number of Claims	Amount of Claims	No of claims	Amount of claims
within 1 months from date of receipt of claim								
Between 1 – 3 Months								
Between 3 to 6 Months								
More than 6 months								

(Note: In respect of data on Repudiations, amount of claim made by the policyholder to be mentioned as the amount of claim repudiated)

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8. Data of Claims Outstanding in respect of Individual Policies;

Description (to be reckoned from the date of receipt of Claim)	Benefit Based Claims		Cashless Claims		Reimbursement Claims		Total	
	Number of Claims	Amount of Claims	Number of Claims	Amount of Claims	Number of Claims	Amount of Claims	No of claims	Amount of claims
within 1 months from date of receipt of claim								
Between 1 – 3 Months								
Between 3 to 6 Months								
More than 6 months								

9. Data of Claims Outstanding in respect of Group Insurance Policies;

Description (to be reckoned from the date of receipt of Claim)	Benefit Based Claims		Cashless Claims		Reimbursement Claims		Total	
	Number of Claims	Amount of Claims	Number of Claims	Amount of Claims	Number of Claims	Amount of Claims	No of claims	Amount of claims
within 1 months from date of receipt of claim								
Between 1 – 3 Months								
Between 3 to 6 Months								
More than 6 months								

10. Data of Claims Outstanding in respect of Total Policies (Individual+Group Policies)

Description (to be reckoned from the date of receipt of Claim)	Benefit Based Claims		Cashless Claims		Reimbursement Claims		Total	
	Number of Claims	Amount of Claims	Number of Claims	Amount of Claims	Number of Claims	Amount of Claims	No of claims	Amount of claims
within 1 months from date of receipt of claim								
Between 1 – 3 Months								
Between 3 to 6 Months								
More than 6 months								

(Note: In respect of data on Claims Outstanding, amount of claim made by the policyholder to be mentioned as the amount of claim Outstanding)

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Schedule – 7

1. Directors Report; to be attached separately.

   (Note: Inter alia, (i) to disclose the shareholding structure as at the end of financial year, (ii) Discuss Corporate Governance norms put-in place)

2. Auditors Report including audited financial and all notes, schedules to audited financials; to be attached separately.

Undertaking from Registered TPA Company.

It is hereby declared that the particulars furnished with respect Annual Report of our TPA Company in Form TPA – 8 and Schedule 1 to 7 there under towards various activities of the TPA Company during the FY _____ were examined, and are true and correct. It is also declared that the TPA Company did not receive any other income or fees from any other sources other than the one that is declared in the above Schedule.

Date:	For and on behalf of (Name of Applicant or Registered TPA Company)	
Place:	(Name of Director)	(Name of Director or CEO / CAO)

----------xx----------

Certificate from the Statutory Auditors of the TPA Company

Certified that the above information about financials furnished in annual report and Schedules 1 to 5 therein by _____(TPA Co.)is as extracted from the transactions of the TPA Company (Name of the TPA Company) for the Financial Year _____.

Date:	For and on behalf of (Name of Auditors)
Place:	Name & Signature of Practicing Chartered Accountant

(Affix seal in case it is a firm / associate)

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Annexure – 17

As per Regulations 19 (10) of IRDAI (TPA – Health Services) Regulations, 2016

FORM TPA – 6B

ANNUAL FORMAT ON CLAIMS DATA FOR TPAS

Instructions for submission of the form: Information for claims data to be furnished for every financial year.
Data to be furnished within 90 days of the end of the financial year (e.g: Data for April-March to be furnished by 29th June along with Annual Returns)

1	**PARTICULARS OF THE TPA COMPANY:**		
1.1		Name of the TPA :	
1.2	(A)	Address - Registered Office:	Pin code: _____ Landline No: _____
			E-mail:_____ Fax No: ----------
1.3	(B)	Financial Year for which data furnished	
1.4	(d)	Name of Insurer (insurer wise data to be submitted in following format)	

Claims Data: Furnish the following information in separate tables;

1. Table – 1a: Government Hospitals who are Network Providers;
2. Table – 1b: Government Hospitals who are not Network Providers;
3. Table – 2a: Private Hospitals who are Network Providers;
4. Table – 2b: Private Hospitals who are not Network Providers;

(Amount in INR)

Sr. No.	Particulars	Cashless Claim		Reimbursement Claim		Benefit Based		Total	
		No. of Claims	Amt. of Claims	No. of Claims	Amt. of Claims	No. of Claims	Amt. of Claims	No. of Claims	Amt. of Claims
	Column Code	(i)	(ii)	(iii)	(iv)	(v)	(vi)	(vii)	(viii)
1	Claims pending at the beginning of the quarter								
2	New claims received during the quarter								
3	Claims settled								
4	Claims repudiated								
5	Claims pending at the end of the quarter {(1+2) – (3+4)}								

Aging of pending claims* Furnish the following information in separate tables;

1. Table – 1a: Government Hospitals who are Network Providers;
2. Table – 1b: Government Hospitals who are not Network Providers;

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3. Table – 2a: Private Hospitals who are Network Providers;
4. Table – 2b: Private Hospitals who are not Network Providers;

(Amount in INR)

Sr. No.	Particulars	Cashless Claim		Reimbursement Claim		Benefit Based		Total	
		No. of Claims	Amt. of Claims	No. of Claims	Amt. of Claims	No. of Claims	Amt. of Claims	No. of Claims	Amt. of Claims
	Column Code	(i)	(ii)	(iii)	(iv)	(v)	(vi)	(vii)	(viii)
1	Claims pending for less than 1 month								
2	Claims pending for 1-3 months								
3	Claims pending for 3.-6 months								
4	Claims pending for 6-12 months								
5	Claims pending for 1-2 years								
	Claims pending for more than 2 years.								

* Reckoned from date of first intimation.

Aging of settled claims**Furnish the following information in separate tables;

1. Table – 1a: Government Hospitals who are Network Providers;
2. Table – 1b: Government Hospitals who are not Network Providers;
3. Table – 2a: Private Hospitals who are Network Providers;
4. Table – 2b: Private Hospitals who are not Network Providers;

(Amount in INR)

Sr. No.	Particulars	Cashless Claim		Reimbursement Claim		Benefit Based		Total	
		No. of Claims	Amt. of Claims	No. of Claims	Amt. of Claims	No. of Claims	Amt. of Claims	No. of Claims	Amt. of Claims
	Column Code	(i)	(ii)	(iii)	(iv)	(v)	(vi)	(vii)	(viii)
1	Claims settled for less than 1 month								
2	Claims settled for 1-3 months								
3	Claims settled for 3.-6 months								
4	Claims settledfor 6-12 months								
5	Claims settled for 1-2 years								
6	Claims settledfor more than 2 years.								

** Reckoned from date of first intimation.

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Aging of repudiated claims* ** Furnish the following information in separate tables;

1. Table – 1a: Government Hospitals who are Network Providers;
2. Table – 1b: Government Hospitals who are not Network Providers;
3. Table – 2a: Private Hospitals who are Network Providers;
4. Table – 2b: Private Hospitals who are not Network Providers;

(Amount in INR)

Sr. No.	Particulars	Cashless Claim		Reimbursement Claim		Benefit Based		Total	
		No. of Claims	Amt. of Claims	No. of Claims	Amt. of Claims	No. of Claims	Amt. of Claims	No. of Claims	Amt. of Claims
	Column Code	(i)	(ii)	(iii)	(iv)	(v)	(vi)	(vii)	(viii)
1	Claims repudiated within 1 month								
2	Claims repudiated within 1-3 months								
3	Claims repudiated within 3.-6 months								
4	Claims repudiated within 6-12 months								
5	Claims repudiated within 1-2 years								
6	Claims repudiated within more than 2 years.								

*** Reckoned from date of receipt of last requirement.

Date:	For and on behalf of (Name of TPA Company)	
Place:	(Name of Director)	(Name of Director or CEO / CAO)

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Annexure – 18

As per Regulations 19 (11) of IRDAI (TPA – Health Services) Regulations, 2016

Annual certificate in the matter of Net Worth of a TPA Company.

Form TPA – 6C

Instructions for Submission of required certificate:

1. Periodicity of submission of this certificate is Annual i.e. as at as at 31st March of every financial year.
2. To be submitted with the Authority along with Annual Report of the TPA Company.
3. This certificate is to be certifiedby Auditors of a TPA Company.

1	**PARTICULARS OF THE TPA COMPANY:**		
1.1		Name of the TPA :	
1.2		Address - Registered Office:	
			Pin code: _____ Landline No: _____
			E-mail:_____ Fax No: ----------
1.3		Financial Year	
1.4		Net worth as at --- (mention date): Methodology adopted for calculation of Net Worth(Refer provisions of Reg. 6 of IRDAI (TPA – Health Services) Regulations, 2016).	

Certified that the above particulars of the Net-worth of _____ (name of TPA Company)_____ are correct and the above details are extracted from financial statements of the TPA Company for the periodupto / Financial year _____.

Date:	For and on behalf of (Name of Auditors)
Place:	Name & Signature of Practicing Chartered Accountant

(Affix seal in case it is a firm / associate)

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Annexure – 19

As per Regulations 19 (11) of IRDAI (TPA – Health Services) Regulations, 2016

Declaration and Undertaking by TPA Company.

Form TPA – 6D

Instructions for Submission of required Declaration and Undertaking:

1. Periodicity of submission of this Declaration and Undertaking is annual.
2. This declaration and undertaking shall be signed by any two directors of a TPA Company.
3. This declaration and undertaking is to be submitted to the Authority along with Annual Report of the TPA Company.

1	**PARTICULARS OF THE TPA COMPANY:**		
1.1		Name of the TPA :	
1.2		Address - Registered Office:	
			Pin code: _____ Landline No: _____
			E-mail:_____ Fax No: ----------
1.3		Financial Year	

2	We ___(names of directors)___ the directors of _____(name TPA Company)_____ hereby declare and undertake that;	
	a)	CEO or CAO possesses the requisite qualifications and practical training as specified by Insurance Regulatory and Development Authority of India. The CEO, CAO of the company is / are also fit and proper as per Regulation 11 of the TPA Regulations. Such a CEO or CAO are engaged in day to day administration of the activities of the TPA and also in ensuring compliance of regulatory requirements.
	b)	The TPA Company is not engaged in any other business apart from Health Services by TPAs, as defined in the TPA regulations.
	c)	A Director with required medical qualification and an appointed Chief Medical Officer have valid registration with the Medical Council of India or Medical Council of the state.
	d)	None of the director(s), promoter(s), shareholder(s), and Key managerial personnel of our company is or are, directly or indirectly engaged in any other insurance or insurance related activity(s).(Note: Where it is to be determined whether officials referred herein are involved in any other insurance or insurance related activities or not, TPA Company shall furnish the detailed information separately along with the form)
	e)	The Company did not violate the code of conduct or not committed any breach of the provisions of the applicable Acts, Regulations and / or circulars issued by the Authority from time to time.

Date:	For and on behalf of (Name of Applicant Company)	
Place:	(Name of Director)	(Name of Director or CEO / CAO)

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Annexure – 20

As per Regulations 20 (4) of IRDAI (TPA – Health Services) Regulations, 2016

Annual Form on Service Level Agreement Details
(Annual Form to be furnished along with the Annual Report)

FORM TPA – 6E

1	**PARTICULARS OF THE TPA:**		
1.1		Name of the TPA :	
1.2	(A)	Address - Registered Office:	Pin code: _____ Landline No: _____ E-mail:_____ Fax No: ----------
1.3		Financial year	
1.4			
1.5		Details of Service level Agreements (SLAs);	

S No	Cumulative SLAs till beginning of the Year					SLAs entered in the Year					Total SLAs at the end of the year				
	1					2					3				
	Fresh	Renewal	Modification	Termination	Total	Fresh	Renewal	Modification	Termination	Total	Fresh	Renewal	Modification	Termination	Total

1.6	a	Details of Service level Agreements (SLAs);	SLA details for complete financial year to be provided. (for the period / up to the period)

S No.	Name of the Insurer	Type of Services to be rendered (Retail Policy / Group Policy/ RSBY / PIMS / Others – Please specify	Type of SLA (Fresh / Renewal / Modification)	Date of Purchase of stamp viz Non Judicial Stamp Paper / e-stamp / Special Adhesive / franking / any other mode	Date of Agreement dd/mm/yyyy	Validity of Agreement	
						From (dd/mm/yyyy)	To (dd/mm/yyyy)

Date:	For and on behalf of (Name of Applicant Company)	
Place:	(Name of Director)	(Name of Director or CEO / CAO)

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Annexure – 21

As per Regulations 20 (5) of IRDAI (TPA – Health Services) Regulations, 2016

Minimum Standard clauses in agreement between Insurer and TPAs.

1. The specific services to be rendered by the TPA, the procedure, as prescribed by the insurer, to be followed by the TPA for providing each of such services as agreed to.
2. The fee payable to the TPA for each of the services rendered by the TPA as detailed below. The complete details on the basis on which payment becomes payable shall be documented.

Rate of Service Fee

Details of Services Provided	Details of Fee payable

3. Turnaround times for each of the services to be rendered by the TPA, the course of action in case of default of services.
4. The TPA and or insurer responsibilities in enforcing the agreement.
5. Confidentiality requirements.
6. Termination notice
7. Inspection, Audit and Access rights to theoffice of TPAs by insurers on regular or on ad-hoc basis.
8. Arbitration and Dispute resolution
9. The minimum details to be incorporated on the id-cards such as; photograph of the insured, name of the insurer, emergency contact number, logo of the insurer.
10. Issue of ID cards, Nature of the Cards (Smart with QR etc.), cost of issuing ID cards and the course of action in case of default.
11. Procedure for cashless facility as per Schedule – A.
12. Procedure for de-empanelment of network providers as per Schedule - B.
13. Customer Service and relations.
14. Services rendered by the TPA to be compliance with the extant laws.
15. Intimation of changes to the insurers, in the key positions in the office of the TPA.
16. Code of conduct.
17. Obligations of the Insurer towards the TPA
18. Obligations of the TPA towards the insurer; such as; notifying (i) the objectionable conduct of either the network provider or any other hospital (ii) fraudulent activities of the policyholder or the claimant (iii) the objectionable activities of other health service providers like diagnostic centers (iv) the objectionable activities pertaining to health services by any insurer or insurance intermediary or any other person.

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19. A clause that obligates TPAs to disclose the policy holders on demand, the rates agreed towards Health Services with the Network Providers with whom the TPA had entered into an agreement.
20. The rates agreed by the network providers towards various health services to be offered under the agreement and the duration or period for which they are valid or when they are reviewable.

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Annexure – 22

As per Regulations 20 (5) of IRDAI (TPA – Health Services) Regulations, 2016

Minimum Standard Clauses in an agreement amongst Insurers, Network Providers and TPAs

Insurance companies may offer policies providing cashless service to the policyholders, provided the services are offered in network providers who have been enlisted to provide medical services either directly under an agreement with the insurer or by an agreement amongst health services provider, the TPA and the insurer.

The Authority specifies, inter alia, the following clauses to be included in such agreements which shall be entered into between insurers, network providers, TPAs and shall cover the following, amongst others:

1. Scope of services provided by the network provider
2. the tariff applicable with respect to various kinds of healthcare services being provided by the network provider.
3. a clause empowering the insurer to cancel or otherwise modify the agreement in case of any fraud, misrepresentation, inadequacy of service or other non-compliance or default on the part of TPA or network provider; provided no such cancellation or modification shall be done by the insurer unless the concerned TPA or network provider is given an opportunity of being heard.
4. at the discretion of the Insurance Company, a standard clause providing for continuance of services by a network provider to the insurance company either directly or through another TPA, if the TPA is changed or the agreement with TPA is terminated.
5. an enabling clause to the network provider for opting out of network for reasons of inadequacy of service rendered either by the TPA or by the Insurance Company.
6. a clause specifically requiring only the insurance company the power to deny a claim.
7. a clause enabling insurer or the TPA that is representing an Insurer to inspect the premises of the network provider at any time without prior intimation.
8. Turnaround times for each of the services rendered by the parties, the course of action in case of default of services.
9. The responsibilities and obligations of each of the parties to the agreement in enforcing the agreement.
10. Display of information on cashless services by the network provider at prominent location, preferably at the reception and admission counter and Casualty/Emergency departments.
11. Confidentiality requirements

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12. Termination notice
13. enabling clause to the Insurers or the TPA that is representing an Insurer to carry out Inspection, Audit and Access rights to the network providers either on regular or on ad-hoc basis
14. Arbitration and Dispute resolution
15. Procedure for cashless facility as in Schedule – A
16. Procedure for de-empanelment of network providers as in Schedule – B
17. Procedure to furnish the standard Discharge summary as in Schedule – C
18. Procedure to furnish the Standard Format for Provider Bills as in Schedule – D
19. Payments to be made through direct electronic fund transfer subject to deduction of tax at source as applicable under the relevant laws.
20. Payment reconciliation process on a regular basis.
21. Customer services and relations
22. Services rendered by the TPA shall be in compliance with the extant laws.
23. Code of Conduct.
24. TPAs and insurers shall endeavour to agree with the network providers for display of rates agreed for rendering health services to policy holders.

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Schedule – A

Provider Services – Cashless Facility Admission Procedure

The insured shall be provided treatment free of cost for all such ailments covered under the policy within the limits / sub-limits and the sum insured, i.e., coverages not specifically excluded under the policy. The Provider shall be reimbursed as per the tariff agreed under the service level agreement for different treatments or procedures. The procedure to be followed for providing cashless facility shall be:

I. Preauthorization Procedure – Planned Admissions:

1. Request for hospitalization shall be forwarded by the provider immediately after obtaining due details from the treating doctor in the preauthorization form prescribed by the Authority i.e. “request for authorization letter” (RAL). The RAL shall be sent electronically along with all the relevant details in electronic form to the 24-hour authorization /cashless department of the insurer or its representative TPA along with contact details of treating physician and the Insured. The insurer’s or its representative TPA’s medical team may consult the treating physician or the insured, if necessary.
2. If the treating physician of the provider identifies any disease or ailment as pre-existing, the treating physician shall record it and also inform the insured immediately.
3. In cases where the symptoms appear vague / no effective diagnosis is arrived at, the medical team of the insurer or its representative TPA may consult with treating physician / insured, if necessary.
4. The RAL shall reach the authorization department of insurer or its representative TPA 7 days prior to the expected date of admission, in case of planned admission.
5. If “clause 3” above is not followed, the clarification for the delay needs to be forwarded along with the request for authorization.
6. The RAL form shall be dully filled in clearly mentioning Yes or No and/or the details as required. The form shall not be sent with nil or blank replies.
7. The guarantee of payment shall be given only for the medically necessary treatment cost of the ailment covered and mentioned in the request for hospitalization. Non covered items as per terms and conditions of the policy, like Telephone usage, food provided to relatives/attendants, Provider registration fees etc must be collected directly from the insured.
8. The authorization letter by the insurer or its representative TPA shall clearly indicate the amount agreed for providing cashless facility for hospitalization.

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9. In the event of the cost of treatment increasing, the provider may check the availability of further limit with the insurer or its representative TPA.
10. When the cost of treatment exceeds the authorized limit, request for enhancement of authorization limit shall be made immediately during hospitalization using the same format as for the initial preauthorization. The request for enhancement shall be evaluated based on the availability of further limits and the hospital may be required to provide valid reasons for the same. No enhancement of limit is possible after discharge of insured.
11. Further, the insurer or the TPA who is acting on behalf of the Insurer shall accept or decline such additional expenses within a maximum of 24 hours of receiving the request for enhancement. Absence of receiving the reply from the [Insurance Company] within 24 hours shall be construed as denial of the additional amount.
12. In case the insurer has opted for a higher accommodation / facility than the one eligible under the policy, the Provider shall explain the effect of such option and also take a written consent from the beneficiary at the time of admission as regard to owing the responsibility of such expenses by the insured including the proportionate expenses which have a direct bearing due to upgradation of room accommodation/facility. In all such cases the Insurer [Insurance Company] shall pay for the expenses which are based on the eligibility limits of theinsured. However provider may charge any advance amount/security deposit from the insured only in such cases where the insured has opted for an upgraded facility to the extent of the amounts to be collected from the insured .
13. Insurance company guarantees payment only after receipt of RAL and the necessary medical details. The Authorization Letter (AL) shall be issued within 48 hours of receiving the RAL.
14. In case the ailment is not covered or the given medical data is not sufficient for the medical team of the authorization department to confirm the eligibility, insurer or its representative TPA shall seek further clarification/ information immediately.
15. Authorization letter [AL] shall mention the authorization number and the amount guaranteed for the procedure.
16. In case the balance sum available is considerably less than the cost of treatment, provider shall follow their norms of deposit/running bills etc. However provider shall only charge the balance amount over and above the amount authorized under the health insurance policy against the package or treatment from the insured.
17. Once the insured is to be discharged, the Provider shall make a final request for the pre-authorization for any residual amount along with the standard discharge summary and the standard billing format. Once the provider receives final pre-authorization for a specific amount, the insured shall be allowed to get discharged by paying the difference between the pre-authorized amount and actual bill, if any.

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Insurer upon receipt of the complete bills and documents shall make payment of the guaranteed amount to the provider directly.

18. Due to any reason if the insured does not avail treatment at the Provider after the pre authorization is released and any payment is made in this regard, the Provider shall return the amount to the insurer immediately.
19. All the payments in respect of pre-authorised amount shall be made electronically by the insurer to the provider as early as possible but not later than a week, provided all the necessary electronic claim documents are received by the insurer.
20. Denial of authorization (DAL) for cashless is by no means denial of treatment by the health facility. The provider shall deal with such case as per their normal rules and regulations.
21. Insurer shall not be liable for payments to the providers in case the information provided in the "request for authorization letter" and subsequent documents during the course of authorization, is found incorrect or not disclosed.
22. Provider, insurer and its representative TPA shall ensure that the procedure specified in this Schedule is strictly complied in all respects.

II. Preauthorization Procedure – Emergency Admissions:

1. In case of emergencies also, the procedure specified in Clause (I) (1), (2) and (3) shall be followed.
2. The insurer or its representative TPA may continue to discuss with treating doctor till conclusion of eligibility of coverage is arrived at. However, any life saving, limb saving, sight saving, emergency medical attention cannot be withheld or delayed for the purpose of waiting for pre-authorisation. Provider meanwhile may consider treating him by taking a token deposit or as per their norms.
3. Once a pre-authorisation is issued after ascertaining the coverage, Provider shall refund the deposit amount to the insured if taken barring a token amount to take care of non covered expenses.

III. <u>Preauthorization Procedure – RTA / MLCs:</u>

1. If requesting a pre-authorisation for any potential medico-legal case including Road Traffic Accidents, the Provider shall indicate the same in the relevant section of the standard format.
2. In case of a road traffic accident and or a medico legal case if the victim was under the influence of alcohol or inebriating drugs or any other addictive substance or resort to intentional self injury, it is mandatory for the Provider to inform this circumstance of emergency to the Insurer or its representative TPA.

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IV. Authorization letter (AL):

1. Authorization letter shall mention the amount, guaranteed class of admission, eligibility of the patient or various sub limits for rooms and board, surgical fees etc. wherever applicable, as per the benefit plan for the patient.
2. The Pre-Authorization letter shall also mention Validity of dates for admission and number of days allowed for hospitalization, if any. The Provider shall see that these rules are strictly followed; else the AL will be considered null and void.
3. In the event of the room category, if any, not being available the same shall be informed to the Insurer or its representative TPA and the Insured. For such cases if the Insured is admitted to a class of accommodation higher than what he is eligible for, the provider shall collect the necessary difference, if any, in charges from the Insured.
4. The AL has a limited period of validity – which is 15 days from the date of sending the authorization.
5. AL is not an unconditional guarantee of payment. It is conditional on facts presented – when the facts change the guarantee changes.

V. Reauthorization:

1. Where there is a change in the line of treatment – a fresh authorization shall be obtained from the insurer immediately – this is called a reauthorization.
2. The same pre-authorization form shall be used for the reauthorization, and the same turnaround times as specified shall apply.

VI. Discharge:

1. The following documents shall be included in the list of documents to be sent along with the claim form to the Insurer or its representative TPA . These shall not be given to the Insured.
   a. Original pre authorization request form,
   b. original authorization letter,
   c. Original discharge card,
   d. original investigation repots,
   e. all original prescription and pharmacy receipt etc
2. Where the Insured requires the discharge card/reports he or she can be asked to take photocopies of the same at his or her own expenses and these have to be clearly stamped as "Duplicate & originals are submitted to [Insurance Company]". Where, the insured requests for any of the original reports, the insurer shall arrange forwarding the originals by duly endorsing the settlement of the claim on such original reports. However, the insurer or its representative TPA may retain a copy of such reports as per their operational requirements.

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3. The discharge card/Summary shall mention the duration of ailment and duration of other disorders like hypertension or diabetes and operative notes in case of surgeries. The clinical detail shall be sufficiently and justifiably informative. In addition, the Provider shall provide all the relevant details pertaining to past treatment availed by the Insured with the Provider.
4. Signature of the Insured on final Provider bill must be obtained.
5. In the event of death or incapacitation of the Insured , the signature of the nominee or any of Insured's family who represents the Insured subject to reasonable satisfaction of Provider shall be sufficient for the Insurer to consider the claim.
6. Standard Claim form duly filled in duly presented to the Insured for signing and identity of the Insured shall be confirmed by the provider.

VII. Billing:

1. The Provider shall submit original invoices directly to Insurer or its representative TPA and such invoices shall contain, at the minimum, following information:

   a. the Insured's full name and date of birth;
   b. the policy number;
   c. the Insured's Address
   d. the admitting consultant;
   e. the date of admission and discharge;
   f. the procedure performed and procedure code according to ICD-10 PCS or any other Code as specified by the Authority from time to time;
   g. the diagnosis at the time of treatment and diagnosis code according to ICD-10 or any other Code as specified by the Authority from time to time;;
   h. whether this is an interim or final bill/account;
   i. the description of each Service performed, together with associated Charges,
   j. the agreed standard billing codes associated with each Service performed and dates on which items of Service were provided; and.
   k. the Insured signature (in original).

2. The Provider shall submit the following documents with the final invoice:
   a. copy of Pre-Authorisation letter;
   b. fully completed claim form (or the relevant claim section of the Pre-Authorisation letter), signed by the Insured and the treating consultant for the Treatment performed;
   c. original and complete discharge summary in the standard form and billing

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form in the standard form, including the treating Consultant's operative notes;

d. original investigation reports with corresponding prescription/request;
e. pharmacy bill with corresponding prescription/request:
f. any other statutory documentary evidence required under law or by the Insured's policy; and
g. photocopy of the Insured's photo identification (eg voter's Smart card/ ID card, passport or driving licence etc).

3. The Provider shall submit the final invoice and all supporting documentation required within 2 days of the discharge date.

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Schedule-B

PROCESS NOTE FOR DE-EMPANELMENT OF PROVIDERS

Process to be Followed For De-Empanelment of Providers:

Step 1 – Putting the Provider on "Watch-list"

1. Based on the claims data analysis and/ or the visits carried out on a Provider, if there is any doubt on the performance of a Provider, the Insurance Company or the TPA that is representing an Insurer can put that Provider in the "watch-list".
2. The data of such Provider shall be analysed very closely on a daily basis by the Insurance Company or the TPA that is representing an Insurer for patterns, trends and anomalies.

Step 2 – Suspension of the Provider

3. A Provider can be temporarily suspended in the following cases:
   a. For the Providers which are in the "Watch-list" if the Insurance Company or the TPA that is representing an Insurer observes continuous patterns or strong evidence of irregularity based on either claims data or field visit to Providers, the Provider shall be suspended from providing services to policyholders/insured patients and a formal investigation shall be instituted.
   b. If a Provider is not in the "Watch-list", but the insurance company or the TPA that is representing an Insurer observes at any stage that it has data/ evidence that suggests that the Provider is involved in any unethical practice/ is not adhering to the major clauses of the contract with the Insurance Company involved in financial fraud related to health insurance patients, either the Insurer or the TPA that is representing an Insurer, may immediately suspend the Provider from providing services to policyholders/insured patients and a formal investigation shall be instituted.

4. A formal letter shall be send to the Provider regarding its suspension with mentioning the timeframe within which the formal investigation will be completed.

Step 3 – Detailed Investigation

5. The Insurance Company or the TPA that is representing an Insurer can launch a detailed investigation into the activities of a Provider in the following conditions:
   a. For the Providers which have been suspended.
   b. Receipt of complaint of a serious nature from any of the stakeholders

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6. The detailed investigation may include field visits to the Providers, examination of case papers, recording the statement of the policyholders/insured (if needed), examination of Provider records etc.
7. If the investigation reveals that the report/ complaint/ allegation against the Provider is not substantiated, the Insurance Company would immediately revoke the suspension (in case it is suspended). A letter regarding revocation of suspension shall be sent to the Provider within 24 hours of that decision.

Step 4 – Action by the Insurance Company or the TPA that is representing an Insurer

8. If the investigation reveals that the complaint/allegation against the Provider is correct then the following procedure shall be followed:
   a. The Provider must be issued a "show-cause" notice seeking an explanation for the aberration.
   b. After receipt of the explanation and its examination, the charges may be dropped or an action can be taken.
   c. The action could entail one of the following based on the seriousness of the issue and other factors involved:
      i. A warning to the concerned Provider,
      ii. De-empanelment of the Provider.

9. The entire process should be completed within 30 days from the date of suspension.

Step 5 – Actions to be taken after De-empanelment

10. Once a Provider has been de-empanelled by insurer or the TPA that is representing an Insurer, following steps shall be taken:
    a. A letter shall be sent to the Provider regarding this decision
    b. This information shall be sent to all the other Insurance Companies which are doing health insurance business and where the action is taken by a TPA in formation shall be also sent to all other TPAs.
    c. An FIR shall be lodged against the Provider by the insurer or the TPA that is representing an Insurer at the earliest in case the de-empanelment is on account of fraud or a fraudulent activity.
    d. The Insurance Company or the TPA that is representing an Insurer which had de-empanelled the Provider, may be advised to notify the same in the local media, for the information of policyholders/insured about the de-empanelment, so that the policyholder do not utilize the services of that particular Provider.
    e. If the Provider appeals against the decision of the Insurance Company, all the aforementioned actions shall be subject to the dispute resolution process agreed in the service level agreement.

Schedule – C

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STANDARD DISCHARGE SUMMARY:

1. Components of Standardization:
   a. List of standard contents in the discharge summary
   b. Standard guidelines for preparing a discharge summary so that the interpretation of the terms in the documents and the information provided is uniform.
2. Standard Contents of Discharge Summary Format:
   a. Patient's Name*:
   b. Telephone No / Mobile No*:
   c. IPD No:
   d. Admission No:
   e. Treating Consultant/s Name, contact numbers and Departments/Specialty:
   f. Date of Admission with Time:
   g. Date of Discharge with Time:
   h. MLC No / FIR No*:
   i. Provisional Diagnosis at the time of Admission:
   j. Final Diagnosis at the time of Discharge:
   k. ICD – 10 code(s) or any other codes, as recommended by the Authority, for Final diagnosis*:
   l. Presenting Complaints with Duration and Reason for Admission:
   m. Summary of Presenting Illness:
   n. Key findings, on physical examination at the time of admission;
   o. History of alcoholism, tobacco or substance abuse, if any:
   p. Significant Past Medical and Surgical History, if any*:
   q. Family History if significant/relevant to diagnosis or treatment:
   r. Summary of key investigation during Hospitalization*:
   s. Course in the Hospital including complication if any*:
   t. Advice on Discharge*:
   u. Name & Signature of treating Consultant / Authorized Team Doctor:
   v. Name & Signature of Patient / Attendant*:

* refer to guide notes below.

3. GUIDE NOTES FOR FILLING DISCHARGE SUMMARY FORMAT:

   a. The patient's name shall be the official name as appearing in the insurance policy document and the attendants should be made aware that it cannot be changed subsequently, because in some cases the attendants give the nick names which are different from documented names. As a matter of

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abundant precaution, all personal information should be shown to the patient/attendant and validated with their signature.

b. The contact numbers shall be specifically those of the patient and if pertaining to attendant, the same should be mentioned.

c. Where applicable, copy of MLC/FIR needs to be attached

d. Responses to point (2) (b), (k) and (p) are desirable but not mandatory

e. Significant past medical and surgical history shall be relevant to present ailment and shall provide the summary of treatment previously taken, reports of relevant tests conducted during that period. In case history is not given by patient, it should be specified as to who provided the same.

f. Summary of key investigations shall appear chronologically consolidated for each type of investigation. If an investigation does not seem to be a logical requirement for the main disease/line of treatment, the admitting consultant should justify the reason for carrying out such test / investigation.

g. The course in the hospital shall specify the line of treatment, medications administered, operative procedure carried out and if any complications arise during course in the hospital, the same should be specified. If opinion from another doctor from outside hospital is obtained, reason for same should be mentioned and also who decided to taken opinion i.e. whether the admitting and treating consultant wanted the opinion as additional expertise or the patient relatives wanted the opinion for their reassurance.

h. Discharge medication, precautions, diet regime, follow up consultation etc should be specified. If patient suffers from any allergy, the same shall be mentioned.

i. The signatures/Thumb impression in the Discharge Summary shall be that of the patient because generally the patient is discharged after having improved. In other cases like Death summary or transfer notes in case of terminal illness, the attendant can sign. In such cases, the inability of the patient to sign should be recorded by the attending doctor.

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Schedule - D

STANDARD FORMAT FOR PROVIDER BILLS

1. Components of standardization: Standardization involves three components:
   i) Bill Format
   ii) Codes for billing items and nomenclature
   iii) Standard guidelines for preparing the bills

2. Format specified: The bill is expected to be in two formats
   i) The summary bill and
   ii) The detailed breakup of the bills

3. Explanation and Guidelines – Summary Bill
   i. The summary format is annexed in the Schedule – D1
   ii. The Bill shall be generated on the letter head of the provider and in A4 size to aid scanning The summary bill shall not have any additional items (only nine)
   iii. The provider has to mention the service tax number in case they charge service tax to the Insurance Company
   iv. The payer mentioned in the Bill has to be necessarily the Insurance Company and not the TPA.
   v. In case of package charged for any procedure / treatment the provider is expected to mention the amount in Serial Number (9) only. Items beyond the package are to be mentioned in Serial Numbers (1) to (8).
   vi. The patient / attendant signature is mandatory on the summary bill
   vii. The additional guidelines to fill the summary format shall be as below:

Field Name	Remarks
Provider Name	Legal entity name and not the trade name
Provider Registration Number	Registration number of the provider with local authorities. once the clinical establishments (registration and regulation) bill, 2007 is passed, then registration number under this act
Address	Address of the Facility where member is admitted. A provider can have more than one facility.
IP No	Unique number identifying the particular hospitalization of the member
Patient Name	Full name of the patient
Payer Name	Name of the Insurance company with whom the member is insured. In case of cash patient then the

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	field is to be left blank. If the bill is raised to more than one insurer then the primary insurer who has given cashless is to be mentioned. The name of insurance company needs to be mentioned and not the TPA.
Member address	Full address of the member
Bill Number	Bill number of the provider
Bill Date	Date on which the bill is generated.
PAN Number	PAN Number – Mandatory
Service Tax Regn No	Registration number from service tax authorities. Mandatory in case service tax is charged in the bill
Date of admission	Date of admission of the member in case of IPD cases. In case of Day care procedures, this is the date of procedure
Date of discharge	Date of discharge of the member in case of IPD cases. In case of Day care procedures, this is the date of procedure(same as date of admission)
Bed Number	Bed number in which the patient is admitted. In case the member is admitted under more than one bed number, all the numbers have to be mentioned.
SL No 1 of billing Summary	All items under the primary head '100000' in the detailed bill have to be summarized into this. In case the procedure is packages, then only bills amount beyond the package needs to be mentioned here.
SL No 2 of billing Summary	All items under the primary head '200000' in the detailed bill have to be summarized into this. In case the procedure is packages, then only bills amount beyond the package needs to be mentioned here.
SL No 3 of billing Summary	All items under the primary head '300000' in the detailed bill have to be summarized into this. In case the procedure is packages, then only bills amount beyond the package needs to be mentioned here.
SL No 4 of billing Summary	All items under the primary head '400000' in the detailed bill have to be summarized into this. In case the procedure is packages, then only bills amount beyond the package needs to be mentioned here.
SL No 5 of billing Summary	All items under the primary head '500000' in the detailed bill have to be summarized into this. In case the procedure is packages, then only bills amount beyond the package needs to be mentioned here.

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SL No 6 of billing Summary	All items under the primary head '600000' in the detailed bill have to be summarized into this. In case the procedure is packages, then only bills amount beyond the package needs to be mentioned here.
SL No 7 of billing Summary	All items under the primary head '700000' in the detailed bill have to be summarized into this. In case the procedure is packages, then only bills amount beyond the package needs to be mentioned here.
SL No 8 of billing Summary	All items under the primary head '800000' in the detailed bill have to be summarized into this. In case the procedure is packages, then only bills amount beyond the package needs to be mentioned here.
SL No 9 of billing Summary	All items under the primary head '900000' in the detailed bill have to be summarized into this. If more than one procedure is done, the total amount of the two procedures needs to be summarized
Total Bill amount	Sum total of all items 1 to 9 in the bill
Amount paid by the member	Amount of bill paid by the member including co-pay, deductible, non-medical items etcincl discount offered to member, if any.
Amount charged to Payer	Amount payable by Insurance company
Discount Amount	Amount offered as discount to the insurance company
Service tax	Service Tax chargeable to insurance company
Amount Payable	Total amount payable by insurance com[any including service tax
Amount in words	Above mount in words for the sake of clarity
Patients signature	Signature of the patient or the attendant of the patient needs to be mandatorily taken
Authorized signatory	The signature of the authorized signatory at the provider

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4. Explanation and Guidelines – Detailed Breakup of the Bill

I. The summary format is annexed in Schedule – D2
II. The Bill shall be generated on the letterhead of the provider and in A4 size paper to aid scanning.
III. The billing has to be done at level 2 or 3
IV. In case of medicines/consumables, the relevant level code three has to be mentioned (40100, 401002) and the text should indicate the actual medicine used
V. If providers have outsourced the pharmacy to external vendors. In such cases the providers can attach the original bills separately. However, the summary of this has to be mentioned in the summary bill.
VI. In case of pharmacy returns the same, the code originally used is to be used with a negative sign in the units
VII. In case of cancellation of any service, the same code originally used is to be used with a negative sign indicating reversal
VIII. The date on which the service is rendered is to be mentioned in the bill. This would be
   a. the date of requisition in case of investigations
   b. date of consultation for professional fees
   c. date of requisition in case of pharmacy/consumables irrespective of when they were used
   d. Date of return of pharmacy items for pharmacy returns.

IX. The additional guidelines to fill the summary format shall be as below, except that the first section of the bill is same as the bill summary referred in 3 above.

Field Name	Remarks
Date	Date on which service is rendered. For example, this is the date of investigation, date of procedure etc.
Code	Level 2 or 3 code of the billing item as per the codes(annex III)
Particulars	Text explanation of the item charged
Rate	Per unit price (per day room rent, per consultation charge)
Unit	No of units charged(hours, days, number as appropriate)
Amount	Rate*unit(s)

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SUMMARY BILL FORMAT

Provider Name	…….	Bill Number	……..……
Provider registration No.		Bill Date	
Address		PAN Number	
IP No		Service Tax Regn No	
Patient Name		Date of admission	
Payer Name	XXXX Insurance Company Ltd	Date of Discharge	
Member Address		Bed Number	

Billing Summary

Sl No	Primary Code	Particulars	Amount
1	100000	Room & Nursing Charges	
2	200000	ICU Charges	
3	300000	OT Charges	
4	400000	Medicine & Consumables	
5	500000	Professional Fees'	
6	600000	Investigation Charges	
7	700000	Ambulance Charges	
8	800000	Miscellaneous Charges	
9	900000	Package Charges	

Total Bill Amount	0
Amount paid by member	……0
Amount charged to Payer	0
Discount Amount	0
Service Tax	0
Amount Payable	0
Amount in Words	Rupees Zero Only

Patients Signature

Authorised Signatory

Schedule – D2

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DETAILED BREAKUP FORMAT

PART - I

Provider Name	…… ……	Bill Number	…… ……
Provider registration No.		Bill Date	
Address		PAN Number	
IP No		Service Tax Regn No	
Patient Name		Date of admission	
Payer Name		Date of Discharge	
Member Address		Bed Number	

Billing Details

Sl No	Date	Code	Particulars	Rate	Nos(Unit)	Amount
1		101001	General Ward Charges	500	1	500.00
2		401001	XXX medicine	50	2	100.00
3		401001	XXX Medicine – return	50	-1	-50.00

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PART - II

Level 1 Code	Level 1	Level 2 Code	Level 2	Level 3 Code	Level 3	Remarks
100000	Room & Nursing Charges					
100000	Room & Nursing Charges	101000	Room Charges			
100000	Room & Nursing Charges	101000	Room Charges	101001	General Ward charges	
100000	Room & Nursing Charges	101000	Room Charges	101002	Semi-private room charges	
100000	Room & Nursing Charges	101000	Room Charges	101003	Single Room charges	
100000	Room & Nursing Charges	101000	Room Charges	101004	Single Deluxe room charges	
100000	Room & Nursing Charges	101000	Room Charges	101005	Deluxe room charges	
100000	Room & Nursing Charges	101000	Room Charges	101006	Suite charges	
100000	Room & Nursing Charges	101000	Room Charges	101007	Electricity charges	
100000	Room & Nursing Charges	101000	Room Charges	101008	Bed sheet charges	
100000	Room & Nursing Charges	101000	Room Charges	101009	Hot water charges	
100000	Room & Nursing Charges	101000	Room Charges	101010	Establishment Charges	
100000	Room & Nursing Charges	101000	Room Charges	101011	Alpha/Water Bed Charges	
100000	Room & Nursing Charges	101000	Room Charges	101012	Attendant Bed Charges	
100000	Room & Nursing Charges	102000	Nursing charges			
100000	Room & Nursing Charges	102000	Nursing charges	102001	Nursing fees	
100000	Room & Nursing Charges	102000	Nursing charges	102002	Dressing	
100000	Room & Nursing Charges	102000	Nursing charges	102003	Nebulization	
100000	Room & Nursing Charges	102000	Nursing charges	102004	Injection charges	
100000	Room & Nursing Charges	102000	Nursing charges	102005	Infusion pump charges	
100000	Room & Nursing Charges	102000	Nursing charges	102006	Aya Charges	
100000	Room & Nursing Charges	102000	Nursing charges	102007	Blood Transfusion Charges	
100000	Room & Nursing Charges	103000	Duty Doctor fee			
100000	Room & Nursing Charges	103000	Duty Doctor fee	103001	Duty Doctor fee	
100000	Room & Nursing Charges	103000	Duty Doctor fee	103002	RMO Fees	
100000	Room & Nursing Charges	104000	Monitor charges			
100000	Room & Nursing Charges	104000	Monitor charges	104001	Pulse Oxymeter charges	If used in normal Room
200000	ICU Charges					
200000	ICU Charges	201000	ICU Charges			
200000	ICU Charges	201000	ICU Charges	201001	Burns Ward	
200000	ICU Charges	201000	ICU Charges	201002	HDU charges	
200000	ICU Charges	201000	ICU Charges	201003	ICCU charges	
200000	ICU Charges	201000	ICU Charges	201004	Isolation ward charges	
200000	ICU Charges	201000	ICU Charges	201005	Neuro ICU charges	
200000	ICU Charges	201000	ICU Charges	201006	Pediatric/neonatal ICU charges	
200000	ICU Charges	201000	ICU Charges	201007	Post Operative ICU	
200000	ICU Charges	201000	ICU Charges	201008	Recovery Room	
200000	ICU Charges	201000	ICU Charges	201009	Surgical ICU	

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200000	ICU Charges	202000	ICU Nursing charges			If ICU nursing charged separately
200000	ICU Charges	202000	ICU Nursing charges	202001	Nursing fees	If ICU nursing charged separately
200000	ICU Charges	202000	ICU Nursing charges	202002	Dressing	If ICU nursing charged separately
200000	ICU Charges	202000	ICU Nursing charges	202003	Nebulization	If ICU nursing charged separately
200000	ICU Charges	202000	ICU Nursing charges	202004	Injection charges	If ICU nursing charged separately
200000	ICU Charges	202000	ICU Nursing charges	202005	Infusion pump charges	
200000	ICU Charges	203000	Monitor charges			
200000	ICU Charges	203000	Monitor charges	203001	Monitor charges	
200000	ICU Charges	203000	Monitor charges	203002	Pulse Oxymeter charges	If used in ICU
200000	ICU Charges	203000	Monitor charges	203003	Cardiac Monitor charges	
200000	ICU Charges	204000	Monitor charges	203004	IABP charges	
200000	ICU Charges	204000	Monitor charges	203005	Phototherapy Charges	
200000	ICU Charges	204000	ICU Supplies & equipment			
200000	ICU Charges	204000	ICU Supplies & equipment	204001	Oxygen charges	
200000	ICU Charges	204000	ICU Supplies & equipment	204002	Ventilator charges	
200000	ICU Charges	204000	ICU Supplies & equipment	204003	Suction pump charges	
200000	ICU Charges	204000	ICU Supplies & equipment	204004	Bipap charges	
200000	ICU Charges	204000	ICU Supplies & equipment		Pacing Charges	Temporary Pacemaker
200000	ICU Charges	204000	ICU Supplies & equipment	20406	Defibrillator Charges	
300000	OT Charges					
300000	OT Charges	301000	OT rent			
300000	OT Charges	301000	OT rent	301001	Major OT charge	
300000	OT Charges	301000	OT rent	301002	Minor OT Charge	
300000	OT Charges	301000	OT rent	301003	Cath Lab Charges	
300000	OT Charges	301000	OT rent	301004	Theatre charges	

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300000	OT Charges	301000	OT rent	301005	Labour Room Charges	
300000	OT Charges	302000	OT Equipment charges			
300000	OT Charges	302000	OT Equipment charges		C-arm charges	
300000	OT Charges	302000	OT Equipment charges	302002	Endoscopy charges	
300000	OT Charges	302000	OT Equipment charges	302003	Laproscope charges	
300000	OT Charges	302000	OT Equipment charges	302004	Equipment charges	If not specified
300000	OT Charges	302000	OT Equipment charges	302005	Monitor charges	for OT monitoring
300000	OT Charges	302000	OT Equipment charges	302006	Instrument charges	for OT instruments
300000	OT Charges	303000	OT Drugs & Consumables			
300000	OT Charges	303000	OT Drugs & Consumables	303001	OT Drugs	
300000	OT Charges	303000	OT Drugs & Consumables	303002	Implants	
300000	OT Charges	303000	OT Drugs & Consumables	303003	OT Consumables	includes guide wires, catheter etc
300000	OT Charges	303000	OT Drugs & Consumables	303004	OT Materials	
300000	OT Charges	303000	OT Drugs & Consumables	303005	OT Gases	
300000	OT Charges	303000	OT Drugs & Consumables	303006	Anaesthetic drugs	
300000	OT Charges	304000	OT Sterlization			
300000	OT Charges	304000	OT Sterlization	304001	CSSD Charges	
400000	Medicine & Consumables charges					
400000	Medicine & Consumables charges	401000	Medicine & Consumables charges			
400000	Medicine & Consumables charges	401000	Medicine & Consumables charges	401001	Ward Medicines	OT drugs under OT charges
400000	Medicine & Consumables charges	401000	Medicine & Consumables charges	401002	Ward Consumables	
400000	Medicine & Consumables charges	401000	Medicine & Consumables charges	401003	Ward disposables	
400000	Medicine & Consumables charges	401000	Medicine & Consumables charges	401004	Ward Materials	
400000	Medicine & Consumables charges	401000	Medicine & Consumables charges	401005	Vaccination drugs	
500000	Professional fees charges					
500000	Professional fees charges	501000	Visit charges			
500000	Professional fees charges	501000	Visit charges	501001	Consultation Charges	

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500000	Professional fees charges	501000	Visit charges	501002	Medical Supervision Charges	
500000	Professional fees charges	501000	Visit charges	501003	Professional fees	
500000	Professional fees charges	502000	Surgery Charges			
500000	Professional fees charges	502000	Surgery Charges	502001	Surgeons Charges	
500000	Professional fees charges	502000	Surgery Charges	502002	Assistant Surgeons Fee	Would also include Standby Surgeon
500000	Professional fees charges	503000	Anaesthetists fee			
500000	Professional fees charges	503000	Anaesthetists fee	503001	Anaesthetists fee	
500000	Professional fees charges	503000	Anaesthetists fee	503002	OT standby charges	Providers charge for standby anaesthetist
500000	Professional fees charges	504000	Intensivist Charges	504000		
500000	Professional fees charges	505000	Technician Charges	505000	OT /Cath Lab Technician	
500000	Professional fees charges	505000	Physiotherapy			
500000	Professional fees charges	504000	Procedure charges			
500000	Professional fees charges	504000	Procedure charges	504001	Bedside procedures	Catheterization, Central IV Line, Tracheostomy, Venesection
500000	Professional fees charges	504000	Procedure charges	504002	Suture charges	
600000	Investigation Charges					
600000	Investigation Charges	601000	Bio Chemistry			Serum Sodium, Ueresetc
600000	Investigation Charges	602000	Cardiology charges			for procedures like echo, ECG etc
600000	Investigation Charges	603000	Haemotology charges			cross matching etc
600000	Investigation Charges	604000	Microbiology charges			blood culture, C&S
600000	Investigation Charges	605000	Neurology			for EMG, EEG etc
600000	Investigation Charges	606000	Nuclear medicine			PET CT, Bone scan etc
600000	Investigation Charges	607000	Pathology charges			
600000	Investigation Charges	608000	Radiology services			X-ra, CT, MRI etc
600000	Investigation Charges	609000	Serology charges			
600000	Investigation Charges	610000	Medical Genetics			Chromosomal Analysis etc
600000	Investigation Charges	611000	Profiles			Profiles instead of individual tests (Lipid profile, LFT etc)
700000	Ambulance Charges					
700000	Ambulance Charges	701000	Ambulance Charges			
800000	Miscellaneous charges					
800000	Miscellaneous charges	801000	Admission charges			
800000	Miscellaneous charges	802000	Attendant food charges			
800000	Miscellaneous charges	803000	Patient food charges			

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800000	Miscellaneous charges	804000	Registration charges			
800000	Miscellaneous charges	805000	MRD Charges			
800000	Miscellaneous charges	806000	Documentation charges			
800000	Miscellaneous charges	807000	Telephone charges			
800000	Miscellaneous charges	808000	Bio Medical Waste Charges			
800000	Miscellaneous charges	809000	Taxes		Luxury Tax/Surcharge/Service Charge	Excluding VAT & Service Tax
900000	Package Charges					To be used only in case of packages
900000	Package Charges	901000	Cardiac Surgery	ICD-10-PCS	CABG	To be used only in case of packages
900000	Package Charges	902000	CardiologyPackages	ICD-10-PCS	PTCA	To be used only in case of packages
900000	Package Charges	903000	Cath Lab	ICD-10-PCS	CAG	To be used only in case of packages
900000	Package Charges	904000	Dental Procedures	ICD-10-PCS	Root Canal Treatment	To be used only in case of packages
900000	Package Charges	905000	ENT	ICD-10-PCS	FESS	To be used only in case of packages
900000	Package Charges	906000	Gastroenterology	ICD-10-PCS	Gastrectomy - Partial	To be used only in case of packages
900000	Package Charges	907000	General Surgery	ICD-10-PCS	Inguinal hernia	To be used only in case of packages
900000	Package Charges	908000	Gynaecology	ICD-10-PCS	LSCS	To be used only in case of packages
900000	Package Charges	909000	Nephrology	ICD-10-PCS	Nephrectomy	To be used only in case of packages
900000	Package Charges	910000	Neuro Surgery	ICD-10-PCS	Craniotomy	To be used only in case of packages
900000	Package Charges	911000	Oncology Procedures	ICD-10-PCS	IMRT	To be used only in case of packages
900000	Package Charges	912000	Opthalmology procedures	ICD-10-PCS	Cataract	To be used only in case of packages
900000	Package Charges	913000	Orthopaedic Surgery	ICD-10-PCS	Bilateral TKR	To be used only in case of packages
900000	Package Charges	914000	Plastic Surgery	ICD-10-PCS	Skin Grafting	To be used only in case of packages
900000	Package Charges	915000	Pulmonology Packages	ICD-10-PCS	Pleural Tapping	To be used only in case of packages
900000	Package Charges	916000	Urology	ICD-10-PCS	ERCP	To be used only in case of packages
900000	Package Charges	917000	Vascular Surgery	ICD-10-PCS	Embolectomy	To be used only in case of packages

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Annexure – 23

As per Regulations 22 (4) of IRDAI (TPA – Health Services) Regulations, 2016

Periodical Returns –Half yearly Information on non-insurance health schemes
(Note: to be furnished within 30 days of the end of every half year. For e.g: Report for April to September to be furnished by 30th October)

Form TPA – 6F

1	**PARTICULARS OF THE TPA COMPANY:**		
1.1		Name of the TPA :	
1.2		Address - Registered Office:	Pin code: _____ Landline No: _____ E-mail:_____ Fax No: ----------
1.3		Financial Year	
1.4		Half Year for which Data is furnished	(April – September / October – March)
1.5		Name of non-insurance scheme and concerned Central / State Government (Scheme wise data to be submitted in following format)	

Sr. No.	Name of Scheme and Description of Services Offered	Central Govt / Department / State Govt	Geography covered	No. of Transactions		Number of lives serviced.		Amount of remuneration received (Rs. INR in Lakhs)	
				For the Half-Year	Up to the Half-Year	For the Half-Year	Up to the Half-Year	For the Half-Year	Up to the Half-Year

The above information furnished is the correct information and as per the records of the Company. It is further declared that other than the permitted non insurance health schemes no other non-insurance activity has been serviced or carried out by our Company.

Date:	For and on behalf of (Name of TPA Company)	
Place:	(Name of Director)	(Name of Director or CEO / CAO)

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Annexure – 24

As per Regulations 22 (3) of IRDAI (TPA – Health Services) Regulations, 2016

Norms on Non Insurance Services under Healthcare Schemes

1. A TPA may render Health Services to only those healthcare schemes promoted, sponsored or approved by Central Government or any State Government.

   Explanation: No Public Sector Undertaking shall come within the ambit of the above clause.

2. A TPA may render services in wellness and Health promoting programmes, only if such activities are covered under insurance policy as issued by the concerned insurer, with whom a TPA has agreement for rendering of such Health Services.

   Provided a TPA shall not render any services directly or indirectly to the policyholder or insured, except such health services that are required to be rendered as per agreement with the insurer and within the terms of the concerned policy contract.

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Annexure – 25

As per Regulations 22 (4) of IRDAI (TPA – Health Services) Regulations, 2016

Format for half yearly information on services rendered in foreign jurisdictions for policies issued by Indian insurers

(to be furnished within 45 days from the date of closure of Half Year)

Form TPA -6G

1	**PARTICULARS OF THE TPA COMPANY:**		
1.1		Name of the TPA :	
1.2		Address - Registered Office:	Pin code: _____ Landline No: _____ E-mail:_____ Fax No: ----------
1.3		Financial Year	
1.4		Half Year for which Data is furnished	April – September; October - March
1.5		Name of insurer (Insurer wise data to be submitted in following format)	

Sr No	Name of Country where services offered	Name of Indian Insurer that issued policy	Number of policies serviced		Number of claims serviced		No. of Claims Outstanding		Amount of claims paid (Rs. INR in Lakhs)		Amount of remuneration received (Rs. INR in Lakhs)	
			For the Half Year	Up to the Half Year	For the Half Year	For the Half Year	For the Half Year	For the Half Year	For the Half Year	For the Half Year	For the Half Year	For the Half Year

The above information furnished is the correct information and as per the records of the Company. It is further declared that other than the above permitted health services no other services for non-insurance activity has been rendered or carried out by our Company.

Date:	For and on behalf of (Name of TPA Company)	
Place:	(Name of Director)	(Name of Director or CEO / CAO)

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Annexure – 26

As per Regulations 22 (4) of IRDAI (TPA – Health Services) Regulations, 2016

Format for half yearly information on health services rendered to policies issued by foreign insurers

(to be furnished within 45 days from the date of closure of every Half Year)

Form TPA - 6H

1	**PARTICULARS OF THE TPA COMPANY:**		
1.1		Name of the TPA :	
1.2	(A)	Address - Registered Office:	 Pin code: _____ Landline No: _____ E-mail:_____ Fax No: ----------
1.3		Financial Year	
1.4		Half Year for which Data is furnished	April – September; October - March
1.5		Name of foreign insurer (foreign Insurer wise data to be submitted in following format)	

	Name of Foreign Insurer:											
Sr No.	**Country of Principal place of Foreign Insurer**	**Geographical location (Name of Indian state) where health services are rendered**	**Number of policies serviced**		**Number of claims serviced**		**No. of Claims Outstanding**		**Amount of claims paid (Rs. INR in Lakhs)**		**Amount of remuneration received (Rs. INR in Lakhs)**	
			For the period	Up to the period	For the period	Up to the period	For the period	Up to the period	For the period	Up to the period	For the period	Up to the period

(Note: Information to be furnished Foreign Insurer wise Indian State wise)

The above information furnished is the correct information and as per the records of the Company. It is further declared that other than the permitted health services no other services for non-insurance activity has been rendered or carried out by our Company.

Date:	For and on behalf of (Name of TPA Company)	
Place:	(Name of Director)	(Name of Director or CEO / CAO)

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Annexure – 27

As per Regulations 23, Schedule – II (2) (z) of IRDAI (TPA – Health Services) Regulations, 2016

Corporate Governance norms for TPAs

1. Board of the applicant TPA Company or Registered TPA Company;
   a) shall ensure for providing of true and correct information to the Authority.
   b) shall ensure proper due diligence before submitting any of the data / information with the Authority including information about Key Managerial Persons of the Company.
   c) shall have a system of monitoring complaints disposal and ensure that corrective action taken for system related improvement.
   d) shall ensure at all times that, there shall not be any conflict of interest of their TPA Company with any other insurance or insurance related activity or business.
   e) shall oversee,
      i) claim settlement process as per claim settlement guidelines issued by concerned insurers,
      ii) time frames / TAT / processes with respect to their TPA business.
      iii) polices with respect to Information Technology (IT), of their TPA Company.
   f) shall appoint CEO or CAO, who is having required qualification as stipulated in IRDAI (TPA – Health Services) Regulations, 2016 and put in place procedures to ensure that they are responsible for complying all regulatory and statutory requirements stipulated either in the Regulations notified by the Authority or any other relevant statutory provisions. Such CEO or CAO who is responsible for compliance shall report to the Board of the TPA Company about the status of all compliance matters at least two times in a Financial Year.
   g) may endeavour to appoint at least one Independent Director who shall be fit &proper as per these extant regulations with adequate experience in the field of Health Care or Health Insurance or TPA business. shall be responsible to put in place internal controls in the TPA Company.
   h) shall be responsible to put in place effective internal audit
   i) may delegate the activities referred at (h) above to board appointed sub-ordinate committee. But the minutes of the said subordinate committee shall be placed before the Board in the immediate Board meeting.

2. The Board is responsible for appointing the statutory auditors of the TPA Company.
3. The Board is responsible to ensure that all directors appointed comply with all the statutory provisions inter alia Companies Act, 2013.

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4. Annual Report prescribed under Form TPA – 8 and all the Forms, Schedules there under shall be disclosed in the website of the TPA Companies.
5. Every TPA Company shall disclose on their respective website the geography wise names and addresses of the Network Providers with whom it has entered into an agreement. Such list shall be updated on the real time basis.

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Annexure – 28

As per Regulations 25 (2) of IRDAI (TPA – Health Services) Regulations, 2016

Form for intimation of opening and closing of the branches or change in office address.
(to be filed as and when a branch is closed or opened or there is a change in the address)

FORM TPA – 9

Instructions for filling up the form:

1. TPAs are requested to submit concerned PART (e.g. Part A, B,C,D etc.) of this form duly fill-in and signed for the records of the Authority.

1	**PARTICULARS OF THE TPA COMPANY:**		
1.1		Name of the TPA :	
1.2	(A)	Address - Registered Office:	
			Pin code: _____ Landline No: _____
			E-mail:_____ Fax No: ----------
1.3	(B)	Address for Correspondence: Principal Place of business or Corporate Office	
			Pin code: _____ Landline No: _____
			E-mail:_____ Fax No: ----------

2	Details of Certificate of Registration		
	A	TPA Registration No.	
	B	Date of First grant of Registration (DD/MM/YYYY)	
	C	Date of Renewal of Registration (DD/MM/YYYY)	
	D	Date of Expiry of current Certificate of Registration (DD/MM/YYYY)	

PART – A			
	Every TPA that opened the branches shall submit the respective particulars in the following format within 15 days of opening the said branches.		
	A	Number of Branches opened:	
	B	Name and address of the locations of the branches opened:	
	C	Date of opening the branch:	
	D	Name of the person in-charge of the Branch:	

PART – B			
	Every TPA that closed the branches shall submit the respective particulars in the following format within 15 days of closing the said branches.		
	A	Number of Branches Closed	
	B	Name and address of the locations of the branches Closed:	

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	C	Date of opening the branch	
	D	Date of Closing the branch:	
	E	Reason for closing the branch:	

PART – C : Change in Branch / Registered Office Address	
	Every TPA shall furnish the particulars of the change in address of its Corporate office or the registered office or Branch Office in the following format within 15 days from the date of effecting the change.

1	**PARTICULARS OF THE TPA Company:**		
1.1		Name of the TPA :	
1.2		Old Address – Corporate / Registered / Branch Office:	
			Pin code: _____ Landline No: _____
			E-mail:_____ Fax No: ----------
1.3		New Address – Corporate / Registered / Branch Office:	
			Pin code: _____ Landline No: _____
			E-mail:_____ Fax No: ----------

#	New Address of office	Region	City/ Town/ Village	State	Person in Charge	No. of staff	Date of Opening of Office	Whether in operation or not (Yes/No)	Date of Closure (IF h = 'No' THEN Date of Closure ELSE Blank)
Column Code	**a**	**b**	**c**	**D**	**E**	**f**	**g**	**h**	**i**

PART – D : To be submitted only in case of existence of foreign offices			
	Every TPA shall furnish the particulars of the Representative Offices or Liaison Offices or Branch Offices opened / closed in Foreign Countries within 15 days of opening / closing the office.		
	A	Financial Year	
	B	Reporting for Opening or Closing of Foreign Office	
	C	Type of Office Opened or Closed:	
	D	Name of Foreign Country where the Office Opened / Closed:	
	E	Number of offices opened for the period	
	F	Number of offices closed for the period	
	G	Number of offices opened up to the period	
	H	Number of offices closed up to the period	
	I	Foreign Country wise number and details of offices in operation:	

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Sr. No.	Name of Foreign Country	Type of Office (Representative Or Branch Office)	Number of offices	Address and Telephone number each office	Name of In-charge Persons responsible for operations of each of the office

Date:	For and on behalf of (Name of TPA Company)	
Place:	(Name of Director)	(Name of Director or CEO / CAO)

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Annexure – 29

As per Regulations 19 (2) of IRDAI (TPA – Health Services) Regulations, 2016

Other than books and accounting records which are to be maintained as per the extant provisions of the Companies Act, 2013, every TPA and the Insurer shall maintain all their other records as specified hereunder:

1. Service Level Agreements (SLAs): SLAs entered into with insurer, network provider as the case may be shall be maintained at least for a period of five years from date of expiry the said agreements.

2. Other operational and transactional records: TPAs shall maintain these records at least for a period of five years or as agreed between the TPA and the insurer.

All TPAs and Insurers shall endeavour to maintain the records in electronic form.

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Annexure – 30

As per Regulations 20 (5) of IRDAI (TPA – Health Services) Regulations, 2016

Part A: Claim Form For Health Insurance Policies Other Than Travel and Personal Accident
Part B: Claim Form
Part C: Request for Cashless Hospitalization for Health Insurance Policy
Part D: Cashless Authorization Letter Format

1. All the Insurers and the TPAs shall ensure that every network provider is notified about the cashless authorization in Part – D specified and a copy of Part D is also simultaneously notified to the policyholder/claimant to enable the policyholder / claimant have information about the package rates agreed with the network provider or the extent of authorization issued to the network provider and related conditions thereof. As and when any supplementary / additional authorization or final approval is issued and notified to the network provider, copy of Part – D shall be also invariably notified to the policyholder.
2. Insurers and TPAs may endeavor to obtain PART-C from the hospitals by electronic / digital means for seamless processing of the cashless requests.
3. Insurers and TPAs may also endeavor to notify Part – D to the network providers and the policyholders through system generated form and may specify accordingly, wherever may be the case.
4. All Insurers and TPAs shall ensure that the font size of these forms is not less than Times New Roman 10 and shall be clear and legible.
5. Insurers and TPAs may capture details of Part – C and Part – D in Optical Character recognition (OCR) / Machine readable format.
6. The Insurer and TPAs may specify any additional terms in Part – D subject to the Service Level Agreement entered with the network provider.

CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT – PART A
TO BE FILLED IN BY THE INSURED

The issue of this Form is not to be taken as an admission of liability

(To be filled in block letters)

DETAILS OF PRIMARY INSURED:

a) Policy No: t) Sl. 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:

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:

a) Name: SURNAME FIRST NAME MIDDLE NAME

b) Gender: Male ☐ Female ☐ c) Age: years Y Y months M M d) 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)

g) Address (if different from above):

City: State:

Pin Code: Phone No: E-mail ID:

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: D D M M Y Y

e) Date of Admission: D D M M Y Y f) Time: H H : 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:

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:

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:___Nos	
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			

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

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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 include the original preauthorization request form in lieu of PART A

(To be filled in block letters)

DETAILS OF HOSPITAL

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

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

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

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a)	ICD 10 Codes	Description	b)	ICD 10 PCS	Description
i. Primary Diagnosis:			i. Procedure 1:		
ii. Additional Diagnosis:			ii. Procedure 2:		
iii. Co-morbidities:			iii. Procedure 3:		
iv. Co-morbidities:			iv. Details of Procedure		

d) Pre-authorization obtained: ☐ Yes ☐ No e) Pre-authorization Number:

f) If authorization by network hospital not obtained, give reason:

g) 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

- ☐ 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 Theatre 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)

a) Address of the Hospital:

City: State:

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

d) Hospital PAN: e) Number 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)

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

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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
l)	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			

SECTION B SECTION C SECTION D SECTION E SECTION F

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Re: Modification of existing format for "Request for Cashless Hospitalization for Health Insurance Policy (Part C)" and introduction of Standard Cashless Authorization Letter Format (Part D)

1. Reference is invited to clause 4 of the Circular ref: IRDA/TPA/REG/CIR/059/03/2016 dated 28.03.2016 issued under the provisions of IRDAI (TPA – Health Services) Regulations, 2016. Annexure 30 of the within referred circular prescribed three claim forms namely; Part A, Part B and Part C.
2. In partial modification of Part C (request for cashless hospitalization for Health Insurance policy), the revised "Part C" is herewith specified.
3. Part D - Cashless Authorization letter Format is now introduced for issuing to the Network Providers at time of authorizing the cashless treatment. All the Insurers and the TPAs shall ensure that every network provider is notified about the cashless authorization in Part – D specified and a copy of Part D is also simultaneously notified to the policyholder/claimant to enable the policyholder / claimant have information about the package rates agreed with the network provider or the extent of authorization issued to the network provider and related conditions thereof. As and when any supplementary / additional authorization or final approval is issued and notified to the network provider, copy of Part – D shall be also invariably notified to the policyholder.
4. Insurers and TPAs may endeavor to obtain PART-C from the hospitals by electronic / digital means for seamless processing of the cashless requests.
5. Insurers and TPAs may also endeavor to notify Part – D to the network providers and the policyholders through system generated form and may specify accordingly, wherever may be the case.
6. All Insurers and TPAs shall ensure that the font size of these forms is not less than Times New Roman 10 and shall be clear and legible.
7. Insurers and TPAs may capture details of Part – C and Part – D in Optical Character recognition (OCR) / Machine readable format.
8. The Insurer and TPAs may specify any additional terms in Part – D subject to the Service Level Agreement entered with the network provider.
9. This Circular would come into effect from 1st July, 2019

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REQUEST FOR CASHLESS HOSPITALISATION FOR HEALTH INSURANCE POLICY PART – C (Revised)

(TO BE FILLED IN BLOCK LETTERS)

DETAILS OF THE THIRD PARTY ADMINISTRATOR/ INSURER/ HOSPITAL:

a. Name of TPA/Insurance company: _____

b. Toll free phone number: _____

c. Toll free fax: _____

d. Name of Hospital: _____

i. Address _____
ii. Rohini ID _____
iii. e-mail id _____

TO BE FILLED BY INSURED/PATIENT

A. Name of the Patient: _____

B. Gender: ☐ Male ☐ Female ☐ Third Gender

C. Age: (Years) / (Month)

D. Date of Birth: (DD/MM/YYYY)

E. Contact number: _____

F. Contact number of attending Relative: _____

G. Insured Card ID number: _____

H. Policy number/Name of Corporate: _____

I. Employee ID: _____

J. Currently do you have any other mediclaim /health insurance: ☐ Yes ☐ No

i.Company Name: _____
ii.Give Details: _____

K: Do you have a family Physician: ☐ Yes ☐ No

L: Name of the Family Physician: _____

M: Contact number, if any: _____

N: Current Address of Insured Patient: _____

O: Occupation of Insured Patient: _____

(PLEASE COMPLETE DECLARATION OF THIS FORM)

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TO BE FILLED BY TREATING DOCTOR/HOSPITAL

A: Name of the treating Doctor: _____

B: Contact number: _____

C: Nature of Illness/Disease with presenting complaint: _____

D: Relevant Critical Findings: _____

E: Duration of the present ailment _____ Days

i. Date of First consultation: DD/MM/YYYY
ii. Past history of present ailment, if any _____

F: Provisional diagnosis: _____

i. ICD 10 code _____

G: Proposed line of treatment:

i. Medical Management ( )
ii. Surgical Management ( )
iii. Intensive care ( )
iv. Investigation ( )
v. Non-allopathic treatment ( )

H: If investigation and/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 injury occur _____

L: In case of accident

i. Is it RTA: ☐ Yes ☐ No
ii. Date of Injury: (DD/MM/YYYY)
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 establish this (if yes, attach report) ☐ Yes ☐ No

m. In case of Maternity ☐ G ☐ P ☐ L ☐ A

i. expected date of Delivery DD/MM/YYYY

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DETAILS OF PATIENT ADMITTED

A. Date of admission _____ (DD/MM/YYYY)

B. Time of admission (HH : MM)

C. Is this an emergency/planned hospitalization event: Emergency ☐ Planned ☐

D. Mandatory Past History of any chronic illness — If yes (Since month/year)

i. Diabetes _____
ii. Heart disease _____
iii. Hypertension _____
iv. Hyperlipidemias _____
v. Osteoarthritis _____
vi. Asthma/COPD/Bronchitis _____
vii. Cancer _____
viii. Alcohol/Drug abuse _____
ix. Any HIV/ or STD Related ailment _____
x. Any other ailment, give details _____

E. Expected number of Days/stay in hospital _____ Days

F. Days in ICU _____ Days

G. Room Type

H. Per day room rent+nursing and service charges+ patients diet _____

I. Expected cost of investigation + diagnostic _____

J. ICU charges _____

K. OT charges _____

L. Professional fees Surgeon + Anesthetist Fees + consultation Charges: _____

M. Medicines + Consumables + Cost of Implants (if applicable please specify) _____

N. Other hospital expenses if any _____

O. All-inclusive package charges if any applicable _____

P. Sum Total expected cost of hospitalization _____

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DECLARATION
(Please read very carefully)

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

a. Name of the treating doctor _____
b. Qualification: _____
c. Registration number with State code _____

Hospital Seal
(Must include Hospital ID)

Patient/Insured Name and Sign

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DECLARATION BY THE PATIENT / REPRESENTATIVE

a. 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.

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 conditions 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/T.P.A 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 / T.P.A

e. 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.

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: _____ e-mail Id (optional) _____

d) Patient's / Insured's Signature: _____

Date: _____ Time:_____

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.

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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.

Hospital Seal Doctor's Signature

Date: Time:

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Cashless Authorization Letter

(Part-D)

Claim Number: ……. (Please quote this number for all further correspondence) Date: DD/MM/YYYY

Authorization is valid for admission up to ……(date)

ABC Hospital Address…….. ……. …….. Rohini Id:	Name of Insurance Company : Name of TPA : Proposer Name : Patient's Member ID/TPA/Insurer Id of the Patient : Relation with Proposer :

Dear Sir /Madam ,

This has reference to the pre-authorization request submitted on ……. We hereby authorize cashless facility as per details mentioned below:

Patient Name :	Age :	Gender :
Policy Number :	Expected Date of Admission :	
Policy Period :	Expected Date of Discharge :	
Room category : Eligible Room Category as per T&C of Policy Contract:	Estimated length of stay :	
Provisional Diagnosis :	Proposed line of treatment :	

Authorization Details:-

Date & Time	Reference number	Amount	Status
dd/mm/yyyy – hh:mm			
dd/mm/yyyy – hh:mm			

Total Authorized amount:- Rs ……..(In words)

Authorization Remarks :

……..

Hospital Agreed Tariff:

I. **Package case**

Agreed Package Rate ……..

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II. Non-package Case:

i. Room Rent/day ……

ii. ICU Rent/day

iii. Nursing Charges/day……

Iv. Consultant Visit Charges/day…….

v. Surgeon's fee/OT/Anaesthetist…….

vi. Others (specify) -------

Authorization Summary:

Total Bill Amount : (INR)

*Other Deductions : (INR) (At the time of Final Authorization)

Discount : (INR) (At the time of Final Authorization)

Co-Pay : (INR)

Deductibles : (INR)

Total Authorised Amount: : (INR)

Amount to be paid by Insured : (INR)(At the time of Final Authorization)

***Other Deduction Details:**

S.no	Description	Bill Amount	Deducted Amount	Admissible Amount	Deduction Reason

Terms and Conditions of Authorization:

1. Cashless Authorization letter issued on the basis of information provided in Pre- Authorization form. In case misrepresentation/concealment of the facts, any material difference/ deviation/ discrepancy in information is observed in discharge summary/ IPD records then cashless authorization shall stand null & void. At any point of claim processing Insurer or TPA reserves right to raise queries for any other document to ascertain admissibility of claim.
2. KYC (Know your customer) details of proposer/employee/Beneficiary are mandatory for claim payout above Rs 1 lakh.
3. Network provider shall not collect any additional amount from the individual 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).
4. Network Provider shall not make any recovery 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).

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5. 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 or get the same refunded to the policyholder from the Network Provider and/or take necessary action, as provided under the MoU.
6. Where a treatment/procedure is to be carried out by a doctor/surgeon of insured's choice (not empaneled with the hospital), Network Provider may give treatment after obtaining specific consent of policyholder.
7. Differential Costs borne by policyholder may be reimbursed by insurers subject to the terms and conditions of the policy.

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. Diagnostic Test Reports and Receipts supported by note from the attending Medical Practitioner / Surgeon recommending such Diagnostic supported by note from the attending Medical Practitioner / Surgeon recommending such diagnostic tests.

4. Surgeon's Certificate stating nature of operation performed and Surgeon's Bill and Receipt.

5. Certificates from attending Medical Practitioner / Surgeon giving patient's condition and advice on discharge.

Name of the Product …….and UIN No ……..: - Important Policy terms & conditions (sub-limits/co-pay/deductible etc)

Authorized signatory :
(Insurer/TPA)

Address: