

Cashless Authorization Letter Part - D

 Claim Number (Please quote this number for all further correspondence)

 Date

 Authorization is valid for admission up to (date)

ABC Hospital	Name of Insurance Company	<input type="text"/>
Address <input type="text"/>	Name of TPA	<input type="text"/>
<input type="text"/>	Proposer Name	<input type="text"/>
<input type="text"/>	Patient's Member	<input type="text"/>
Rohini ID <input type="text"/>	ID/TPA, Insurer ID of the Patient	<input type="text"/>
	Relation with Proposer	<input type="text"/>

Dear Sir /Madam ,

This has reference to the pre-authorization request submitted on _____. We here by 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 ₹ (in words)

 Authorization Remarks

HOSPITAL AGREED TARIFF

I) Package Case

 i) Agreed Package Rate
II) Non-package Case

 i) Room Rent / Day

 ii) ICU Rent / Day

 iii) Nursing Charges / Day

 iv) Consultant Visit Charges / Day

 v) Surgeon's Fees / OT / Anaesthetist

 vi) Others (specify)

AUTHORIZATION SUMMARY

Total Bill Amount	:	₹	<input type="text"/>	
Other Deductions*	:	₹	<input type="text"/>	(At the Time of Final Authorization)
Discount	:	₹	<input type="text"/>	(At the Time of Final Authorization)
Co - Pay	:	₹	<input type="text"/>	
Deductibles	:	₹	<input type="text"/>	
Total Authorised Amount	:	₹	<input type="text"/>	
Amount to be Paid by Insured	:	₹	<input type="text"/>	(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

- 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.
- KYC (Know your customer) details of Proposer / Employee / Beneficiary are mandatory for claim payout above ₹1 lakh.
- 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)'.
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 empanelled with the hospital), Network Provider may give treatment after obtaining specific consent of policy holder.
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

- Detailed Discharge Summary and all Bills from the hospital.
- Cash Memos from the Hospitals / Chemists supported by proper prescription.
- 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.
- Surgeon's Certificate stating nature of operation performed and Surgeon's Bill and Receipt.
- Certificates from attending Medical Practitioner / Surgeon giving patient's condition and advice on discharge.

Authorised Signatory

(Insurer/TPA)

Address:

Kotak Mahindra General Insurance Company Ltd.

CIN: U66000MH2014PLC260291. Registered Office: 27 BKC, C 27, G Block, Bandra Kurla Complex, Bandra East, Mumbai – 400051. Maharashtra, India.

Office: 8th Floor, Zone IV, Kotak Infinity, Bldg. 21, Infinity IT Park, Off WEH, Gen. AK Vaidya Marg, Dindoshi, Malad (E), Mumbai – 400097. India

Toll Free: 1800 266 4545 Email: care@kotak.com Website: www.kotakgeneralinsurance.com IRDAI Reg. No. 152.