**PROCESSING OF CLAIM FOR REIMBURSEMENT :**
**NON EMPANELLED HOSPITAL**

1. Reference our letter No B/49773/AG/ECHS/Policy dt 16 May 2007.

2. All high cost hospital bills are required to be processed through concerned Regional Centres vide our letter under reference.

3. Please ensure the following while forwarding such bills to Central Org ECHS :-

(a) Every bill should have a check list as per Appdix A attached which should be duly completed, checked and attached.

(b) Documents attached with the bills should be flagged as indicated in the check list (Appx A).

(c) The processing of bills should be carried out in the format enclosed as Appx B (4 pages) duly signed by all concerned.

(d) All bills/documents should be placed in a folder neatly marked on top as per Appx C.

4. The above instructions be implemented with imdt effect.

Sd/xxxxxx

Dir (Med)
For Managing Director

Authority : B/49773/AG/ECHS/ 06 Sep 07

**Appx 'A'**
(Refer to Para 3 (a) of Central Org ECHS letter No B/49778/AG/ECHS/Policy Dt 06 Sep 2007)

## CHECK LIST OF MEDICAL DOCUMENTS : BILL ABOVE 4 LAKHS CASES

Name of Hospital _____ Date of Empanelement _____

Name of ECHS Member _____

| Ser No | Description | Availability Yes/No/NA | Flag |
|---|---|---|---|
| 1. | Proof of membership(Photocopy of Smart Card/ Regn receipt | | A |
| 2 | Referral Form | | B |
| 3 | Discharge/Case Summary | | C |
| 4 | Bills on Original | | D |
| 5 | Cover Note | | E |
| 6 | Work sheet and Recommendation of Regionl Centre | | F |
| 7 | Emergency Certificate (If applicable) | | G |
| 8 | "Emergency Treatment in Empanelled Hospital" superscribed in RED on all bills (If applicable) | | H |
| 9 | Sanction letter of Medical Advance drawn (if applicable) | | J |
| 10 | Prior Approval (Appx 'A') | | K |
| 11 | Justification if Prior Approval not obtained (if applicable) | | L |

(Refer to Para 3 (c) of Central Org ECHS letter No B/49778/AG/ECHS/Policy Dt 06 Sep 2007)

## CHECK LIST (Dealing Clk)

**Name of Regional Centre** _____

## CLAIM DOCUMENTS ON RECEIPT

Name of Hospital _____ Date of Empanelement _____

Name of Patient _____ Name of Member _____

ECHS No_____ dt _____

Date claim received at Regional Centre _____

| Ser No | Required Information/Doc | Remarks | |
|---|---|---|---|
| | | Available | Not Available |
| 1. | Date of membership | | |
| 2 | Proof of membership (Photocopy of Smart card/Receipt | | |
| 3 | Referral form | | |
| 4 | Emergency Certificate (If applicable) | | |
| 5 | Original bills and Photocopy authenticated by OIC Polyclinic | | |
| 6 | Emergency bills super scribed in Red | | |
| 7 | Prior Approval | | |
| 8 | Breakdown of charges by Hospital/OIC Polyclinic | | |
| 9 | Receipt/Proof of payment of Hospital | | |
| 10 | Endorsement by OIC Polyclinic regarding Beds/Speciality/Facility NA in Service Hospital | | |
| 11 | Discharge/Case Summary/Patient record by treating Hospital | | |
| 12 | Cover Note has endorsement of :- | | |
| | (a) OIC Polyclinic | | |
| | (b) SEMO | | |
| | (c) Stn Cdr | | |

Remarks :

Date : Initial of Dealing Clk

**Verified by Jt Dir (Accts & Assets)**

Date : (Signature)

**REVISED WORK SHEET AND ASSESMENT**

Amount Entitled (Details Listed below) :-

| ECHS Ref No | Name of Tests/Procedures | Amount Claimed | Amount Entitled | Remarks |
|---|---|---|---|---|
| **PACKAGE DEAL** | | | | |
| | Major Procedure : Name of Procedure | | | |
| | Minor Procedure : Name of Procedure | | | 50% of authorized rate |
| **HOSPITAL CHARGES** (Where Package deal rates are not specified) | | | | |
| | Accommodation – Type of Ward – Private/Semi Private/General/ICU/CCU/Day Care | | | = Rate for type of ward x Duration of stay |
| | Dietary charges | | | Auth/Not auth |
| | Procedure/Treatment/Surgery/Physiotherapy or Dental Procedure | | | |
| | Pathology | | | |
| | Radiology | | | |
| | Specialised Investigations | | | |
| | Medicines | | | |
| | Chemotherapy Administration Charges (Oncology) | | | |
| | Radiotherapy Charges (Oncology) Consultation Charges OPD/Indoor | | | |
| | Ordinary Nursing<br><br>Special Nursing<br><br>Ambulance Charges<br><br>Other Charges | | | = Rate for type of ward x Duration<br>= Rate for type of ward x Duration<br>Not auth |
| | **Total** | | | |

Remarks/Comments

Recommendation

(a) Recommended sanction for an amount of Rs_____

(b) Not Recommended

Date : (Signature of Med Offr)

## WORK SHEET AND ASEMENT

1. Reference

2. ECHS Member ID

   (a) Name of Member

   (b) Name of Patient

   (c) ECHS No

   (d) Diagnosis :

4. Hospital/Diagnostic Centre :
   (For Emergency Treatment/Urgent Investigation

5. (a) Date of Admission _____ (b) date of Discharge _____

6. Type of Claim (a) Empanelled Bill (b) Reimbursement Emergency/Urgernt

7. **Clinical Notes**

8. **Bill Details**

   (a) Amt billed :

   (b) Amt Admissible :

   (c) Amt Disallowed :

9. Reasons for Disallowance

10. Recommendations :-

    Rs _____ may be approved/sanction.

Date : (Signature of Med Offr)

Refer to Para 3(c) of Central Org, ECHS letter No B/49778/AG/ECHS/Policy dt 06 Sep 07)

## REMARKS OF DIR REGIONAL CENTRE

| | | | |
|---|---|---|---|
| 1. | Membership Established | : | Yes/No |
| 2. | Date of Hospital admission after membership | : | Yes/No |
| 3. | Facilities NA at Service Hospital | : | Yes/No |
| 4. | Referral Verified | : | Yes/No |
| 5. | Prior Approval obtained/Condoned/NA | : | Yes/No |
| 6. | Remarks/Recommendations : | | |

Station :

Date : 9Signature of Director)