DECLARATION/CONSENT LETTER

Date: _____

From,

_____

_____

_____

To,

The CEO,
M/s The Bhai Ghanhya Trust,
SCO-175-187,
Punjab State Cooperative Bank Building,
Ground Floor, Sector-34-A
Chandigarh

Dear Sir,

I am willing to be a part of the Bhai Ghanhya Sehat Sewa Scheme Hospital Network to serve the beneficiaries of the Bhai Ghanhya Sehat Sewa Scheme (BGSSS), as per the terms and conditions.
We hereby give our consent to follow the Bhai Ghanhya Schedule of Rates as designed for Bhai Ghanhya Sehat Sewa Scheme & agreed upon by us by way of entering into an MOU with Reliance General Insurance Company Pvt. Ltd. /MD India Health Insurance TPA Pvt. Ltd.

We declare that no criminal case is pending against our company and / or any of its directors or partners.

This letter of consent holds good till the date of expiry of policy plan period.

Thanking you,

Yours faithfully,
For ***Participating Network***

EMPANELMENT FORM

FOR OFFICIAL USE ONLY (Not to be filled by Hospital Authority)

Name of the Hospital _____
D/D No._____D/D dated _____
Amount Rs. _____Name of the Bank _____
Category of Hospital _____
*The cost of Empanelment Form is non-refundable, irrespective of the fact, the application of the hospital for empanelment is accepted or not.

Detail of the DD for Software Installation Fee

Name of the Hospital _____
D/D No. _____D/D dated _____
Amount Rs. _____Name of the Bank _____
*The cost of software installation shall be returned in an event the application of the hospital For empanelment is not accepted.
* The hospitals who already have softwares installed being an empanelled hospital under the previous/ existing BGSSS Schemes, need not make any payment towards the cost of software.

Name and Designation of the Officer accepting the empanelment form _____
Signature _____
Date : Place : Seal :

Name of the Hospital	
Name of the Med. Director / Med. Superintendent	
Name of the Contact person & Tel / Mobile No.	
Address	

District	
Telephone/Mobile No.	
Fax No.	
Email Address	
Minimum Floor area of Hospital (Sq. feet)	
Date of inception of the Hospital	
Hospital Bank A/c No. & Bank Name (For EFT):	

PAN Number	
TAN Number	
Cheque to be Issued in Favor of	

*Requirements for Electronic Fund Transfer (Please attach the required documents with empanelment form.

Sr. No.	**Particular**	**Submitted (YES / NO)**
1	Duly Filled Contact details sheet.	
2	Duly Filled NEFT/EFT Mandate Form.	
3	Duly Filled Payee Name Confirmation Format	
4	Sample Cheque / Cancelled Cheque	
5	Vendor details for NEFT	

Details of the Hospital

Owner	Administrator
Name _____	Name _____

Qualification _____	Qualification _____
Designation _____	Designation _____
Tel/Mobile No._____	Tel/Mobile No._____

Ownership	Services available
a. Individual ☐	a. No. of Beds ☐
b. Partnership ☐	b. No. of O.T.s ☐
c. Pvt. Limited ☐	c. No. of ICU Beds ☐
d. Other (specify) ☐	d. No. of specialties Single ☐ Multi ☐
_____	
_____	Name the Specialties (in Capital letter)
	_____
	_____
	_____
	_____
	_____
	_____
	_____
	_____
	_____
	_____

Eye Specialty - Number of beds _____	**ENT Specialty** - Number of beds _____
Procedures done _____	Procedures done _____
_____	_____
_____	Myringoplasty, skull base surgeries, etc)
Equipment Available _____	Equipment Available _____
_____	_____

Other Speciality Units
(E.g. Burn ward, Dialysis unit etc)

Name	Facilities
1	1
2	2
3	3
4	4
5	5

Details of Services available

	Yes/No	Number	Intensive Care Units	Yes/No	# Beds
Anesthesia Machine			Surgical ICU		
High Pressure Autoclave			Medical ICU		
Suction Apparatus			Cardiac ICU		
Diathermy			Neurology ICU		
Monitors			Pediatrics ICU		
Operating Microscope					
Ventilators/ Respirators					

Labour Room	Yes	No.	
Neonatal resuscitation kit		Blood Type	Syphilis
Fetal Doppler		Hepatitis A	HIV
Radiant warmer		Hepatitis B	Other (please specify below) _____
Suction apparatus		Hepatitis C	
Oxygen		Hepatitis B core Antigen	

Staff Profile

Total No. of licenced permanent doctors (M.B.B.S.) on Staff _____

Total No. of licenced permanent doctors (M.D/M.S.) on Staff _____

Total No. of licenced permanent doctors (D.M/Mch.) on Staff _____

Total No. of M.D. /M.S. on panel/sharing basis _____

Total No. of D.M. /Mch. on panel/sharing basis _____

Total No. of nurses (on permanent roles) on staff that are registered with Nurses Registration Council _____

Nursing Staff (N) to patient (P) ratio during three different shifts _____

Emergency Services	Yes	No
Emergency Services available 24 hours a day & 7 days a week		
Licenced Physician (MBBS/MD) on site 24 hours a day & 7 days a week		
Specialists (MD/MS/DM/Mch) on call 24 hours a day & 7 days a week		
Full time nursing staff with emergency service training		
Ambulance service available		
If yes, owned by the hospital		

Intensive Care/Critical Care Services	Yes	No
Licenced Physician (MBBS/MD) on site 24 hours a day & 7 days a week		
Specialists (MD/MS/DM/Mch) on call 24 hours a day & 7 days a week		
Full time nursing staff with critical care training		
Blood Transfusion Services	Yes	No
Blood Transfusion Service available		
Blood product services available		

Do you agree to provide complete cashless treatment to the members of BHAI GHANHYA SEHAT SEWA SCHEME? Once you have given your consent to Bhai Ghanhya Schedule of rates & have entered into an MOU with Reliance General Insurance Company Ltd. and MD India Health Insurance TPA Pvt. Ltd.

a) Yes ☐

b) No ☐

Do you agree to identify/appoint two coordinators in your hospital who would coordinate between the patients, treating doctor and billing department ensuring timely

submission of PAL, resolution of all queries put forth by the TPA, Cooperation with the representative of the TPA / Insurer during his hospital visit and hassle free hospitalization of the beneficiaries of the scheme.

a) Yes ☐

b) No ☐

Details of the Specialty services available:-

Specialty	Facilities	Tick
Cardiothoracic Surgery	Open Heart Surgery Closed Heart Surgery CABG	
Cardiology	Non-Invasive Procedures • ECG • ECHO • Stress test • Holter Monitor Invasive Procedures • Cath Lab procedures	
Obs. and Gyne	Labour Room Fetal Incubator	
Orthopaedics	C-Arm	
Urology	PCNL Lithotripsy	
Oncology	Medical Onco. Surgical Onco. Radiation Onco.	
GE (medicine)	Endoscopy	
GE (surgical)	Laparoscopy	
ENT	Audiometery	
Ophthalmology	Phaco Laser	
Pulmonology	PFT	
Neurology	EEG EMG	
Nephrology	**Dialysis**	

Willingness for Installing our Software Modules		Yes _____	No._____
Computers used in	Appointments : Yes / No	Billing : Yes / No	Ward : Yes / No
	Doctors : Yes/ No	Clinical Area : Yes/No	

If No, are you willing to invest on infrastructure such as computer, Software, Fax, Phone Scanner / Printer Machine etc?

a) Yes ☐

b) No ☐

Medical Records: World Health Organization Coding

* ICD - 10 Coding Yes _____/No._____
(International Coding of Disease – 10)

Medical Staff Profile

Please fill in number of physicians for each category (Note: Some Physicians may be counted in more than one column)

Specialty	Visiting Consultants Name/Qualification	Full Time Consultant	House Staff (Residents and Registrars)
Anesthesia			
General Surgery			
Thoracic Surgery			
Primary/Family practice			
Internal Medicine			
Cardiology			
Obstertrics/ Gynaecology			
Pediatrics			
Psychiatry			
Orthopedics			
Neurology			
Urology			
Oncology			
Pulmonology			
G.E. (Medicine)			
G.E. (Surgical)			
E.N.T.			

Neuro Surgery			
Plastic Surgery + Burns			
Ophthalmology			
Others (specify)			
Total			

Pharmacy

In House Pharmacy a) Yes ☐

b) No ☐

If **yes**, name of your pharmacy _____

If **No**, does your hospital has tie up with outside pharmacy

a) Yes ☐

If Yes, Name of the Tie – Up Pharmacy _____ _____

b) No ☐

If No, do you agree to have a tie up arrangements with outside pharmacy and arrange for medicines on credit basis for the members of the Bhai Ghanhya Sehat Sewa Scheme and pay the outside pharmacy when your bills are reimbursed by the TPA; to extend completely cashless facility to the beneficiaries of Bhai Ghanhya Sehat Sewa Scheme?

a) Yes ☐

b) No ☐

Pathology

In House Pathology a) Yes ☐

b) No ☐

If yes, Name of the Pathology Center_____

Name/Qualification of your pathologist _____

Facilities available at your pathological Lab. _____

If No, does your hospital have tie up with outside pathology/diagnostic centre?

a) Yes ☐

b) No ☐

If yes, Name of the Tie – Up Pathology Center_____

If no, do you agree to have a tie up arrangement with outside pathology Lab. Diagnostic Centre and arrange for investigations on credit basis for the members of the Bhai Ghanhya Sehat Sewa Scheme and pay the outside pathology lab/diagnostic centre when your bills are reimbursed by the TPA; to extend completely cashless facility to the beneficiaries of Bhai Ghanhya Sehat Sewa Scheme.

a) Yes ☐

b) No ☐

Are you willing to offer discount to OPD services

a) Yes ☐

b) No ☐

If yes, please specify the following:-
% Discount on BGSSS Card Holder on OPD services _____
% Discount on BGSSS Card Holder on investigations _____

Are you willing to offer free ambulance services to the beneficiaries in case of emergency.

a) Yes ☐

b) No. ☐

If yes, please specify the limit in Kms._____

I/We hereby furnish the unconditional approval for the following:-

1. Establishment of a helpdesk exclusively for beneficiary of BGSSS.

2. Ensure that Hospitalization of a beneficiary of a scheme is completely cashless. In case the hospital does not have facility to carry out some of the diagnostic tests or have facility to provide in house drugs/pharmacy items/consumables required for treatment of the member, the network hospital shall try to arrange for these

tests or drugs/pharmacy items/ consumables from other Diagnostic Centers/Pharmacies and submit the bills of such services to TPA along with the final hospital bill. Patient shall not under no circumstances make any payment against medicines/Consumables/Investigation carried out during his/her hospitalization stay (Stay that has been authorized by the TPA) at network hospital.

3. Hospital shall ensure to arrange the entire necessary infrastructure, Hardware & Software required mandatorily for implementation of the scheme at their premises & at their own expenses only.

4. The Hospital shall raise an invoice in line with the tariff approved by The BGSSS Trust and shall forward the claim as per the checklist to the TPA within 7 days of discharge of patient, for seeking payment of its invoice. Hospital shall ensure that deficient documents are sent to TPA with in 7 days of receipt of such intimation for deficient documents from TPA.

5. Ensure that reason for admission and treatment mentioned in pre-authorization letter for which approval has been given by the TPA through Authorization letter and the treatment extended to the member are same. The hospital shall intimate to the TPA with respect to any change in the line of treatment/diagnosis of the beneficiary for which they have sought pre authorization/approval from TPA. In an event of planned hospitalization if the hospital has sought authorization from TPA in advance and later patient does not turn up for treatment/Treatment is deferred for any reason what so ever, it shall be sole responsibility of the hospital to intimate the TPA & get such authorization approval cancelled within 5 days of receipt of such authorization/Approval from the TPA.

6. Ensure obtaining signature of the patient and the main member on the claim form and on the consolidated bill before discharge unless which the claim is invalid.

7. Extend credit treatment only for services covered & authorized by TPA.

8. Ensure preferred & priority attention/admission to the BGSSS beneficiary and immediate intimation to TPA office in pre-authorization format after getting it duly filled by the treating doctor.

9. Ensure complete co-operation in providing any additional information/assistance or case sheet as required by TPA for setting the bills/claims.

10. Purchasing of empanelment form, submission of this filled empanelment form or compliance of the minimum eligibility criteria for empanelment of NWH, do not

imply, the automatic empanelment or inclusion of the hospital in the Network for the BGSSS.

11. Hospital shall ensure, that under no circumstances it shall charge/bill any kind of payment to the patient against the treatment/hospitalization that has already been authorized by the TPA, failing which the hospital shall be liable to de-empanelment/Blacklisting/any other action as considered appropriate by the Trust.

The BGSSS Trust reserves the right to accept or reject any application of Hospital without assigning any reasons.

Bhai Ghanhya Trust reserves itself the right to reject the incomplete / incorrect / false conditional applications without assigning any reason thereto.

I/We hereby certify that all information furnished by me/us pertaining to my/our hospital/ nursing home is genuine and true in all the respects and Empanelment Form is being signed only by the authorized individual.

In case, the information submitted by my/our hospital is found inadequate/false/incorrect, at any point of time from the date of submission of the empanelment form to the policy plan period, the application/empanelment of my/our hospital will liable to be rejected by the Bhai Ghanhya Trust without assigning any reasons. In addition, BGSSS reserves its right to prosecute my/our Hospital for cheating/forgery/fraud etc as per the law. BGSSS Trust shall also have the absolute right to take any action as deemed fit without any prior intimation to my/our Hospital.

_____ _____

Signatures & seal of authorized Signatory. Date & Place

Hospital's Staff Details:

SR	Name (Doctor or Paramedical Staff)	Qualification	Specialty (if any)	Registration No,(if any)	On Roll or Visiting	Contact No.

Contact Details Sheet

Part A: To be filled by the Hospital:-

Sr. No.	Name of Person	Designation	Department	Email ID	Contact No.
1.			TPA		
2.			Marketing		
3.			Accounts		
4.					

1: Kindly note that the Email IDs & contact details should contain at least 1 member from the TPA, Accounts & Marketing department for the purpose of communication related to AL/ Claim query (TPA), Payment query (Accounts) & Other query (Marketing).
2: Please fill all fields clearly.

Details in the mandate from verified & confirmed by:
Date & Time:

Part B: To be filled by Accepting officer:

1.	Mandate form completely filled, signed & stamped by Hospital Authority	Yes		No	
2.	Cancelled Cheque	Yes		No	
3.	T&C Form signed & stamped by hospital authority	Yes		No	
4.	Contact Details & Email IDs	Yes		No	
5.	Payee Name Confirmation duly signed & stamped by Hospital Authority	Yes		No	

Name of Accepting officer:_____

Date & Signature: _____

To,

Date:-

Reliance General Insurance Company Pvt. Ltd.

Sub: Release of Payment towards Reimbursement of claims settled as network hospital under Bhai Ghanhya Sehat Sewa Scheme

Dear Sir / Madam,

This is with respect to the reimbursement(s) towards the claims settled by us as network hospital under Bhai Ghanhya Sehat Sewa Scheme

Please note that all the reimbursements shall be made as per details provided herein below. I / We affirm that payment made as per below details would release Reliance General Insurance Company Pvt. Ltd. / MD India Health Insurance TPA Pvt. Ltd towards any obligation and no dispute would be instituted against them for such payment at any time.

- Hospital Name :-
- Payee Name :-
- PAN No. :-
- PAN Card Holder Name :-
- Service Tax No. :-

I / We hereby declare that the particulars given above are correct and complete. If the transaction is delayed for reasons of any error, inaccuracy or mistake due to incompleteness or delay in providing above details, I/We would not hold Insurance Company / TPA responsible for same.

Date: - Signature & Seal of Hospital

Place_____ Designation of Authorized Signatory

_____

Annexure: - PAN Card Copy.

RELIANCE
General Insurance

Vendor code (If existing) _____

Mandate for Electronic Payment to Vendor (For Accounts Team Verification)

Vendor Information (To be filled by the Vendor's Accounts Team)

Vendor Name: (IN BLOCK LETTER) _____

Address: _____

City: _____ District: _____ State: _____ PIN Code: _____

Telephone Number/ Mobile: _____ Fax: _____ Email: _____

Nature of Product / Service Provided: _____

PAN / TAN Number: _____ Service Tax Reg no: _____ Any Other Regn No: _____ Regn Authority: _____

Dear Sir,

Subject: Mandate for Electronic payment to Vendor (via NEFT/ECS/Direct Credit etc.)
I/we refer to your letter regarding Electronic Payment facility being offered by you and I wish to avail the same with immediate effect. The amount payable to me/us may be directly credited to my/our below mentioned account

Vendor Information - Bank Account Details* (To be filled by the Firm)

Beneficiary Name (Bank A/c holder Name): _____

Beneficiary A/c No*: _____

Beneficiary A/c Type*: ☐ Savings ☐ Current ☐ NRO ☐ NRE ☐ FCNR

Bank Name*: _____ Branch Name*: _____

Branch Address*: _____

Branch City*: _____ State: _____ PIN Code: _____

9 Digit MICR Code No*: _____ IFSC Code*: _____

(Please provide MICR code for ECS credit, MICR starting and/or ending with 000 are not valid for ECS.)

Payee Name Confirmation (To be filled in case of Payee name differs from Service Provider Name)

Applicable for the Vendor falls under any Group / Trust / Mission / HUF / Proprietorship / Others (Please specify) _____

I/We affirm that payment made as per below details would release Reliance General Insurance Company Ltd. towards any obligation and no dispute would be instituted against them for such payment at any time.

Vendor Name: _____ wherein Payment to be released in

Name of i.e. Payee Name / Bank Account Name is: _____

I/We hereby declare that the particulars given above are correct and complete. If the transaction is delayed for reasons of any error, inaccuracy or mistake due to incompleteness or delay in providing above details, I/We would not hold Reliance General Insurance Company Ltd. responsible for same.

Declaration for Proprietorship Firm

PAN Card Type ☐ Individual ☐ Company ☐ Firm ☐ Trust ☐ HUF Others

Name on PAN Card: _____ PAN No.: _____

I state that, The " _____ " is a sole proprietary /Firm / HUF / Trust / Company/concern under any Group and declare that we did not have any separate PAN card in the name of the above mentioned firm. PAN card copy is attached for your reference.

Declaration

I / We hereby declare that - the above information provided by me / us is best to my / our knowledge and also accept the Electronic payment facility as offered by Reliance General Insurance Co. Ltd (RGICL) and declare that I/we is/or holder in the above mentioned bank account and any liability arising out of this facility, directly or indirectly, now or in future, would be borne by me/us. I/we understand that this facility is subject to a minimum amount of payment (as decided by RGICL), being payable to me/us.

Thanking You

Place _____

_____
Signature
(Authorized Signatory with Stamp/Seal)

Enclosures (To be submitted by the Vendor)

1. PAN Card copy
2. Cancelled cheque original only / Bank NEFT confirmation letter
3. Service tax registration copy
4. Bank statement / Pass book copy (in case of Payee name not printed on cheque)

Note - 1. To be filled in English & block letters. **2.** All the details needs to be filled / provided mandatorily, failing of which application shall be considered incomplete. **3.** RGICL reserves the right to physically verify the facts by visiting the centers. 4. All documents need to be duly signed and stamped.