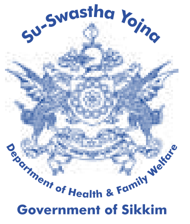
Su-Swastha Yojna

A Government of Sikkim Initiative



CASHLESS CLAIM FORM

TO BE FILLED IN BLOCK LETTERS

Hospital Name

Hospital Address | Hospital Id

Email Id | **ROHINI ID**

TO BE FILLED BY MEMBER/PATIENT

a) Name of Patient — Mr./Mrs./Ms. | First Name* | Middle Name | Last Name*

b) Gender ☐ Male ☐ Female ☐ Other | c) Contact No.

d) Alternate Contact No. | e) Age Y Y M M

f) Date of Birth D D M M Y Y Y Y | g) Member Id Card No.

h) Name of Employer | i) Employee Id

j) Currently do you have any health insurance | j.1) (give details) ☐ Yes ☐ No

j.2) Insurer Name

k) Do you have a family physician? If yes, Name

k.1) Contact No. | l) Occupation of Patient

m) Address of Patient

Line 1 | Line 2

Line 3 | City Village/City/Town

District | State | Pin Code

TO BE FILLED BY THE TREATING DOCTOR/HOSPITAL

a) Name Of Admitting Doctor

b) Contact No.

c) Name of Illness/Disease with presenting complaints

d) Relevant clinical findings

e) Duration of present ailment ____ days | e.1) Date of First Consultation D D M M Y Y Y Y

e.2) Relevant history, if any

Su-Swastha Yojna

A Government of Sikkim Initiative

CASHLESS CLAIM FORM

TO BE FILLED IN BLOCK LETTERS

Su-Swastha Yojna
Department of Health & Family Welfare
Government of Sikkim

TO BE FILLED BY THE TREATING DOCTOR/HOSPITAL

f) Provisional Diagnosis

f.1) ICD 10 Code

g) Proposed Line of Treatment

☐ Medical Management ☐ Surgical Management ☐ Intensive Care ☐ Investigation ☐ Day Care Treatment

h) If investigation and/or medical management, provide details:

h.1) Route of drug administration

☐ IV
☐ Oral
☐ Other

i) If surgical, name of surgery

i.1) ICD 10 PCS Code

j) If other treatments, provide details

k) How did injury occur, if there is injury

l) In case of accidents i) Is it RTA ☐ Yes ☐ No ii) Date of Injury D D M M Y Y Y Y

iii) Reported to police ☐ Yes ☐ No iv) FIR No.

v) Injury/Disease caused due to substance abuse/alcohol consumption/ self harm ☐ Yes ☐ No

vi) Test conducted to establish this, If yes attach reports ☐ Yes ☐ No

m) In case of maternity G P L A n) Expected Date of Delivery D D M M Y Y Y Y

DETAILS OF THE PATIENT ADMITTED

a) Date of Admission D D M M Y Y Y Y b) Time of Admission H H M M

c) This is ☐ an emergency ☐ a planned hospitalization event

d) Expected No. of Days stay in Hospital Days e) Days in ICU Days f) Room Type

g) Per Day Room Rent + Nursing Charges + Diet Rs.

h) Expected Cost for Diagnostic Tests Rs.

i) ICU Charges Rs.

j) OT Charges Rs.

k) Professional fees + Surgeon fee + Anesthetist fees + Consultation charges Rs.

l) Medicines + Consumables + cost of Implants (specify implants and brand) Rs.

m) Other hospital expenses if any (specify what) Rs.

n) All inclusive package charges if any applicable Rs.

Su-Swastha Yojna

A Government of Sikkim Initiative

CASHLESS CLAIM FORM

TO BE FILLED IN BLOCK LETTERS

DETAILS OF THE PATIENT ADMITTED

o) Sum Total expected cost of hospitalization Rs. ☐☐☐☐☐☐☐☐

p) Mandatory past history of any chronic illness. If yes (since month/year)

	Illness	Since (MM YY)
☐	1. Diabetes	MM YY
☐	2. Heart Disease	MM YY
☐	3. Hypertension	MM YY
☐	4. Hyperlipidemias	MM YY
☐	5. Osteoarthritis	MM YY
☐	6. Asthma/ COPD / Bronchitis	MM YY
☐	7. Cancer	MM YY
☐	8. Alcohol or drug abuse	MM YY
☐	9. Any HIV or STD Related Ailments	MM YY

10. Any Other Ailment, Give Details

DECLARATION (PLEASE READ VERY CAREFULLY)

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

a) Name Of the Treating Doctor

b) Qualification ☐☐☐☐☐☐☐☐☐☐

c) Registration No. with State Code ☐☐☐☐☐☐☐☐☐☐

a. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Su Swastha Yojna 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 scheme. In case the Su Swastha Yojna 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 Su Swastha Yojna not governed by the terms and conditions of the scheme 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 Su Swastha Yojna.
e. I agree and understand that Su Swastha Yojna is in no way warranting the service of the hospital & that the Su Swastha Yojna 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 Su Swastha Yojna.
h. I/We authorize Su Swastha Yojna to contact me/us through mobile/email for any update on this claim.

a) Patient's/Member's Name First Name* | Middle Name | Last Name*

b) Contact No. ☐☐☐☐☐☐☐☐☐☐ c) Email Id(optional)

Signature

Date DD MM YYYY

Time HH MM

d) Patient's/Member's Signature

Su-Swastha Yojna

A Government of Sikkim Initiative

CASHLESS CLAIM FORM

TO BE FILLED IN BLOCK LETTERS

Su-Swastha Yojna
Department of Health & Family Welfare
Government of Sikkim

HOSPITAL DECLARATION

a. We have no objection to any authorized Su Swastha Yojna official verifying documents pertaining to hospitalization.
b. All valid original documents duly countersigned by the member / patient as per the checklist below will be sent to Su Swastha Yojna within 7 days of the patient's discharge.
c. We agree that Su Swastha Yojna 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.
g. We confirm that no additional amount would be collected from the member 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 member/ patient 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 member in excess of Agreed Package Rates, Su Swastha Yojna 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.

DOCUMENTS TO BE PROVIDED BY THE HOSPITAL IN SUPPORT OF THE CLAIM

1. Detailed Discharge Summary and all Bills from the hospital.
2. Cash Memos from the Hospitals / Chemists supported by proper prescription.
3. Receipts and Pathological Test Reports from Pathologists, Supported by note from the attending Medical Practitioner / Surgeon recommending such pathological Tests.
4. Surgeon's Certificate stating nature of Operation performed and Surgeon's Bill and Receipt.
5. Certificates from attending Medical Practitioner / Surgeon that the patient is fully cured.

Hospital Seal

Doctor's Signature

Date D D M M Y Y Y Y

Time H H M M

www.suswasthasikkim.com info@suswasthasikkim.com +91-98003-47944