Appendix 5 – Draft MoU between Insurance Company and the Hospital. It may get modify at the time of MoU signing between State Government & Insurance company

Service Agreement

Between

(Insert Name of the Hospital)

and

_____New India Assurance Company Limited

_____

_____

_____

This Agreement (Hereinafter referred to as “Agreement”) made at _____ on this _____ day of _____ 2014__.

BETWEEN

_____(Hospital) an institution located in _____, having their registered office at _____ (here in after referred to as “Hospital”, which expression shall, unless repugnant to the context or meaning thereof, be deemed to mean and include it's successors and permitted assigns) as party of the FIRST PART

AND

__New India_____ Insurance Company Limited, a Company registered under the provisions of the Companies Act, 1956 and having its registered office _____ (hereinafter referred to as “Insurer” which expression shall, unless repugnant to the context or meaning thereof, be deemed to mean and include it's successors, affiliate and assigns) as party of the SECOND PART.

The (hospital) and Insurer are individually referred to as a "Party” or “party" and collectively as "Parties” or “parties")

WHEREAS

1. Hospital is a health care provider duly recognized and authorized by appropriate authorities to impart heath care services to the public at large.
2. Insurer is registered with Insurance Regulatory and Development Authority to conduct general insurance business including health insurance services. Insurer has entered into an agreement with the Government of the State of Chhattisgarh wherein it has agreed to provide the health insurance services to identified Beneficiary families covered under Rashtriya Swasthya Bima Yojana & Mukhyamantri Swasthya Bima Yojana (RSBY & MSBY).
3. Hospital has expressed its desire to join Insurer's network of hospitals and has represented that it has requisite facilities to extend medical facilities and treatment to beneficiaries as covered under RSBY & MSBY Policy on terms and conditions herein agreed.
4. Insurer has on the basis of desire expressed by the hospital and on its representation agreed to empanel the hospital as empanelled healthcare provider for rendering complete health services.

In this **AGREEMENT**, unless the context otherwise requires:

1. the masculine gender includes the other two genders and vice versa;
2. the singular includes the plural and vice versa;
3. natural persons include created entities (corporate or incorporate) and vice versa;
4. marginal notes or headings to clauses are for reference purposes only and do not bear upon the interpretation of this **AGREEMENT**.
5. should any condition contained herein, contain a substantive condition, then such substantive condition shall be valid and binding on the **PARTIES** notwithstanding the fact that it is embodied in the definition clause.

In this **AGREEMENT** unless inconsistent with, or otherwise indicated by the context, the following terms shall have the meanings assigned to them hereunder, namely:

Definition

A. **Institution** shall for all purpose mean a Hospital or other healthcare provider.

B. **Health Services** shall mean all services necessary or required to be rendered by the Institution under an agreement with an insurer in connection with “health insurance business”

or "health cover" as defined in regulation 2(f) of the IRDA (Registration of Indian Insurance Companies) Regulations, 2000 but does not include the business of an insurer and or an insurance intermediary or an insurance agent.

C. **Beneficiaries** shall mean the person/s that are covered under the RSBY & MSBY health insurance scheme of Government of India & the state Government of Chattishgarh and holds a valid smart card issued for RSBY & MSBY.

D. **Confidential Information** includes all information (whether proprietary or not and whether or not marked as 'Confidential') pertaining to the business of the Company or any of its subsidiaries, affiliates, employees, Companies, consultants or business associates to which the Institution or its employees have access to, in any manner whatsoever.

E. **Smart Card** shall mean Identification Card for beneficiaries issued under Rashtriya Swasthya Bima Yojana & Mukhyamantri Swasthya Bima Yojana (RSBY & MSBY). by the Insurer as per specifications given by MoLE, Government of India. See **Appendix 4** for details.

NOW IT IS HEREBY AGREED AS FOLLOWS:

Article 1:
Term

This Agreement shall be for a period of One years. However, it is understood and agreed between the Parties that the term of this agreement may be renewed yearly upon mutual consent of the Parties in writing, either by execution of a Supplementary Agreement or by exchange of letters.

Article 2:
Scope of services

1. The Institution undertakes to provide the service in a precise, reliable and professional manner to the satisfaction of Insurer and in accordance with additional instructions issued by Insurer in writing from time to time.

2. The Institution shall treat the beneficiaries of RSBY & MSBY according to good business practice.

3. The institution will extend priority admission facilities to the beneficiaries, whenever possible.

4. The Institution shall provide packages for specified interventions/ treatment to the beneficiaries as per the rates mentioned in **Annexure D**. It is agreed between the parties that the package will include:

   The charges for medical/ surgical procedures/ interventions under the Benefit package will be no more than the package charge agreed by the Parties, for that particular year. In the case of medical conditions, a flat per day rate will be paid depending on whether the patient is admitted in general or ICU.

These package rates (in case of surgical) or flat per day rate (in case of medical) will include:

a. Registration Charges
b. Bed charges (General Ward in case of surgical)
c. Nursing and Boarding charges
d. Surgeons, Anesthetists, Medical Practitioner, Consultants fees etc.
e. Anesthesia, Oxygen, O.T. Charges, Cost of Surgical Appliances etc.
f. Medicines and Drugs
g. Cost of Prosthetic Devices, implants
h. X-Ray and other Diagnostic Tests etc.
i. Food to patient

j. Expenses incurred for consultation, diagnostic test and medicines up to 1 day before the admission of the patient and cost of diagnostic test and medicine up to 5 days after discharge from the hospital for the same ailment / surgery.
k. Transportation Charge of INR 100/- (payable to the beneficiary in cash by the institution at the time of discharge).
l. Any other expenses related to the treatment of the patient in the hospital.

5. The Institution shall ensure that under this agreement, medical treatment/facility is provided with all due care and accepted standards is extended to the beneficiary.

6. The Institution shall allow Insurance Company official to visit the beneficiary. Insurer shall not interfere with the medical team of the Institution; however Insurer reserves the right to discuss the treatment plan with treating doctor. Further access to medical treatment records and bills prepared in the Institution will be allowed to Insurer on a case to case basis with prior appointment from the Institution.

7. The Institution shall also endeavor to comply with future requirements of the Insurer to facilitate better services to beneficiaries e.g. providing for standardized billing, ICD coding, etc. and if mandatory by statutory requirement both parties agree to review the same.

8. The Institution agrees to have its bills audited on a case to case basis as and when necessary through the Insurer audit team. This will be done on a pre-agreed date and time and on a regular basis.

9. The Institution will convey to its medical consultants to keep the beneficiary only for the required number of days of treatment and carry out only the required investigation & treatment for the ailment, for which the beneficiary is admitted. Any other incidental investigation required by the patient on their request needs to be approved separately by the Insurer and if it is not covered under Insurer policy will not be paid by Insurer and the Institution needs to recover it from the patient.

Article 3:
Identification of Beneficiaries

1. Smart Cards would be the proof of the eligibility of beneficiaries for the purpose of the scheme. The beneficiaries will be identified by the hospital on the basis of smart cards issued to them**.** The smart cards shall have the photograph and finger print details of the beneficiaries. The smart card would be read by the smart card reader. The patients/ relative's finger prints would also be captured by the bio metric scanner. The POS machine will identify a person if the finger prints match with those stored on the card. In case the patient is not in a position to give fingerprint, any other member of the family who is enrolled under the scheme can verify the patient's identity by giving his/ her fingerprint.

2. The Institution will set up a Help desk for RSBY & MSBY beneficiaries and sitting space for two help desk personnel provided by Insurance Company/TPA.The desk shall be easily accessible and will have all the necessary hardware and software required to identify the patients.

3. For the ease of the beneficiary, the Institution must display the recognition and promotional material, network status, and procedures for admission supplied by Insurer at prominent location, including but not limited to outside the Institution, at the reception and admission counter and Casualty/ Emergency departments. The format for sign outside the Institution and at the reception counter will be provided by the Insurance Company as given on Annexure -X

Article 4:

Hospital Services- Admission Procedure

1. Planned Admission
   It is agreed between the parties that on receipt of request for hospitalization on behalf of the beneficiary the process to be followed by the Institution will be as prescribed in **Annex I**.

2. Emergency admission

   a. The Parties agree that the Institution shall admit the Beneficiary (ies) in the case of emergency but the smart card will need to be produced and authenticated within 24 hours of admission.
   b. Institution upon deciding to admit the Beneficiary should inform/ intimate over phone immediately to the 24 hour Insurer's helpdesk or the local/ nearest Insurer office.

   c. The data regarding admission shall be sent electronically to the server of the insurance company

   d. If the package selected for the beneficiary is already listed in the package list, no pre-authorisation will be needed from the Insurance Company except for the listed packages in Annexure- Y.

   e. If the treatment to be provided is not part of the package list, the Institution will need to get the pre-authorisation from the Insurance Company as given in part 2 of Annex I.

   f. On receipt of the preauthorization form from the Institution giving the details of the ailments for admission and the estimated treatment cost, which is to be forwarded within 12 hours of admission, Insurer undertakes to issue the confirmation letter for the admissible amount within 12 hours of the receipt of the preauthorization form subject to policy terms & conditions.

   g. In case the ailment is not covered or given medical data is not sufficient for the medical team to confirm the eligibility, Insurer can deny the guarantee of payment, which shall be addressed, to the Insured under intimation to the Institution. The hospital will have to follow their normal practice in such cases.

   h. Hospital has to maintain minimum mandatory pre & post hospitalization documents of the patient.

   i. Denial of Authorization/ guarantee of payment in no way mean denial of treatment. The hospital shall deal with each case as per their normal rules and regulations.

   j. Authorization certificate will mention the amount guaranteed class of admission, eligibility of beneficiary or various sub-limits for rooms and board, surgical fees etc. wherever applicable. Institution must take care to ensure compliance.

   k. The guarantee of payment is given only for the necessary treatment cost of the ailment covered and mentioned in the request for hospitalization. Any investigation carried out at the request of the patient but not forming the necessary part of the treatment also must be collected from the patient.

   l. In case the sum available is considerably less than the estimated treatment cost, Institution should follow their normal norms of deposit/ running bills etc., to ensure that they realize any excess sum payable by the beneficiaries not provided for by indemnity.

Article 5:
Checklist for Institution at the time of Patient Discharge

1. Original discharge summary, counterfoil generated at the time of discharge, original investigation reports, all original prescription & pharmacy receipt etc. must not be given to the patient. These are to be forwarded to billing department of the hospital who will compile and keep the same with the hospital.

2. The Discharge card/Summary must mention the duration of ailment and duration of other disorders like hypertension or diabetes and operative notes in case of surgeries.

3. Signature or thumb impression of the patient/ beneficiary on final hospital bill must be obtained.

Article 6:
Payment terms

1. Hospital will submit online claim report along with the discharge summary in accordance with the rates as prescribed in the **Annexure D**.
2. The Insurer will have to take a decision and settle every claim within one month of the claim being raised by the Institution. In case the insurer decides to reject the claim, the decision will need to be taken within one month of the claim being raised by the Institution.
3. If the insurer does not settle the claim within 30 days of the claim being raised by the hospital, Insurer shall pay @1% of claimed amount per 15 days of delay to the hospital.
4. However if required, Insurer can visit the Institution to gather further documents related to treatment to process the case.
5. Payment will be done by Electronic Fund Transfer only.
6. The Empanelled Health Care Provider shall have a right of appeal, against a rejection of a Claim, by the Insurer if the Empanelled Health Care Provider feels that the Claim is payable.

Article 7:
Declarations and Undertakings of Institution

1. The Institution undertakes that they have obtained all the registrations/ licenses/ approvals required by law in order to provide the services pursuant to this agreement and that they have the skills, knowledge and experience required to provide the services as required in this agreement.

2. The Institution undertakes to uphold all requirement of law in so far as these apply to them and in accordance to the provisions of the law and the regulations enacted from time to time, by the local bodies or by the Central or the State Government. The Institution declares that it has never committed a criminal offence which prevents it from practicing medicines and no criminal charge has been established against it by a court of competent jurisdiction.

3. Hospital shall follow all the guidelines of RSBY & MSBY scheme and provide cashless services to the beneficiaries. In any cases hospital shall not charge any additional amount from beneficiaries until and unless smart card has the requisite balance amount.

4. Hospital shall follow clinical pathways as defined by the State Nodal Agency & Insurer.

Article 8:
General responsibilities & obligations of the Institution

1. Ensure that no confidential information is shared or made available by the Institution or any person associated with it to any person or entity not related to the Institution without prior written consent of Insurer.

2. The Institution shall provide cashless facility to the beneficiary in strict adherence to the provisions of the agreement.

3. The services shall be provided as per the package rate of RSBY & MSBY. Annexure Z

4. The Institution will have their facility covered by proper indemnity policy including errors, omission and professional indemnity insurance and agrees to keep such policies in force during entire tenure of the MoU. The cost/ premium of such policy shall be borne solely by the Institution.

5. The Institution shall provide the best of the available medical facilities to the beneficiary.

6. The Institution shall endeavor to have an officer in the administration department assigned for insurance/contractual duties and the officers will eventually learn the various types of medical benefits offered under the different insurance plans.

7. The Institution must display their status of preferred service provider of RSBY & MSBY at their reception/ admission desks along with the display of other materials supplied by Insurer whenever possible for the ease of the beneficiaries.

8. The Institution shall at all times during the course of this agreement maintain a helpdesk to manage all RSBY & MSBY patients. This helpdesk would contain the following:
   a. Facility of telephone
   b. Facility of fax machine
   c. PC/ Computer
   d. Internet/ Any other connectivity to the Insurance Company Server
   e. PC enabled POS machine with a biometric scanner to read and manage smart card transactions to be purchased at a pre negotiated price from the vendor specified by Insurer. The maintenance of the same shall be responsibility of the vendor specified by Insurer.
   f. A person to man the helpdesk at all times.
   g. Get Two (2) persons in the Institution trained on the use of software and hardware devices for helping RSBY & MSBY beneficiaries during registration and discharge.

The above should be installed within 15 days of signing of this agreement. The Institution also needs to inform and train personnel on the handling of POS machine and also on the process of obtaining Authorization for conditions not covered under the list of packages, and have a manned helpdesk at their reception and admission facilities for aiding in the admission procedures for beneficiaries of RSBY & MSBY.

Article 9:
General responsibilities of Insurer

Insurer has a right to avail similar services as contemplated herein from other institution(s) for the Health services covered under this agreement.

Article 10:
Relationship of the Parties

Nothing contained herein shall be deemed to create between the Parties any partnership, joint venture or relationship of principal and agent or master and servant or employer and employee or any affiliate

or subsidiaries thereof. Each of the Parties hereto agrees not to hold itself or allow its directors employees/agents/representatives to hold out to be a principal or an agent, employee or any subsidiary or affiliate of the other.

Article 11:
Reporting

In the first week of each month, beginning from the first month of the commencement of this Agreement, the Institution and Insurer shall exchange information on their experiences during the month and review the functioning of the process and make suitable changes whenever required. However, all such changes have to be in writing and by way of suitable supplementary agreements or by way of exchange of letters.

All official correspondence, reporting, etc. pertaining to this Agreement shall be conducted with Insurer at its corporate office at the address _____.

Article 12:
Termination

1. This Agreement may be terminated by either party by giving one month's prior written notice by means of registered letter or a letter delivered at the office and duly acknowledged by the other, provided that this Agreement shall remain effective thereafter with respect to all rights and obligations incurred or committed by the parties hereto prior to such termination.

2. Either party reserves the right to inform public at large along with the reasons of termination of the agreement by the method which they deem fit.

Article 13:
Confidentiality

This clause shall survive the termination/expiry of this Agreement.

1. Each party shall maintain confidentiality relating to all matters and issues dealt with by the parties in the course of the business contemplated by and relating to this agreement. The Institution shall not disclose to any third party, and shall use its best efforts to ensure that its, officers, employees, keep secret all information disclosed, including without limitation, documents marked confidential, medical reports, personal information relating to insured, and other unpublished information except as maybe authorized in writing by Insurer. Insurer shall not disclose to any third party and shall use its best efforts to ensure that its directors, officers, employees, sub-contractors and affiliates keep secret all information relating to the Institution including without limitation to the Institution's proprietary information, process flows, and other required details.

2. In Particular the Institution agrees to:

   a) Maintain confidentiality and endeavour to maintain confidentiality of any persons directly employed or associated with health services under this agreement of all information received by the Institution or such other medical practitioner or such other persons by virtue of this agreement or otherwise, including Insurer's proprietary information, confidential information relating to insured, medicals test reports whether created/ handled/ delivered by the Institution. Any personal information relating to a Insured received by the Institution shall be used only for the purpose of inclusion/preparation/finalization of medical reports/ test reports for transmission to Insurer only and shall not give or make available such information/ any documents to any third party whatsoever.

   b) Keep confidential and endeavour to maintain confidentiality by its medical officer, employees, medical staff, or such other persons, of medical reports relating to Insured, and that the

information contained in these reports remains confidential and the reports or any part of report is not disclosed/ informed to the Insurance Agent / Advisor under any circumstances.

c) Keep confidential and endeavour to maintain confidentiality of any information relating to Insured, and shall not use the said confidential information for research, creating comparative database, statistical analysis, or any other studies without prior authorization from the State Nodal Agency..

Article 14:
Indemnities and other Provisions

1. Insurer will not interfere in the treatment and medical care provided to its beneficiaries. Insurer will not be in any way held responsible for the outcome of treatment or quality of care provided by the Institution.

2. Insurer shall not be liable or responsible for any acts, omission or commission of the Doctors and other medical staff of the Institution and the Institution shall obtain professional indemnity policy on its own cost for this purpose. The Institution agrees that it shall be responsible in any manner whatsoever for the claims, arising from any deficiency in the services or any failure to provide identified service.

3. Notwithstanding anything to the contrary in this agreement neither Party shall be liable by reason of failure or delay in the performance of its duties and obligations under this agreement if such failure or delay is caused by acts of God, Strikes, lock-outs, embargoes, war, riots civil commotion, any orders of governmental, quasi-governmental or local authorities, or any other similar cause beyond its control and without its fault or negligence.

4. The Institution will indemnify, defend and hold harmless the Insurer against any claims, demands, proceedings, actions, damages, costs, and expenses which the company may incur as a consequence of the negligence of the former in fulfilling obligations under this Agreement or as a result of the breach of the terms of this Agreement by the Institution or any of its employees or doctors or medical staff.

Article 15:
Notices

All notices, demands or other communications to be given or delivered under or by reason of the provisions of this Agreement will be in writing and delivered to the other Party:
a. By registered mail;
b. By courier;
c. By facsimile; followed with a registered mail

In the absence of evidence of earlier receipt, a demand or other communication to the other Party is deemed given

- If sent by registered mail, seven working days after posting it; and
- If sent by courier, seven working days after posting it; and
- If sent by facsimile, two working days after transmission. In this case, further confirmation has to be done via telephone and e-mail.

The notices shall be sent to the other Party to the above addresses (or to the addresses which may be provided by way of notices made in the above said manner):

-if to the hospital:

Attn: ……
Tel : …….
Fax: ……

-if to _____
_____ Insurance Company Limited
_____
_____
_____

Article 16
Miscellaneous

1. This Agreement together with any Annexure attached hereto constitutes the entire Agreement between the parties and supersedes, with respect to the matters regulated herein, and all other mutual understandings, accord and agreements, irrespective of their form between the parties. Any annexure shall constitute an integral part of the Agreement.

2. Except as otherwise provided herein, no modification, amendment or waiver of any provision of this Agreement will be effective unless such modification, amendment or waiver is approved in writing by the parties hereto.

3. Should specific provision of this Agreement be wholly or partially not legally effective or unenforceable or later lose their legal effectiveness or enforceability, the validity of the remaining provisions of this Agreement shall not be affected thereby.

4. The Institution may not assign, transfer, encumber or otherwise dispose of this Agreement or any interest herein without the prior written consent of Insurer, provided whereas that the Insurer may assign this Agreement or any rights, title or interest herein to an Affiliate without requiring the consent of the Institution.

5. The failure of any of the parties to insist, in any one or more instances, upon a strict performance of any of the provisions of this Agreement or to exercise any option herein contained, shall not be construed as a waiver or relinquishment of such provision, but the same shall continue and remain in full force and effect.

6. The Institution will indemnify, defend and hold harmless the Insurer against any claims, demands, proceedings, actions, damages, costs, and expenses which the latter may incur as a consequence of the negligence of the former in fulfilling obligations under this Agreement or as a result of the breach of the terms of this Agreement by the Institution or any of its employees/doctors/other medical staff.

7. Law and Arbitration

   a. The provisions of this Agreement shall be governed by, and construed in accordance with Indian law.

   b. Any dispute, controversy or claims arising out of or relation to this Agreement or the breach, termination or invalidity thereof, shall be settled by arbitration in accordance with the provisions of the (Indian) Arbitration and Conciliation Act, 1996.

   c. The arbitral tribunal shall be composed of three arbitrators, one arbitrator appointed by each Party and one another arbitrator appointed by the mutual consent of the arbitrators so appointed.

d. The place of arbitration shall be _____ and any award whether interim or final, shall be made, and shall be deemed for all purposes between the parties to be made, in _____.

e. The arbitration procedure shall be conducted in the English language and any award or awards shall be rendered in English. The procedural law of the arbitration shall be Indian law.

f. The award of the arbitrator shall be final and conclusive and binding upon the Parties, and the Parties shall be entitled (but not obliged) to enter judgement thereon in any one or more of the highest courts having jurisdiction.

g. The rights and obligations of the Parties under, or pursuant to, this Clause including the arbitration agreement in this Clause, shall be governed by and subject to Indian law.

h. The cost of the arbitration proceeding would be borne by the loser of the arbitration procedure, as determined by the award of the arbitrator. In case there is no winner of the arbitration proceeding, as determined by the award of the arbitrator, the cost shall be borne by the parties on equal sharing basis.

NON–EXCLUSIVITY

A. Insurer reserves the right to appoint any other Institution for implementing the packages envisaged herein and the Institution shall have no objection for the same.

8. Severability

The invalidity or unenforceability of any provisions of this Agreement in any jurisdiction shall not affect the validity, legality or enforceability of the remainder of this Agreement in such jurisdiction or the validity, legality or enforceability of this Agreement, including any such provision, in any other jurisdiction, it being intended that all rights and obligations of the Parties hereunder shall be enforceable to the fullest extent permitted by law.

9. Captions

The captions herein are included for convenience of reference only and shall be ignored in the construction or interpretation hereof.

SIGNED AND DELIVERED BY the hospital. - the within named_____, by the Hand of _____ its Authorised Signatory

In the presence of:

SIGNED AND DELIVERED BY _____ INSURANCE COMPANY LIMITED, the within named _____, by the hand of _____ it's Authorised Signatory

In the presence of:

Annex I
Hospital Services- Admission Procedure

1. Case 1: Package covered and sufficient funds available

1.1. Beneficiary approaches the RSBY & MSBY helpdesk at the empanelled healthcare provider.
1.2. Helpdesk verifies that beneficiary has genuine card issued under RSBY & MSBY (Key authentication) and that the person carrying the card is enrolled (fingerprint matching).
1.3. After verification, a slip shall be printed giving the person's name, age and amount of Insurance cover available.
1.4. The beneficiary is then directed to a doctor for diagnosis.
1.5. Doctor shall issue a diagnosis sheet after examination, specifying the problem, examination carried out and line of treatment prescribed.
1.6. The beneficiary approaches the RSBY & MSBY helpdesk along with the diagnostic sheet.
1.7. The help desk shall re-verify the card & the beneficiary and select the package under which treatment is to be carried out. Verification is to be done preferably using patient fingerprint, only in situations where it is not possible for the patient to be verified, it can be done by any family member enrolled in the card.
1.8. The terminal shall automatically block the corresponding amount on the card.
1.9. In case during treatment, requirement is felt for extension of package or addition of package due to complications, the patient or any other family member would be verified and required package selected. This would ensure that the Insurance Company is apprised of change in claim. The availability of sufficient funds is also confirmed thereby avoiding any such confusion at time of discharge.
1.10. Thereafter, once the beneficiary is discharged, the beneficiary shall again approach the helpdesk with the discharge summary.
1.11. After card & beneficiary verification, the discharge details shall be entered into the terminal.
1.12. In case the treatment is covered, beneficiary may claim the transport cost from the help desk.

1.13. In case treatment of one family member is under way when the card is required for treatment of another member, the software shall consider the insurance cover available after deducting the amount blocked against the package.

1.14. Due to any reason if the beneficiary does not avail treatment at the healthcare provider after the amount is blocked, the RSBY & MSBY helpdesk would need to unblock the amount.

2. Case 2: Package(s) not covered under the scheme

2.1. Hospital shall take Authorization from Insurance Company in case the package is not covered under the RSBY & MSBY scheme.

2.2. Steps from 1.1 to 1.7

2.3. In case the line of treatment prescribed is not covered under RSBY & MSBY, the helpdesk shall advice the beneficiary accordingly and initiate approval from Insurer manually (authorization request).

2.4. The hospital will fax to Insurer a pre-authorization request. Request for hospitalization on behalf of the beneficiary may be made by the healthcare provider/consultant attached to the healthcare provider as per the prescribed format. The preauthorization form would need to give the beneficiary's proposed admission along with the necessary medical details and the treatment planned to be administered and the break-up of the estimated cost.

2.5. Insurer shall either approve or reject the request. In case Insurer approves, they will also provide the AL (authorization letter) number and amount authorized to the healthcare provider via return fax. Authorization certificate will mention the amount guaranteed class of admission, eligibility of beneficiary or various sub-limits for rooms and board, surgical fees etc. wherever applicable. Healthcare Provider must take care to ensure admission accordingly.

2.6. On receipt of approval, the RSBY & MSBY helpdesk would manually enter the amount and package details (authorization ID) into the transaction software which will verify the authenticity of the authorization ID.

2.7. Steps 1.9 to 1.14

3. **Case 3: Insufficient funds:** In case the amount available is less than the package cost, the hospital shall follow the norms of deposit / running bills.

3.1. Steps from 1.1 to 1.7

3.2. In case of insufficient funds the balance amount could be utilized and the rest of the amount would be paid by the beneficiary after their confirmation.

3.3. The transaction software would have a provision to capture the amount collected from the beneficiary.

3.4. Steps from 1.9 to 1.14.

Appendix 6 - Process for de-empanelment of Healthcare Providers

Background

This process note provides broad operational guidelines regarding de-empanelment of hospitals. The process to be followed and roles of different stakeholders have been outlined.

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

1. Based on the claims data analysis and/ or visits, if there is any doubt on the performance of the healthcare provider, the Insurance Company or its representative can put that healthcare provider on watch list.
2. The data of such healthcare provider shall be analyzed very closely on a daily basis by the Insurance Company or its representatives for patterns, trends and anomalies.
3. The Insurance Company will inform the State Nodal Agency within 24 hours of putting the healthcare provider on watch-list.

Step 2 – Suspension of the Healthcare Provider

4. A healthcare provider can be temporarily suspended in the following cases:
   a. For healthcare providers which are on "Watch-list", if the Insurance Company observes continuous patterns or strong evidence of irregularity based on either claims data or field visits. The Insurer will submit a report to SNA and seek a written approval before suspending the healthcare provider from providing services to RSBY & MSBY patients and a formal investigation shall be instituted.
   b. If a healthcare provider is not on "Watch-list", but the insurance company observes at any stage that it has data/ evidence that suggests that they are involved in any unethical practice/ is not adhering to the major clauses of the contract with the Insurance Company or their representatives/ involved in financial fraud related to RSBY & MSBY patients, it may immediately suspend the healthcare provider from providing services to RSBY & MSBY patients after taking approval from SNA and a formal investigation shall be instituted.
   c. A directive is given by the State Nodal Agency based on the complaints received directly or the data analysis/ field visits done by State Nodal Agency.

5. The Healthcare Provider and District Authority should be informed without fail of the decision to suspend the healthcare provider within 6 hours of this action. At least 24 hours intimation must be given to the healthcare provider prior to the suspension so that admitted patients may be discharged and no fresh admission can be done.
6. For informing the beneficiaries, within 24 hours of suspension, an advertisement in the local newspaper 'mentioning about temporary stoppage of RSBY & MSBY services' must be given by the Insurer. The newspaper and the content of the message will be jointly decided by the Insurer and the District Authority.
7. To ensure that suspension of the healthcare provider results in their not being able to treat RSBY & MSBY patients, a provision shall be made in the software so that the healthcare provider cannot send electronic claims data to the Insurance Company or their representatives.
8. A formal letter shall be send to the healthcare provider regarding its suspension and mentioning the timeframe within which the formal investigation will be completed.

Step 3 – Detailed Investigation

9. The Insurance Company can launch a detailed investigation into the activities of a healthcare provider in the following conditions:
   a. For the healthcare providers which have been suspended.
   b. Receipt of complaint of a serious nature from any of the stakeholders
10. The detailed investigation may include field visits to the healthcare providers, examination of case papers, talking with the beneficiaries (if needed), examination of healthcare provider records, etc.
11. If the investigation reveals that the report/ complaint/ allegation against the healthcare provider is not substantiated, the Insurance Company would immediately revoke the suspension (in case it is suspended) and inform the same to the healthcare provider, district and the SNA.
    a. A letter regarding revocation of suspension shall be sent to the healthcare provider within 24 hours of that decision.
    b. Process to receive claims from the healthcare provider shall be restarted within 24 hours.
12. For informing the beneficiaries, within 24 hours of revoking the suspension, an advertisement in the local newspaper 'mentioning about activation of RSBY & MSBY services' must be given by the Insurer. The newspaper and the content of message will be jointly decided by the Insurer and the District Authority.

Step 4 – Action by the Insurance Company

13. If the investigation reveals that the complaint/allegation against the healthcare provider is correct, the following procedure shall be followed:
    a. The healthcare provider must be issued a "show-cause" notice seeking an explanation for the aberration and a copy of the show cause notice is sent to the State Nodal Agency.
    b. After receipt of the explanation and its examination, the charges may be dropped or an action can be taken with the concurrence of SNA.
    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 healthcare provider
       ii. De-empanelment of the healthcare provider.
14. <u>The entire process should be completed within 30 days from the date of suspension.</u>

Step 5 – Actions to be taken after De-empanelment

15. Once a healthcare provider has been de-empanelled from RSBY & MSBY, following steps shall be taken:
    a. A letter shall be sent to the healthcare provider regarding this decision with a copy to the State Nodal Agency
    b. MHC card of the healthcare provider shall be taken by the Insurance Company and given to the District Key Manager
    c. Details of de-empanelled healthcare provider shall be sent by State Nodal Agency to MoLE so that it can be put on RSBY & MSBY national website.
    d. This information shall be sent to National Nodal Officers of all the other Insurance Companies which are working in RSBY & MSBY.
    e. An FIR shall be lodged against the healthcare provider by the Insurer/State Nodal Agency at the earliest in case the de-empanelment is on account of fraud or a fraudulent activity.

f. The Insurance Company which had de-empanelled the healthcare provider, may be advised to notify the same in the local media, informing all beneficiaries about the de-empanelment, so that the beneficiaries do not utilize the services of that particular healthcare provider.
g. If the healthcare provider appeals against the decision, all the aforementioned actions shall be subject to the decision of the concerned Committee.

Grievance by the Healthcare Provider

16. The healthcare provider can approach the Grievance Redressal Committee for the redressal. The Grievance Redressal Committee will take a final view within 30 days of the receipt of representation. However, the healthcare provider will continue to be de-empanelled till the time a final view is taken by the Grievance Redressal Committee.

The Grievance Redressal Mechanism has been developed separately and is available on www.rsbycg.nic.in website.

Annexure D