DECLARATION/CONSENT LETTER

Date :-_____

From

_____

_____

_____

_____

To,

The
Nodal Department,

Dear Sir,

I am willing to be a part of the PGEPHIS Hospital Network to serve the beneficiaries of the PGEPHIS, as per the terms and conditions laid by the Nodal Agency.

We hereby give our consent to follow the PGEPHIS Schedule of Rates as designed for PGEPHIS.

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

*The cost of the empanelment form is non-refundable, irrespective of whether the application of the hospital for empanelment is accepted or not.

Detail of the DD for e-preauth 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 if the application of the hospital for empanelment is not accepted.
*The cost of software installation for E -Pre Auth which is Rs -26000/- shall be returned in an event if the application of the hospital for empanelment is not accepted.
*The hospitals who are already having SW for E Pre Auth installed in their hospitals need not submit DD for SW installation fee along with filled empanelment form.

Name of the Hospital	
Name of the Med. Director / Med. Suptendt	
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. And Bank Name	

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 ICUs ☐
d. Other (specify) ☐	d. No. of specialties Single ☐ Multi ☐
_____	Name them _____
_____	_____

Eye Specialty Number of beds _____	ENT Specialty - Number of beds _____
Procedures done _____	Procedures done _____

_____ _____ Equipment Available _____ _____	_____ Myringoplasty, skull base surgeries, etc) Equipment Available _____ _____

Other Speciality Units
(Eg. 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 _____

Number of nurses registered with Nurses Registration Council _____

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

B.Sc Nurses _____

Emergency Services	Yes	No
Emergency Services available 24 hours a day & 7 days a week		
Licenced Physician on site 24 hours a day & 7 days a week		
Specialists on call 24 hous 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 on site 24 hours a day & 7 days a week		
Specialists 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 PGEPHIS, provided your bill is reimbursed in 30 working days.

☐

a) Yes

b) No ☐

Do you agree to identify/appoint two coordinators in your hospital who would coordinate between the patient, treating doctor and billing department ensuring hassle free exit and entry of the patient.

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	Billing : Yes/No.	Ward : Yes/No	Appointments : Yes/No
Doctors : Yes/No.	Clinical Area : Yes/No		

If No, are you willing to invest on infrastructure such as computer, fax, phone etc.

a) Yes ☐

b) No ☐

Medical Records: World Health Organization Coding

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

Medical Staff Profile

Note: Consultants are specialists with Post Graduation, Super Specialization and minimum 5 years after Post Graduation OR Specialists above 45 years of age with Post Graduation in their respective fields.

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 you hospital has tie up with outside pharmacy

a) Yes ☐

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 PGEPHIS and pay the outside pharmacy when your bills are reimbursed by the TPA; to extend completely cashless facility to the beneficiaries of PGEPHIS.

a) Yes ☐

b) No ☐

Pathology

In House Pathology a) Yes ☐

b) No ☐

If yes, name/qualification of your pathologist _____
Facilities available at your pathological Lab. _____

If No, does your hospital has tie up with outside pathology/diagnostic centre.

a) Yes ☐

b) No ☐

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 PGEPHIS 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 PGEPHIS.

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 PGEPHIS Card Holder on OPD services _____
% Discount on PGEPHIS 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 PGEPHIS

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.

3. The Hospital shall raise an invoice in line with the tariff approved by the Nodal Agency 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.

4. 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.

5. 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.

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

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

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

9. 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 PGEPHIS.

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

Nodal Agency 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 an 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 Nodal Agency without assigning any reasons. In addition, Nodal Agency reserves its

right to prosecute my/our Hospital for cheating/forgery/fraud etc as per the law. Nodal Agency 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