Annexure – 22

As per Regulations 20 (5) of IRDAI (TPA – Health Services) Regulations, 2016

Minimum Standard Clauses in an agreement amongst Insurers, Network Providers and TPAs

Insurance companies may offer policies providing cashless service to the policyholders provided the services are offered in network providers who have been enlisted to provide medical services either directly under an agreement with the insurer or by an agreement amongst health services provider, the TPA and the insurer.

The Authority prescribes, inter alia, the following clauses to be included in such agreements as stipulated in the Agreements which shall be entered into between insurers, network providers, TPAs and shall cover the following, amongst others:

1. Scope of services provided by the network provider
2. the tariff applicable with respect to various kinds of healthcare services being provided by the network provider.
3. a clause empowering the insurer to cancel or otherwise modify the agreement in case of any fraud, misrepresentation, inadequacy of service or other non-compliance or default on the part of TPA or network provider; provided no such cancellation or modification shall be done by the insurer unless the concerned TPA or network provider is given an opportunity of being heard.
4. at the discretion of the Insurance Company, a standard clause providing for continuance of services by a network provider to the insurance company either directly or through another TPA, if the TPA is changed or the agreement with TPA is terminated.
5. an enabling clause to the network provider for opting out of network for reasons of inadequacy of service rendered either by the TPA or by the Insurance Company.
6. a clause specifically requiring only the insurance company the power to deny a claim.
7. a clause enabling insurer or the TPA that is representing an Insurer to inspect the premises of the network provider at any time without prior intimation.
8. Turnaround times for each of the services rendered by the parties, the course of action in case of default of services.
9. The responsibilities and obligations of each of the parties to the agreement in enforcing the agreement.
10. Display of information on cashless services by the network provider at prominent location, preferably at the reception and admission counter and Casualty/Emergency departments.
11. Confidentiality requirements

12. Termination notice
13. enabling clause to the Insurers or the TPA that is representing an Insurer to carry out Inspection, Audit and Access rights to the network providers either on regular or on ad-hoc basis
14. Arbitration and Dispute resolution
15. Procedure for cashless facility as in Schedule – A
16. Procedure for de-empanelment of network providers as in Schedule – B
17. Procedure to furnish the standard Discharge summary as in Schedule – C
18. Procedure to furnish the Standard Format for Provider Bills as in Schedule – D
19. Payments to be made through direct electronic fund transfer subject to deduction of tax at source as applicable under the relevant laws.
20. Payment reconciliation process on a regular basis.
21. Customer services and relations
22. Services rendered by the TPA shall be in compliance with the extant laws.
23. Code of Conduct.
24. TPAs and insurers shall endeavour to agree with the network providers for display of rates agreed for rendering health services to policy holders.

Schedule – A

Provider Services – Cashless Facility Admission Procedure

The insured shall be provided treatment free of cost for all such ailments covered under the policy within the limits / sub-limits and the sum insured, i.e., coverages not specifically excluded under the policy. The Provider shall be reimbursed as per the tariff agreed under the service level agreement for different treatments or procedures. The procedure to be followed for providing cashless facility shall be:

I. Preauthorization Procedure – Planned Admissions:

1. Request for hospitalization shall be forwarded by the provider immediately after obtaining due details from the treating doctor in the preauthorization form prescribed by the Authority i.e. "request for authorization letter" (RAL). The RAL shall be sent electronically along with all the relevant details in electronic form to the 24-hour authorization /cashless department of the insurer or its representative TPA along with contact details of treating physician and the Insured. The insurer's or its representative TPA's medical team may consult the treating physician or the insured, if necessary.
2. If the treating physician of the provider identifies any disease or ailment as pre-existing, the treating physician shall record it and also inform the insured immediately.
3. In cases where the symptoms appear vague / no effective diagnosis is arrived at, the medical team of the insurer or its representative TPA may consult with treating physician / insured, if necessary.
4. The RAL shall reach the authorization department of insurer or its representative TPA 7 days prior to the expected date of admission, in case of planned admission.
5. If "clause 3" above is not followed, the clarification for the delay needs to be forwarded along with the request for authorization.
6. The RAL form shall be dully filled in clearly mentioning Yes or No and/or the details as required. The form shall not be sent with nil or blank replies.
7. The guarantee of payment shall be given only for the medically necessary treatment cost of the ailment covered and mentioned in the request for hospitalization. Non covered items as per terms and conditions of the policy, like Telephone usage, food provided to relatives/attendants, Provider registration fees etc must be collected directly from the insured.
8. The authorization letter by the insurer or its representative TPA shall clearly indicate the amount agreed for providing cashless facility for hospitalization.

9. In the event of the cost of treatment increasing, the provider may check the availability of further limit with the insurer or its representative TPA.
10. When the cost of treatment exceeds the authorized limit, request for enhancement of authorization limit shall be made immediately during hospitalization using the same format as for the initial preauthorization. The request for enhancement shall be evaluated based on the availability of further limits and the hospital may be required to provide valid reasons for the same. No enhancement of limit is possible after discharge of insured.
11. Further, the insurer or the TPA who is acting on behalf of the Insurer shall accept or decline such additional expenses within a maximum of 24 hours of receiving the request for enhancement. Absence of receiving the reply from the [Insurance Company] within 24 hours shall be construed as denial of the additional amount.
12. In case the insurer has opted for a higher accommodation / facility than the one eligible under the policy , the Provider shall explain the effect of such option and also take a written consent from the beneficiary at the time of admission as regard to owing the responsibility of such expenses by the insured including the proportionate expenses which have a direct bearing due to upgradation of room accommodation/facility. In all such cases the Insurer [Insurance Company] shall pay for the expenses which are based on the eligibility limits of theinsured. However provider may charge any advance amount/security deposit from the insured only in such cases where the insured has opted for an upgraded facility to the extent of the amounts to be collected from the insured .
13. Insurance company guarantees payment only after receipt of RAL and the necessary medical details. The Authorization Letter (AL) shall be issued within 48 hours of receiving the RAL.
14. In case the ailment is not covered or the given medical data is not sufficient for the medical team of the authorization department to confirm the eligibility, insurer or its representative TPA shall seek further clarification/ information immediately.
15. Authorization letter [AL] shall mention the authorization number and the amount guaranteed for the procedure.
16. In case the balance sum available is considerably less than the cost of treatment, provider shall follow their norms of deposit/running bills etc. However provider shall only charge the balance amount over and above the amount authorized under the health insurance policy against the package or treatment from the insured.
17. Once the insured is to be discharged, the Provider shall make a final request for the pre-authorization for any residual amount along with the standard discharge summary and the standard billing format. Once the provider receives final pre-

authorization for a specific amount, the insured shall be allowed to get discharged by paying the difference between the pre-authorized amount and actual bill, if any. Insurer upon receipt of the complete bills and documents shall make payment of the guaranteed amount to the provider directly.

18. Due to any reason if the insured does not avail treatment at the Provider after the pre authorization is released and any payment is made in this regard, the Provider shall return the amount to the insurer immediately.
19. All the payments in respect of pre-authorised amount shall be made electronically by the insurer to the provider as early as possible but not later than a week, provided all the necessary electronic claim documents are received by the insurer.
20. Denial of authorization (DAL) for cashless is by no means denial of treatment by the health facility. The provider shall deal with such case as per their normal rules and regulations.
21. Insurer shall not be liable for payments to the providers in case the information provided in the "request for authorization letter" and subsequent documents during the course of authorization, is found incorrect or not disclosed.
22. Provider, insurer and its representative TPA shall ensure that the procedure specified in this Schedule is strictly complied in all respects.

II. Preauthorization Procedure – Emergency Admissions:

1. In case of emergencies also, the procedure specified in Clause (I) (1), (2) and (3) shall be followed.
2. The insurer or its representative TPA may continue to discuss with treating doctor till conclusion of eligibility of coverage is arrived at. However, any life saving, limb saving, sight saving, emergency medical attention cannot be withheld or delayed for the purpose of waiting for pre-authorisation. Provider meanwhile may consider treating him by taking a token deposit or as per their norms.
3. Once a pre-authorisation is issued after ascertaining the coverage, Provider shall refund the deposit amount to the insured if taken barring a token amount to take care of non covered expenses.

III. <u>Preauthorization Procedure – RTA / MLCs:</u>

1. If requesting a pre-authorisation for any potential medico-legal case including Road Traffic Accidents, the Provider shall indicate the same in the relevant section of the standard format.
2. In case of a road traffic accident and or a medico legal case if the victim was under the influence of alcohol or inebriating drugs or any other addictive

substance or resort to intentional self injury, it is mandatory for the Provider to inform this circumstance of emergency to the Insurer or its representative TPA.

IV. Authorization letter (AL):

1. Authorization letter shall mention the amount, guaranteed class of admission, eligibility of the patient or various sub limits for rooms and board, surgical fees etc. wherever applicable, as per the benefit plan for the patient.
2. The Pre-Authorization letter shall also mention Validity of dates for admission and number of days allowed for hospitalization, if any. The Provider shall see that these rules are strictly followed; else the AL will be considered null and void.
3. In the event of the room category, if any, not being available the same shall be informed to the Insurer or its representative TPA and the Insured. For such cases if the Insured is admitted to a class of accommodation higher than what he is eligible for, the provider shall collect the necessary difference, if any, in charges from the Insured.
4. The AL has a limited period of validity – which is 15 days from the date of sending the authorization.
5. AL is not an unconditional guarantee of payment. It is conditional on facts presented – when the facts change the guarantee changes.

V. Reauthorization:

1. Where there is a change in the line of treatment – a fresh authorization shall be obtained from the insurer immediately – this is called a reauthorization.
2. The same pre-authorization form shall be used for the reauthorization, and the same turnaround times as specified shall apply.

VI. Discharge:

1. The following documents shall be included in the list of documents to be sent along with the claim form to the Insurer or its representative TPA . These shall not be given to the Insured.
   a. Original pre authorization request form,
   b. original authorization letter,
   c. Original discharge card,
   d. original investigation repots,
   e. all original prescription and pharmacy receipt etc
2. Where the Insured requires the discharge card/reports he or she can be asked to take photocopies of the same at his or her own expenses and these have to be clearly stamped as "Duplicate & originals are submitted to [Insurance Company]". Where, the insured requests for any of the original reports, the

insurer shall arrange forwarding the originals by duly endorsing the settlement of the claim on such original reports. However, the insurer or its representative TPA may retain a copy of such reports as per their operational requirements.

3. The discharge card/Summary shall mention the duration of ailment and duration of other disorders like hypertension or diabetes and operative notes in case of surgeries. The clinical detail shall be sufficiently and justifiably informative. In addition, the Provider shall provide all the relevant details pertaining to past treatment availed by the Insured with the Provider.
4. Signature of the Insured on final Provider bill must be obtained.
5. In the event of death or incapacitation of the Insured , the signature of the nominee or any of Insured's family who represents the Insured subject to reasonable satisfaction of Provider shall be sufficient for the Insurer to consider the claim.
6. Standard Claim form duly filled in duly presented to the Insured for signing and identity of the Insured shall be confirmed by the provider.

VII. Billing:

1. The Provider shall submit original invoices directly to Insurer or its representative TPA and such invoices shall contain, at the minimum, following information:

    a. the Insured's full name and date of birth;
    b. the policy number;
    c. the Insured's Address
    d. the admitting consultant;
    e. the date of admission and discharge;
    f. the procedure performed and procedure code according to ICD-10 PCS or any other Code as specified by the Authority from time to time;
    g. the diagnosis at the time of treatment and diagnosis code according to ICD-10 or any other Code as specified by the Authority from time to time;;
    h. whether this is an interim or final bill/account;
    i. the description of each Service performed, together with associated Charges,
    j. the agreed standard billing codes associated with each Service performed and dates on which items of Service were provided; and.
    k. the Insured signature (in original).

2. The Provider shall submit the following documents with the final invoice:
    a. copy of Pre-Authorisation letter;
    b. fully completed claim form (or the relevant claim section of the Pre-

Authorisation letter), signed by the Insured and the treating consultant for the Treatment performed;

c. original and complete discharge summary in the standard form and billing form in the standard form, including the treating Consultant's operative notes;
d. original investigation reports with corresponding prescription/request;
e. pharmacy bill with corresponding prescription/request:
f. any other statutory documentary evidence required under law or by the Insured's policy;and
g. photocopy of the Insured's photo identification (eg voter's Smart card/ ID card, passport or driving licence etc).

3. The Provider shall submit the final invoice and all supporting documentation required within 2 days of the discharge date.

Schedule-B

PROCESS NOTE FOR DE-EMPANELMENT OF PROVIDERS

Process to be Followed For De-Empanelment of Providers:

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

1. Based on the claims data analysis and/ or the visits carried out on a Provider, if there is any doubt on the performance of a Provider, the Insurance Company or the TPA that is representing an Insurer can put that Provider in the "watch-list".
2. The data of such Provider shall be analysed very closely on a daily basis by the Insurance Company or the TPA that is representing an Insurer for patterns, trends and anomalies.

Step 2 – Suspension of the Provider

3. A Provider can be temporarily suspended in the following cases:
   a. For the Providers which are in the "Watch-list" if the Insurance Company or the TPA that is representing an Insurer observes continuous patterns or strong evidence of irregularity based on either claims data or field visit to Providers, the Provider shall be suspended from providing services to policyholders/insured patients and a formal investigation shall be instituted.
   b. If a Provider is not in the "Watch-list", but the insurance company or the TPA that is representing an Insurer observes at any stage that it has data/ evidence that suggests that the Provider is involved in any unethical practice/ is not adhering to the major clauses of the contract with the Insurance Company involved in financial fraud related to health insurance patients, either the Insurer or the TPA that is representing an Insurer, may immediately suspend the Provider from providing services to policyholders/insured patients and a formal investigation shall be instituted.

4. A formal letter shall be send to the Provider regarding its suspension with mentioning the timeframe within which the formal investigation will be completed.

Step 3 – Detailed Investigation

5. The Insurance Company or the TPA that is representing an Insurer can launch a detailed investigation into the activities of a Provider in the following conditions:
   a. For the Providers which have been suspended.
   b. Receipt of complaint of a serious nature from any of the stakeholders

6. The detailed investigation may include field visits to the Providers, examination of case papers, recording the statement of the policyholders/insured (if needed), examination of Provider records etc.
7. If the investigation reveals that the report/ complaint/ allegation against the Provider is not substantiated, the Insurance Company would immediately revoke the suspension (in case it is suspended). A letter regarding revocation of suspension shall be sent to the Provider within 24 hours of that decision.

Step 4 – Action by the Insurance Company or the TPA that is representing an Insurer

8. If the investigation reveals that the complaint/allegation against the Provider is correct then the following procedure shall be followed:
    a. The Provider must be issued a "show-cause" notice seeking an explanation for the aberration.
    b. After receipt of the explanation and its examination, the charges may be dropped or an action can be taken.
    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 Provider,
        ii. De-empanelment of the Provider.

9. The entire process should be completed within 30 days from the date of suspension.

Step 5 – Actions to be taken after De-empanelment

10. Once a Provider has been de-empanelled by insurer or the TPA that is representing an Insurer, following steps shall be taken:
    a. A letter shall be sent to the Provider regarding this decision
    b. This information shall be sent to all the other Insurance Companies which are doing health insurance business and where the action is taken by a TPA in formation shall be also sent to all other TPAs.
    c. An FIR shall be lodged against the Provider by the insurer or the TPA that is representing an Insurer at the earliest in case the de-empanelment is on account of fraud or a fraudulent activity.
    d. The Insurance Company or the TPA that is representing an Insurer which had de-empanelled the Provider, may be advised to notify the same in the local media, for the information of policyholders/insured about the de-empanelment, so that the policyholder do not utilize the services of that particular Provider.
    e. If the Provider appeals against the decision of the Insurance Company, all the aforementioned actions shall be subject to the dispute resolution process agreed in the service level agreement.

Schedule – C

STANDARD DISCHARGE SUMMARY:

1. Components of Standardization:
   a. List of standard contents in the discharge summary
   b. Standard guidelines for preparing a discharge summary so that the interpretation of the terms in the documents and the information provided is uniform.
2. Standard Contents of Discharge Summary Format:
   a. Patient's Name*:
   b. Telephone No / Mobile No*:
   c. IPD No:
   d. Admission No:
   e. Treating Consultant/s Name, contact numbers and Departments/Specialty:
   f. Date of Admission with Time:
   g. Date of Discharge with Time:
   h. MLC No / FIR No*:
   i. Provisional Diagnosis at the time of Admission:
   j. Final Diagnosis at the time of Discharge:
   k. ICD – 10 code(s) or any other codes, as recommended by the Authority, for Final diagnosis*:
   l. Presenting Complaints with Duration and Reason for Admission:
   m. Summary of Presenting Illness:
   n. Key findings, on physical examination at the time of admission;
   o. History of alcoholism, tobacco or substance abuse, if any:
   p. Significant Past Medical and Surgical History, if any*:
   q. Family History if significant/relevant to diagnosis or treatment:
   r. Summary of key investigation during Hospitalization*:
   s. Course in the Hospital including complication if any*:
   t. Advice on Discharge*:
   u. Name & Signature of treating Consultant / Authorized Team Doctor:
   v. Name & Signature of Patient / Attendant*:

* refer to guide notes below.

3. GUIDE NOTES FOR FILLING DISCHARGE SUMMARY FORMAT:

   a. The patient's name shall be the official name as appearing in the insurance policy document and the attendants should be made aware that it cannot be changed subsequently, because in some cases the

attendants give the nick names which are different from documented names. As a matter of abundant precaution, all personal information should be shown to the patient/attendant and validated with their signature.

b. The contact numbers shall be specifically those of the patient and if pertaining to attendant, the same should be mentioned.

c. Where applicable, copy of MLC/FIR needs to be attached

d. Responses to point (2) (b), (k) and (p) are desirable but not mandatory

e. Significant past medical and surgical history shall be relevant to present ailment and shall provide the summary of treatment previously taken, reports of relevant tests conducted during that period. In case history is not given by patient, it should be specified as to who provided the same.

f. Summary of key investigations shall appear chronologically consolidated for each type of investigation. If an investigation does not seem to be a logical requirement for the main disease/line of treatment, the admitting consultant should justify the reason for carrying out such test / investigation.

g. The course in the hospital shall specify the line of treatment, medications administered, operative procedure carried out and if any complications arise during course in the hospital, the same should be specified. If opinion from another doctor from outside hospital is obtained, reason for same should be mentioned and also who decided to taken opinion i.e. whether the admitting and treating consultant wanted the opinion as additional expertise or the patient relatives wanted the opinion for their reassurance.

h. Discharge medication, precautions, diet regime, follow up consultation etc should be specified. If patient suffers from any allergy, the same shall be mentioned.

i. The signatures/Thumb impression in the Discharge Summary shall be that of the patient because generally the patient is discharged after having improved. In other cases like Death summary or transfer notes in case of terminal illness, the attendant can sign. In such cases, the inability of the patient to sign should be recorded by the attending doctor.

Schedule - D

STANDARD FORMAT FOR PROVIDER BILLS

1. Components of standardization: Standardization involves three components:
   i) Bill Format
   ii) Codes for billing items and nomenclature
   iii) Standard guidelines for preparing the bills

2. Format specified: The bill is expected to be in two formats
   i) The summary bill and
   ii) The detailed breakup of the bills

3. Explanation and Guidelines – Summary Bill
   i. The summary format is annexed in the Schedule – D1
   ii. The Bill shall be generated on the letter head of the provider and in A4 size to aid scanning The summary bill shall not have any additional items (only nine)
   iii. The provider has to mention the service tax number in case they charge service tax to the Insurance Company
   iv. The payer mentioned in the Bill has to be necessarily the Insurance Company and not the TPA.
   v. In case of package charged for any procedure / treatment the provider is expected to mention the amount in Serial Number (9) only. Items beyond the package are to be mentioned in Serial Numbers (1) to (8).
   vi. The patient / attendant signature is mandatory on the summary bill
   vii. The additional guidelines to fill the summary format shall be as below:

Field Name	Remarks
Provider Name	Legal entity name and not the trade name
Provider Registration Number	Registration number of the provider with local authorities. once the clinical establishments (registration and regulation) bill, 2007 is passed, then registration number under this act
Address	Address of the Facility where member is admitted. A provider can have more than one facility.
IP No	Unique number identifying the particular hospitalization of the member
Patient Name	Full name of the patient
Payer Name	Name of the Insurance company with whom the member is insured. In case of cash patient then the

	field is to be left blank. If the bill is raised to more than one insurer then the primary insurer who has given cashless is to be mentioned. The name of insurance company needs to be mentioned and not the TPA.
Member address	Full address of the member
Bill Number	Bill number of the provider
Bill Date	Date on which the bill is generated.
PAN Number	PAN Number – Mandatory
Service Tax Regn No	Registration number from service tax authorities. Mandatory in case service tax is charged in the bill
Date of admission	Date of admission of the member in case of IPD cases. In case of Day care procedures, this is the date of procedure
Date of discharge	Date of discharge of the member in case of IPD cases. In case of Day care procedures, this is the date of procedure(same as date of admission)
Bed Number	Bed number in which the patient is admitted. In case the member is admitted under more than one bed number, all the numbers have to be mentioned.
SL No 1 of billing Summary	All items under the primary head '100000' in the detailed bill have to be summarized into this. In case the procedure is packages, then only bills amount beyond the package needs to be mentioned here.
SL No 2 of billing Summary	All items under the primary head '200000' in the detailed bill have to be summarized into this. In case the procedure is packages, then only bills amount beyond the package needs to be mentioned here.
SL No 3 of billing Summary	All items under the primary head '300000' in the detailed bill have to be summarized into this. In case the procedure is packages, then only bills amount beyond the package needs to be mentioned here.
SL No 4 of billing Summary	All items under the primary head '400000' in the detailed bill have to be summarized into this. In case the procedure is packages, then only bills amount beyond the package needs to be mentioned here.
SL No 5 of billing Summary	All items under the primary head '500000' in the detailed bill have to be summarized into this. In case the procedure is packages, then only bills amount beyond the package needs to be mentioned here.

SL No 6 of billing Summary	All items under the primary head '600000' in the detailed bill have to be summarized into this. In case the procedure is packages, then only bills amount beyond the package needs to be mentioned here.
SL No 7 of billing Summary	All items under the primary head '700000' in the detailed bill have to be summarized into this. In case the procedure is packages, then only bills amount beyond the package needs to be mentioned here.
SL No 8 of billing Summary	All items under the primary head '800000' in the detailed bill have to be summarized into this. In case the procedure is packages, then only bills amount beyond the package needs to be mentioned here.
SL No 9 of billing Summary	All items under the primary head '900000' in the detailed bill have to be summarized into this. If more than one procedure is done, the total amount of the two procedures needs to be summarized
Total Bill amount	Sum total of all items 1 to 9 in the bill
Amount paid by the member	Amount of bill paid by the member including co-pay, deductible, non-medical items etc incl discount offered to member, if any.
Amount charged to Payer	Amount payable by Insurance company
Discount Amount	Amount offered as discount to the insurance company
Service tax	Service Tax chargeable to insurance company
Amount Payable	Total amount payable by insurance com[any including service tax
Amount in words	Above mount in words for the sake of clarity
Patients signature	Signature of the patient or the attendant of the patient needs to be mandatorily taken
Authorized signatory	The signature of the authorized signatory at the provider

4. Explanation and Guidelines – Detailed Breakup of the Bill

I. The summary format is annexed in Schedule – D2
II. The Bill shall be generated on the letterhead of the provider and in A4 size paper to aid scanning.
III. The billing has to be done at level 2 or 3
IV. In case of medicines/consumables, the relevant level code three has to be mentioned (40100, 401002) and the text should indicate the actual medicine used
V. If providers have outsourced the pharmacy to external vendors. In such cases the providers can attach the original bills separately. However, the summary of this has to be mentioned in the summary bill.
VI. In case of pharmacy returns the same, the code originally used is to be used with a negative sign in the units
VII. In case of cancellation of any service, the same code originally used is to be used with a negative sign indicating reversal
VIII. The date on which the service is rendered is to be mentioned in the bill. This would be
    a. the date of requisition in case of investigations
    b. date of consultation for professional fees
    c. date of requisition in case of pharmacy/consumables irrespective of when they were used
    d. Date of return of pharmacy items for pharmacy returns.

IX. The additional guidelines to fill the summary format shall be as below, except that the first section of the bill is same as the bill summary referred in 3 above.

Field Name	Remarks
Date	Date on which service is rendered. For example, this is the date of investigation, date of procedure etc.
Code	Level 2 or 3 code of the billing item as per the codes(annex III)
Particulars	Text explanation of the item charged
Rate	Per unit price (per day room rent, per consultation charge)
Unit	No of units charged(hours, days, number as appropriate)
Amount	Rate*unit(s)

Schedule – D1

SUMMARY BILL FORMAT

Provider Name	……..…… …	Bill Number	……..……..…… …
Provider registration No.		Bill Date	
Address		PAN Number	
IP No		Service Tax Regn No	
Patient Name		Date of admission	
Payer Name	XXXX Insurance Company Ltd	Date of Discharge	
Member Address		Bed Number	

Billing Summary

Sl No	Primary Code	Particulars	Amount
1	100000	Room & Nursing Charges	
2	200000	ICU Charges	
3	300000	OT Charges	
4	400000	Medicine & Consumables	
5	500000	Professional Fees'	
6	600000	Investigation Charges	
7	700000	Ambulance Charges	
8	800000	Miscellaneous Charges	
9	900000	Package Charges	

Total Bill Amount	0
Amount paid by member	……0
Amount charged to Payer	0
Discount Amount	0
Service Tax	0
Amount Payable	0
Amount in Words	Rupees Zero Only

Patients Signature

Authorised Signatory

Schedule – D2

DETAILED BREAKUP FORMAT

PART - I

Provider Name	……	Bill Number	……
Provider registration No.		Bill Date	
Address		PAN Number	
IP No		Service Tax Regn No	
Patient Name		Date of admission	
Payer Name		Date of Discharge	
Member Address		Bed Number	

Billing Details

Sl No	Date	Code	Particulars	Rate	Nos (Unit)	Amount
1		101001	General Ward Charges	500	1	500.00
2		401001	XXX medicine	50	2	100.00
3		401001	XXX Medicine – return	50	-1	-50.00

PART - II

Level 1 Code	Level 1	Level 2 Code	Level 2	Level 3 Code	Level 3	Remarks
100000	Room & Nursing Charges					
100000	Room & Nursing Charges	101000	Room Charges			
100000	Room & Nursing Charges	101000	Room Charges	101001	General Ward charges	
100000	Room & Nursing Charges	101000	Room Charges	101002	Semi-private room charges	
100000	Room & Nursing Charges	101000	Room Charges	101003	Single Room charges	
100000	Room & Nursing Charges	101000	Room Charges	101004	Single Deluxe room charges	
100000	Room & Nursing Charges	101000	Room Charges	101005	Deluxe room charges	
100000	Room & Nursing Charges	101000	Room Charges	101006	Suite charges	
100000	Room & Nursing Charges	101000	Room Charges	101007	Electricity charges	
100000	Room & Nursing Charges	101000	Room Charges	101008	Bed sheet charges	
100000	Room & Nursing Charges	101000	Room Charges	101009	Hot water charges	
100000	Room & Nursing Charges	101000	Room Charges	101010	Establishment Charges	
100000	Room & Nursing Charges	101000	Room Charges	101011	Alpha/Water Bed Charges	
100000	Room & Nursing Charges	101000	Room Charges	101012	Attendant Bed Charges	
100000	Room & Nursing Charges	102000	Nursing charges			
100000	Room & Nursing Charges	102000	Nursing charges	102001	Nursing fees	
100000	Room & Nursing Charges	102000	Nursing charges	102002	Dressing	
100000	Room & Nursing Charges	102000	Nursing charges	102003	Nebulization	
100000	Room & Nursing Charges	102000	Nursing charges	102004	Injection charges	
100000	Room & Nursing Charges	102000	Nursing charges	102005	Infusion pump charges	
100000	Room & Nursing Charges	102000	Nursing charges	102006	Aya Charges	
100000	Room & Nursing Charges	102000	Nursing charges	102007	Blood Transfusion Charges	
100000	Room & Nursing Charges	103000	Duty Doctor fee			
100000	Room & Nursing Charges	103000	Duty Doctor fee	103001	Duty Doctor fee	
100000	Room & Nursing Charges	103000	Duty Doctor fee	103002	RMO Fees	
100000	Room & Nursing Charges	104000	Monitor charges			
100000	Room & Nursing Charges	104000	Monitor charges	104001	Pulse Oxymeter charges	If used in normal Room
200000	ICU Charges					
200000	ICU Charges	201000	ICU Charges			
200000	ICU Charges	201000	ICU Charges	201001	Burns Ward	
200000	ICU Charges	201000	ICU Charges	201002	HDU charges	
200000	ICU Charges	201000	ICU Charges	201003	ICCU charges	
200000	ICU Charges	201000	ICU Charges	201004	Isolation ward charges	
200000	ICU Charges	201000	ICU Charges	201005	Neuro ICU charges	
200000	ICU Charges	201000	ICU Charges	201006	Pediatric/neonatal ICU charges	
200000	ICU Charges	201000	ICU Charges	201007	Post Operative ICU	
200000	ICU Charges	201000	ICU Charges	201008	Recovery Room	
200000	ICU Charges	201000	ICU Charges	201009	Surgical ICU	

200000	ICU Charges	202000	ICU Nursing charges			If ICU nursing charged separately
200000	ICU Charges	202000	ICU Nursing charges	202001	Nursing fees	If ICU nursing charged separately
200000	ICU Charges	202000	ICU Nursing charges	202002	Dressing	If ICU nursing charged separately
200000	ICU Charges	202000	ICU Nursing charges	202003	Nebulization	If ICU nursing charged separately
200000	ICU Charges	202000	ICU Nursing charges	202004	Injection charges	If ICU nursing charged separately
200000	ICU Charges	202000	ICU Nursing charges	202005	Infusion pump charges	
200000	ICU Charges	203000	Monitor charges			
200000	ICU Charges	203000	Monitor charges	203001	Monitor charges	
200000	ICU Charges	203000	Monitor charges	203002	Pulse Oxymeter charges	If used in ICU
200000	ICU Charges	203000	Monitor charges	203003	Cardiac Monitor charges	
200000	ICU Charges	204000	Monitor charges	203004	IABP charges	
200000	ICU Charges	204000	Monitor charges	203005	Phototherapy Charges	
200000	ICU Charges	204000	ICU Supplies & equipment			
200000	ICU Charges	204000	ICU Supplies & equipment	204001	Oxygen charges	
200000	ICU Charges	204000	ICU Supplies & equipment	204002	Ventilator charges	
200000	ICU Charges	204000	ICU Supplies & equipment	204003	Suction pump charges	
200000	ICU Charges	204000	ICU Supplies & equipment	204004	Bipap charges	
200000	ICU Charges	204000	ICU Supplies & equipment		Pacing Charges	Temporary Pacemaker
200000	ICU Charges	204000	ICU Supplies & equipment	20406	Defibrillator Charges	
300000	OT Charges					
300000	OT Charges	301000	OT rent			
300000	OT Charges	301000	OT rent	301001	Major OT charge	
300000	OT Charges	301000	OT rent	301002	Minor OT Charge	
300000	OT Charges	301000	OT rent	301003	Cath Lab Charges	
300000	OT Charges	301000	OT rent	301004	Theatre charges	

300000	OT Charges	301000	OT rent	301005	Labour Room Charges	
300000	OT Charges	302000	OT Equipment charges			
300000	OT Charges	302000	OT Equipment charges		C-arm charges	
300000	OT Charges	302000	OT Equipment charges	302002	Endoscopy charges	
300000	OT Charges	302000	OT Equipment charges	302003	Laproscope charges	
300000	OT Charges	302000	OT Equipment charges	302004	Equipment charges	If not specified
300000	OT Charges	302000	OT Equipment charges	302005	Monitor charges	for OT monitoring
300000	OT Charges	302000	OT Equipment charges	302006	Instrument charges	for OT instruments
300000	OT Charges	303000	OT Drugs & Consumables			
300000	OT Charges	303000	OT Drugs & Consumables	303001	OT Drugs	
300000	OT Charges	303000	OT Drugs & Consumables	303002	Implants	
300000	OT Charges	303000	OT Drugs & Consumables	303003	OT Consumables	includes guide wires, catheter etc
300000	OT Charges	303000	OT Drugs & Consumables	303004	OT Materials	
300000	OT Charges	303000	OT Drugs & Consumables	303005	OT Gases	
300000	OT Charges	303000	OT Drugs & Consumables	303006	Anaesthetic drugs	
300000	OT Charges	304000	OT Sterlization			
300000	OT Charges	304000	OT Sterlization	304001	CSSD Charges	
400000	Medicine & Consumables charges					
400000	Medicine & Consumables charges	401000	Medicine & Consumables charges			
400000	Medicine & Consumables charges	401000	Medicine & Consumables charges	401001	Ward Medicines	OT drugs under OT charges
400000	Medicine & Consumables charges	401000	Medicine & Consumables charges	401002	Ward Consumables	
400000	Medicine & Consumables charges	401000	Medicine & Consumables charges	401003	Ward disposables	
400000	Medicine & Consumables charges	401000	Medicine & Consumables charges	401004	Ward Materials	
400000	Medicine & Consumables charges	401000	Medicine & Consumables charges	401005	Vaccination drugs	
500000	Professional fees charges					
500000	Professional fees charges	501000	Visit charges			
500000	Professional fees charges	501000	Visit charges	501001	Consultation Charges	

500000	Professional fees charges	501000	Visit charges	501002	Medical Supervision Charges	
500000	Professional fees charges	501000	Visit charges	501003	Professional fees	
500000	Professional fees charges	502000	Surgery Charges			
500000	Professional fees charges	502000	Surgery Charges	502001	Surgeons Charges	
500000	Professional fees charges	502000	Surgery Charges	502002	Assisstant Surgeons Fee	Would also include Standby Surgeon
500000	Professional fees charges	503000	Anaesthetists fee			
500000	Professional fees charges	503000	Anaesthetists fee	503001	Anaesthetists fee	
500000	Professional fees charges	503000	Anaesthetists fee	503002	OT standby charges	Providers charge for standby anaesthetist
500000	Professional fees charges	504000	Intensivist Charges	504000		
500000	Professional fees charges	505000	Technician Charges	505000	OT /Cath Lab Technician	
500000	Professional fees charges	505000	Physiotherapy			
500000	Professional fees charges	504000	Procedure charges			
500000	Professional fees charges	504000	Procedure charges	504001	Bedside procedures	Catheterization, Central IV Line, Tracheostomy, Venesection
500000	Professional fees charges	504000	Procedure charges	504002	Suture charges	
600000	Investigation Charges					
600000	Investigation Charges	601000	Bio Chemistry			Serum Sodium, Ueres etc
600000	Investigation Charges	602000	Cardiology charges			for procedures like echo, ECG etc
600000	Investigation Charges	603000	Haemotology charges			cross matching etc
600000	Investigation Charges	604000	Microbiology charges			blood culture, C&S
600000	Investigation Charges	605000	Neurology			for EMG, EEG etc
600000	Investigation Charges	606000	Nuclear medicine			PET CT, Bone scan etc
600000	Investigation Charges	607000	Pathology charges			
600000	Investigation Charges	608000	Radiology services			X-ra, CT, MRI etc
600000	Investigation Charges	609000	Serology charges			
600000	Investigation Charges	610000	Medical Genetics			Chrosomal Analysis etc
600000	Investigation Charges	611000	Profiles			Profiles instead of individual tests (Lipid profile, LFT etc)
700000	Ambulance Charges					
700000	Ambulance Charges	701000	Ambulance Charges			
800000	Miscellaneous charges					
800000	Miscellaneous charges	801000	Admission charges			
800000	Miscellaneous charges	802000	Attendant food charges			
800000	Miscellaneous charges	803000	Patient food charges			

800000	Miscellaneous charges	804000	Registration charges			
800000	Miscellaneous charges	805000	MRD Charges			
800000	Miscellaneous charges	806000	Documentation charges			
800000	Miscellaneous charges	807000	Telephone charges			
800000	Miscellaneous charges	808000	Bio Medical Waste Charges			
800000	Miscellaneous charges	809000	Taxes		Luxury Tax/Surcharge/Service Charge	Excluding VAT & Service Tax
900000	Package Charges					To be used only in case of packages
900000	Package Charges	901000	Cardiac Surgery	ICD-10-PCS	CABG	To be used only in case of packages
900000	Package Charges	902000	CardiologyPackages	ICD-10-PCS	PTCA	To be used only in case of packages
900000	Package Charges	903000	Cath Lab	ICD-10-PCS	CAG	To be used only in case of packages
900000	Package Charges	904000	Dental Procedures	ICD-10-PCS	Root Canal Treatment	To be used only in case of packages
900000	Package Charges	905000	ENT	ICD-10-PCS	FESS	To be used only in case of packages
900000	Package Charges	906000	Gastroenterology	ICD-10-PCS	Gastrectomy - Partial	To be used only in case of packages
900000	Package Charges	907000	General Surgery	ICD-10-PCS	Inguinal hernia	To be used only in case of packages
900000	Package Charges	908000	Gynaecology	ICD-10-PCS	LSCS	To be used only in case of packages
900000	Package Charges	909000	Nephrology	ICD-10-PCS	Nephrectomy	To be used only in case of packages
900000	Package Charges	910000	Neuro Surgery	ICD-10-PCS	Craniotomy	To be used only in case of packages
900000	Package Charges	911000	Oncology Procedures	ICD-10-PCS	IMRT	To be used only in case of packages
900000	Package Charges	912000	Opthalmology procedures	ICD-10-PCS	Cataract	To be used only in case of packages
900000	Package Charges	913000	Orthopaedic Surgery	ICD-10-PCS	Bilateral TKR	To be used only in case of packages
900000	Package Charges	914000	Plastic Surgery	ICD-10-PCS	Skin Grafting	To be used only in case of packages
900000	Package Charges	915000	Pulmonology Packages	ICD-10-PCS	Pleural Tapping	To be used only in case of packages
900000	Package Charges	916000	Urology	ICD-10-PCS	ERCP	To be used only in case of packages
900000	Package Charges	917000	Vascular Surgery	ICD-10-PCS	Embolectomy	To be used only in case of packages