" JeevanBhagya ", 3rd Floor, Secretariat Road, Saifabad, Hyderabad – 500063
Telephone: 040 24785022 Email : co_health@licindia.com

Annexure-IV

(Annexure to the Financial Bid to be submitted by the TPA)

For Health Insurance Plans (901, 902, 903, 904 & 906) (Fixed Benefit Health Insurance Plans)

Scope of Work of Third Party Administrator (TPA)

The TPA shall hold a valid Certificate of Registration as a Third Party Administrator under the Insurance Regulatory Development Authority of India (Third Party Administrators - Health Services) Regulations, 2016 , IRDAI(Third Party Administrators-Health Services)(Amendment) Regulations,2019 as amended from time to time. It should comply with the regulations, circulars, guidelines and directions that may be issued by IRDAI from time to time.

Part A

Customer Service at the Commencement of the Policy

Health Insurance Division of LIC of India, Hyderabad proposes to engage **REGION-WISE TPAs** for servicing of Health Insurance Policies.

The details of the Products for servicing are:

1. LIC's Health Plus (Plan-901)

2. LIC's Health Protection Plus (Plan-902)

3. LIC's Jeevan Arogya (Plan-903)

4.LIC's Jeevan Arogya (Plan-904)

(The above four policies are withdrawn for sale)

5. LIC`s Arogya Raksha (Plan – 906)

6. Any other product introduced by LIC HI during the contract period

The TPA shall forward a TPA Booklet as per the format approved by the Insurer (to be printed in English and Hindi) containing related information to the Insured person within 5 working days of receipt of information regarding the issuance of Policy from the Insurer and the scanned images of the Photo addendums which contains photo, name and date of birth of insured members which will be uploaded by the Divisions. The TPA has to download the data of Health Policy Masters (Information regarding the issuance of Policy to the Insured person from the Insurer, and modifications in the Policy Master thereof)

from LIC's server on a daily basis without fail. As a onetime activity, TPA is supposed to send the above guidelines/booklet to all in-force policyholders.

The TPA is not authorized to edit any data downloaded from LIC Master files. After posting the date of issuance of user TPA Booklet to the insured, the soft copy shall be sent to LIC HI.

The Guidebook shall inter-alia contain information regarding the following:

a) Information regarding the TPA and its address, fax number, website address, Toll free number of the Call Center Service and other contact information with dedicated number to Senior Citizens ;

b) A complete set of claim forms;

c) Procedure to be adopted for claiming hospitalization benefits in a Network or a Non-Network Hospital

d) Any information that would be useful to the Insured which is agreed between the TPA and the Insurer.

Part B

Customer Service during the Policy Term

1. **Spread of Offices:** The TPA shall endeavour to open more offices or expand the Network Providers to allow easy and convenient access to the Insured persons.

2. **Network Providers:** The TPA shall make available the list of Network Providers affiliated to the TPA to the Insured on their website.

3. **Changes in the Network Provider:** The TPA shall intimate from time to time any changes in the number and details of the Network Providers. The directory shall be updated regularly in the website of the TPA.

4. **Call Center services:** The TPA shall provide Call Center services for the guidance and benefit of the Insured Persons. The Call Center shall function for 24 hours a day, 7 days a week, round the year. As part of the Call Center Service, the TPA shall provide the following:

- General guidance on the Service.
- Information on Network Providers and contact numbers.
- Claim status information to the Insured Person.
- Advising the Insured Person regarding the deficiencies in the documents submitted for a claim.
- Any other information relevant & available to the Insured at the Call Center.

5. **Toll Free Number:** The TPA shall operate a Toll Free number with a facility of minimum of 10 lines. In case of non-availability of the 10 line facility immediately, the TPA shall as soon as possible and in any case within 30 days provide for the facility and intimate the Insurer. The Toll Free numbers shall be restricted only to the incoming calls of the clients and outward facilities from those numbers shall be barred to prevent misuse.

6. **Language:** The TPA shall provide the information on services to the Insured Persons in English, Hindi and the regional language applicable to the region.

7. Website Services: The TPA shall have a Website for the benefit of all Insured Persons/Insurer. As part of the Website service, the TPA shall provide the following:

- General guidance on the Services.
- Information on Network Providers and contact numbers.
- Claim status information to the Insured Person.
- Advising the Insured Person regarding the deficiencies in the documents submitted.
- Any other relevant information required by the Insured Person.
- Guidance and information to the senior citizens.

The information shall be updated dynamically or at least at the end of the day.
The system shall have facility which can be accessed by the Insured/Insurer and both.

8. **Grievance handling :** The TPA shall provide adequate services to the Policyholders and ensure that their grievances are resolved to the best of their satisfaction, under intimation to the Insurer. The TPA shall establish a separate channel to address the health insurance related claims and grievances of senior citizens.

9. **Redressal Mechanism :** The TPA shall act as a frontline redresser of Insured Persons' grievances and shall attempt to solve the customer grievance at their end. The grievances shall be recorded by the TPA and the grievances so recorded shall be numbered consecutively and the Insured Person shall be provided the number assigned to his/her grievance. The TPA shall attempt to solve the customer grievance at their end within 15 days of receipt of the same – as per the IRDAI (Protection of Policyholders' Interests) Regulations, 2017, as amended from time to time.

10. **Co-ordination with the Insurer:** The TPA shall co-ordinate with the Insurer to solve the grievance of the Insured Person/s, as and when required depending upon the nature and circumstances of the grievance.

11.Claims Processing services
The Processing of the Claims shall be handled by the TPA at their designated Offices.

12. Non Disclosure / Confidentiality:

The TPA shall maintain confidentiality of data collected by it from the Insurer and policies serviced and data of claims processed and shall not under any circumstances divulge any such data to any other person or entity unless authorized in writing by the Insurer.

- The TPA shall not influence directly or indirectly the policyholders to shift their insurance portfolio from the Insurer with whom this agreement is entered into, to another Insurer
- The TPA shall not act or do anything which shall prejudice the interests of the Insurer or do anything that can create a conflict of interest.
- The TPA or the Network provider shall keep such medical information / records of the Insured person as confidential as per guidelines / instructions of GOI in respect of certain ailments / diseases and shall not part with the information, unless duly authorized by IMA / concerned department of GOI or the courts.

Part C
Customer Service / Claim Settlement

1.Maintenance and Claims settlement consists of the following:

a. Maintenance of the policy and claim records.
b. Transfer of data with regard to processed claims to the insurer on monthly basis, before 7th of the following month.
c. Transfer of policy & claim Records to other TPA as and when insurer intimates.
d. TPAs shall provide recommendations as to the admissibility of claim as per terms and conditions of the policy under the plan.
e. Policy particulars (short policy master) shall be made available to them on Corporations website. If further information is required regarding a policy under claim, the TPA should obtain data from the Claims Department of the respective Divisional Office. .
f. The identity of the Insured as given in the Hospital Treatment Form (HTF) is to be cross checked with the photo addendum which contains Photo, Name and DOB of the Insured members.
g. Putting up of claim status with specific requirements necessary for adjudication of claim.

h. Verifying of the identity of the claimant.
i. Verifying whether the hospitalization/treatment was actually availed.
j. Verifying whether the Hospitalization treatment claimed i s medically necessary.
k. Verifying whether the duration of hospitalization was reasonable for the ailment as compared to the standard duration applicable for the ailment.
l. Verify whether the Insured's ailment precedes cover commencement /revival date. In case the pre-existing ailment is noticed, the TPA has to investigate and take suitable decision and investigation report has to be submitted to LIC in the prescribed format. The Exclusions/PED Clause as per Policy Conditions is to be referred in this context
m. Verify eligible benefits along with the imposed limits, Policy year, Policy term and age and Coverage permissible under the Policy conditions ("exclusions" mentioned in the Policy conditions should be borne in mind) while processing the claim vis-à-vis the Claim submitted by the Policy Holder.

n.Verify benefits and Coverage eligibility of the Insured Person/Member ("exclusions" mentioned in the Policy conditions should be borne in mind) while processing the claim. The eligibility of the Policy Holder/member for the claim applied for should be thoroughly verified.
o. Doctors not below the ranks of MBBS shall make/ note down the recommendation with justification for the same in claims summary sheet.
p. Claim recommendation to be substantiated with proper reasoning quoting the policy terms and conditions either for acceptance or for rejection.
q. In case of any excess payment made as a result of wrong recommendation, TPAs shall indemnify the Corporation to the extent of loss suffered by it.
r. Conducting of claim investigation in case of frauds based on fraud triggers and submission of reports where investigation is done.

The table below provides the mandatory Claim investigations to be carried out by the TPA on claims arising in Network/Non-Network Hospitals as a percentage of total claims lodged with them. In case of PED rejections, all cases need to be investigated invariably.

Sl. No.	Type of Claims	% of Claims to be investigated	
1	Claims for treatment taken in Network Hospitals /Non Net Work Hospitals of TPA.	Claim Rejections for Pre Existence of Disease (PED)	100%
2	Claims for treatment taken in Network Hospitals of TPA	All claims other than Pre- Existence of Disease (PED)	10%
3	Claims for treatment taken in Non-Network Hospitals of TPA	All claims other than Pre Existence of Disease cases	20%
4	The TPA should complete the investigation within 10 days from the date of intimation of the claim		

s. Furnishing MIS data in the format prescribed by the Insurer and at the frequency that is desired by LIC (Health Insurance).

t.TPA shall accept only those cases sent to it by LIC Claims Department, Divisional Office with mandatory claim requirements along with the checklist duly filled and initialed by authorized officials at Claims Department, Divisional Office. If not, they shall be returned to the Claims Department, Divisional Office with appropriate remarks. The checklist as per which claim forms can be accepted from the Claims Department, Divisional Office is attached**. (Annexure 1A)**

u. 1) TPA has to collect claim documents from Claims Department of the respective Divisional Office on a daily basis.

2) The TPA should scan and upload all the claims documents required for claim adjudication in their website as well as in EDMS portal through the link provided by the Corporation.

3) TPA shall provide access to their website to LIC CO (HI)/ZO (HI) and Claims Department of the respective Divisional Office .

4) Any technical /administrative changes as required by the Corporation from time to time are to be adopted with regard to claim processing

v.<u>TPAs shall provide claim recommendation for intimated claims as per terms and conditions of the Policy /Plan, observe the following benchmarks :</u>

i) TPAs shall consider and recommend all claim cases within three (3) days, where further

requirements (based on the submitted requirements and history provided) and / or investigations (based on investigation triggers/red alerts) are not required.

ii) **T**PAs shall consider and recommend all other claim cases where the requirements have been called for within three (3) days from the date of receipt of last requirement, provided no further requirements are triggered (based on the submitted documents & history provided) / or further investigation is necessary (based on compliance documents/investigation triggers)

iii) No claim shall be kept pending beyond 45 days for want of requirements from claimants.

w. Where requirements are to be called for based on the information provided in the mandatory requirements, TPAs are required to send the first letter calling for requirement/s within 2 days of receipt of claim forms. This shall be followed by reminders every 10th day till the requirements are received. Telephone calls, emails/SMSs shall also be made/ sent, every 3rd day in addition to the written reminder letter. TPAs shall endeavour to engage claimant and obtain all data necessary for adjudication of claim.

Once claims recommendations are ready, TPAs shall send claims data to Health Insurance Department, Divisonal Office for processing. The claim transaction file format will be provided.

x. After the claim is decided by the Corporation, TPAs are required to send communication of claim admission to policyholder. (The format will be provided) If the claim is recommended for rejection, TPAs are requested to send the communication to Claims Department of the respective Divisional Office with reasons for rejection for onward communication of the decision by the Claims Department of the respective Divisional Office after review.

y. The claim files are to be returned to the Claims Department of the respective Divisional Office within 3 days from the date of recommendation/ opinion by TPA.

z. TPA Shall provide a menu with following options to view in their portal.

i) Claim cases with their recommendation of admission
ii) Claim cases with their recommendation of rejection
iii) Claim cases pending for recommendation
iv) Claim cases pending for want of requirements
v) Claim cases pending for investigations
vi) Claim pending cases, Claim decided cases etc., pertaining to the Corporation.

Processing of claims submitted by the policyholders under the Quick cash facility method shall be as under:

II. <u>Quick Cash facility</u>:

1. The Term Quick Cash denotes that money would be made available to the policyholder even during period of hospitalization instead of waiting for making a claim for the benefit after discharge.

2. It is only an advance payment to the policy holder in the event of planned hospitalization for any defined major surgical treatment (MSB) defined in the surgeries listed and permissible under the policy conditions of the relevant product.

3. The policy holder has to give prior intimation of the surgery to be undergone, if it is a planned surgery.

4. As per our policy conditions, different surgeries under MSB are allowed varying % of Sum Assured as maximum benefit payable per year / per term. 50% of the notified benefit defined for the surgical treatment shall be paid as advance payment to the policy holder as soon as he/she is hospitalized (either planned or emergency due to accident). This is however, subject to approval from the TPA, and the advance amount will be adjusted from the final settlement of the hospitalization bill.

For example: If 100% MSB is allowed under the product for a defined surgery, the advance payable shall be the 50% of the MSB payable for the surgery or 50% of the balance MSB eligible for the policy year/policy term, whichever is less.

5. This facility of advance payment shall be available only to those policyholders who have submitted the Bank Account and correct IFSC code so that direct credit to the policy holder's account can be made. The amount of advance shall under no circumstances be paid to the TPA or the hospital.

A. Requirements for Quick Cash facility

1. Admission in Network Hospital of TPA.
2. Hospitalization only for Major Surgical treatment.
3. Advance payment only for MSB component.
4. Availability of Bank Account Number & information on IFSC for making payment.

B. Process for Quick Cash facility:

1.**Day Zero**: Policyholders to send the details of their hospitalization etc., to TPA/LIC HI through Scanned images of the documents/Fax or hand over through his Agent personally wherever feasible.

2.**Day One:** TPA processes the request and advises LIC HI Department on admissibility or otherwise. Scanned copies of the claim forms will be sent to Claims Department of the respective Divisional Office s. If not permissible, TPA shall inform the policyholder accordingly under intimation to LIC CO HI / Claims Department, Divisional Office.

3.**Day Two**: LIC admits the request for advance payment through Quick Cash facility and uploads payment instructions to the Bank for crediting to the Policyholders Bank Account through NEFT.

C. Role of Policy holder:

The policyholder or his / her representative shall submit

1. Advance Claim intimation form in the prescribed format of LIC HI Department.

2. A statement with the following requirements from the hospital / doctor on the letter head of the hospital where the PI or beneficiary is admitted for surgical treatment.

a. Name of the patient & policy details.
b. Address and other contact details.
c. Date of hospitalization.
d. Duration of the present ailment necessitating surgery, nature and Diagnosis of the problem.
e. Treatment if any, taken in the past for this ailment preceding the current hospitalization.
f. Details of surgery done earlier along with diagnostic reports.
g. Present Diagnostic reports and the details of surgery to be performed.
h. Expected cost involved for the surgery.

3. Intimation about the Bank IFSC code and the Bank Account number along with the blank cancelled cheque leaf.

4. Undertaking from the PI that the advance amount shall be repaid by him, if it is found later

- That there was a mistake in the claim
- That the intended surgery was not performed

- That the surgery performed does not fall under the categories defined in the terms and conditions of the policy.
- That any pre existing disease is noticed before commencement of policy/Date of revival subsequently.
- That the Surgery performed differs with the original plan or
- Any other reason which makes the PI/Beneficiary not eligible for the above advance.

In case the ailment is not covered for one or more of the above reasons, the PI shall refund the amount within a fortnight, failing which the rate of interest as applicable in Banks shall be charged.

5. The documents clearly scanned/faxed should be sent directly to the TPA or to the LIC Claims Department, Divisional Office for processing.

6. Discharge voucher (in LIC's prescribed format) which shall be used against the advance payment, if it is considered by LIC Claims Department, Divisional Office.

It shall always be the endeavour of the TPA to recommend the claims Correctly and Quickly.

In case of non adherence to benchmarks in any areas of claim processing, penalties will be levied, as mentioned below, which shall be deducted from the service fee payable to the TPA.

Chart of Penalties

1) Penalty for not maintaining Timelines (TL) in submission of statements:

i. Weekly Statements: Rs. 500/- per lapse (TL-next working day of the following week)

ii. Monthly Statements: Rs.750/- per lapse (TL- 5th working day of the following month)

iii. Quarterly IRDA Statements: Rs. 2000/- per lapse (TL- 5th working day of the first month in the following quarter)

2) Penalty for not maintaining benchmarks in claim settlement (Quarterly Review) – Quarters are from April - June, July - September, October - December and January - March.
A deduction of 1% from servicing charges payable for each month of the Quarter under review.
(Please see Part 'C' under point1 (v&w)

3) Penalty for not conducting requisite % of investigations in prescribed time frame Under Part "C" (PI See point 1(r))

Review is done every quarter and if requisite percentage of investigations is not done in any month of a quarter, it will be treated as lapse (Quarters are from April to June, July to September, October to December and January to March)

Quarter	First lapse in any Quarter	Second lapse in any subsequent quarter	Third lapse in any subsequent quarter	Fourth lapse in any subsequent quarter
April-June	Deduction of 3% from monthly servicing charges of respective month payable.	Deduction of 5% from monthly servicing charges of respective month payable.	Deduction of 7% from monthly servicing charges of respective month payable.	Deduction of 9% from monthly servicing charges of respective month payable.
July-Sept	Deduction of 3% from monthly servicing charges of respective month payable.			

Oct-Dec	Deduction of 3% from monthly servicing charges of respective month payable.			
Jan-Mar	Deduction of 3% from monthly servicing charges of respective month payable.			

Part D

Coordination between the TPA and the Insurer

1. **Call Center Analysis :** The TPA shall provide general call center statistics in a format to the Insurer on a monthly basis including the aspects of grievance redressed. Any specific format, if required, shall be intimated by the Insurer in advance to the TPA.

2. Management Information System : The TPA shall provide management information System reports whereby the Insurer can have access to the information regarding the enrolment, pre-authorization, claims settlement and reimbursement and such other information regarding the Services. The reports shall be submitted by the TPA to the Insurer on a regular basis preferably monthly or as agreed between the Parties. (Formats will be sent later)

3. **TPA Service Fees :** In consideration of the Services mentioned above, the Insurer shall pay to the TPA the Fees per Policy as agreed upon between the TPA and the Insurer every month.

a. Any applicable taxes and other levies of the Government or any Governmental Authority in relation to the Fees payable, shall be borne by the Insurer provided the TPA is a regular payee of Goods & Service tax and they are having the GST tax Account with the concerned Department of the Government of India which shall be mentioned in the service fee bill raised by the TPA.

b. The TPA Service Fee shall be paid only as long as the policy is in force. In other terms, policies lapsed/discontinued shall not be eligible for any TPA Service Fee.

PART - E

General Code of Conduct for TPAs

In accordance with the Regulation 23 of IRDAI (TPA – Health Services) Regulations, 2016 and IRDAI (Third Party Administrators – Health Services) Regulations, 2019 as amended from time to time, without prejudice to the generality of the provisions contained in these regulations, it shall be the duty of every TPA, its Chief Administrative Officer or CEO and Chief Medical Officer and its employees or representatives to

1. Establish their identity to the insured, claimant, policyholder and that of the insurer with which it has entered into an agreement, other entities and the public.
2. Disclose its certificate of registration on demand to the insured, policyholder, claimant, prospect, public or to any other entity relating to the services under a policy issued by an insurer.
3. Disclose on demand to the insured, policyholder, claimant, prospect, public or to any other entity the details of the services it is authorized to render in respect of health insurance products under an agreement with an insurer.
4. Bring to the notice of the insurer with whom it has an agreement, any adverse report or inconsistencies or any material fact that is relevant for the insurer.
5. Obtain all the requisite documents pertaining to the examination of an insurance claim arising out of an insurance contract.
6. Render such assistance as mentioned under the agreement and advice to policyholders or claimants or beneficiaries to comply with the requirements for settlement of claims with the insurer;
7. Conduct itself or himself in a courteous and professional manner.
8. Refrain from acting in a manner which may influence, either directly or indirectly, the insured or policyholder of a particular insurer to migrate from one insurer to another.
9. Refrain from dissuading or discouraging policyholder from approaching specific hospital of his / her choice or persuade or encourage the policy holder to approach any specific Hospitals which are in their Network, other than offering advice and guidance when specifically sought for.
10. Have effective grievance management systems in place.
11. Ensure to resolve the grievances of policyholders within fifteen days of receipt of the same.
12. Ensure to resolve the grievances or disputes with hospitals or network providers expeditiously and ensure that the policyholder is not adversely affected due to such disputes.
13. Refrain from trading on information and records of its business except for sharing of the same as provided in regulations and maintain the confidentiality of the data collected by it and not share the same except as provided in regulation 19 (4) of IRDAI (TPA – Health Services) Regulations, 2016 , and IRDAI (Third Party Administrators – Health Services) Regulations, 2019 as amended from time to time.
14. Refrain from issuing advertisements of its business or the services carried out by it on behalf of a particular insurer, without prior written approval of the insurer.
15. Refrain from inducing an insured, policyholder, network provider to omit any material information or submit wrong information.
16. Refrain from demanding or receiving a share of the proceeds or a part of the claim amount from the policy holder, claimant, network provider.
17. Comply with the regulations, circulars, guidelines and directions that may be issued by the regulator from time to time.
18. Not submit any wrong, incorrect, misleading data or information or undertaking to the insurer of the TPA business.
19. Not to outsource the job of servicing of those insurance policies for which he is appointed as TPA to any other registered entity including TPA or unregistered entity.

LIC OF INDIA DIVISIONAL OFFICE :

Annexure 1 A

Check List.

Policy Number:

Name of the person hospitalized: **Claim forms Received by CLAIMS DEPARTMENT, DIVISIONAL OFFICE on:**

Sent to TPA on: **Registration No:** **Registration date**:

Total No of pages in the claim file:

Please verify the following items in this check list before sending claim forms to the TPA.

Sl.no	Title	Please mention specific and clear answers for 10, 11 & 12
1 (a)	Claim form is duly filled in	YES ◯ NO◯
(b)	Hospital Treatment Form (HTF) duly filled in& self attested	YES ◯ NO◯
(c)	Xerox copy of Health Card / Photo-identity Card is pasted on the Hospital Treatment Form and attested by hospital authorities	YES ◯ NO◯
(d)	Hospital Treatment Form is signed by Hospital Authorities / Treating Doctor with seal	YES ◯ NO◯
2	Original or Attested copy of Hospital Discharge Summary, should be **attested by the PI also**	YES ◯ NO◯
3	Original or Attested copy of the Final Hospital Bill, should be **attested by PI** also	YES ◯ NO◯
4	Original or Attested copies of the pathological / USG / MRI reports **if mentioned in the Discharge Summary**, should be **attested by the PI** also	YES ◯ NO◯ NA ◯
5	Original or Attested copies of the Surgical reports/OT Notes **in case surgery is performed**, should be **attested by the PI** also	YES ◯ NO◯ NA ◯
6	Original or Attested copies of MLC / FIR reports **in case of Road Traffic Accident**,should be **attested by the PI** also	YES ◯ NO◯ NA ◯
7	Self Declaration explaining cause of Accident / Fall **in case of accident other than RTA**	YES ◯ NO◯ NA ◯
8	Whether consumption of alcohol is ruled out by Treating doctor in case of accident	YES ◯ NO◯ NA ◯
9	**Whether any disease or surgery mentioned in the proposal form/DGH at the time of Revival. If Yes mention the particulars in Remarks column.**	YES ◯ NO◯
10	Pl. mention Underwriting Decision including exclusions if any at proposal stage	
11	Pl. mention Underwriting Decision including exclusions if any at Revival stage (if revived) with date of revival.	
12	Is **NEFT** Master & **Address** Master created / updated	YES ◯ NO◯
13	whether delay is condoned if claim form is submitted beyond 30 days from date of discharge of hospital(Mention the date of condonation in Remarks column)	YES ◯ NO◯ NA ◯

DATA SHEET

Hospital Registration No	No. of beds	Is the definition of Hospital fulfilled for the type of Claim?**(YES/NO)**	Date of Admission in Hospital	Date of discharge from Hospital	Whether policy is in force during the Hospitalization period**(Yes/No)**

REMARKS:-

Certified that the requirements are checked against items in the Check List

Manager (Claims)

Life Insurance Corporation of India **Annexure 2A**
Claims Department , Divisional Office :

CLAIM INVESTIGATION REPORT FORM (for HEALTH INSURANCE POLICIES)

(To be completed by the TPA while entrusting the Claim for investigation)

Part 'A'

A. Policy Number		Date of Commencement of the Policy/Revival	
B. Name and occupation of the Principal Insured			
C. Address of the Principal Insured			
D. Name of the Insured hospitalized		Age	
E. Name and address of the Hospital where the insured was hospitalized:			
F. Period of Hospitalization including ICU:			
G. Illness Diagnosed as per claim forms:			
H. Date of Surgery (if done):			
I. Surgery as per claim forms:			

Part-B

(to be completed by the Investigating Official)

1. Mention the details in the of enquiry	Sl.No.	Name of Doctor/Hospital visited	Place of visit	Date of visit
2. (a) Are you satisfied with the identity of the Insured hospitalized and age? Pl. satisfy yourself that there is no overstatement or understatement of age. **(b)** Mention any critical information related to health & habits of the Insured gathered during the enquiries.				
3. Have you verified the Indoor case papers in a Hospital to ascertain the Pre Existing Disease (PED) /Surgery, before date of commencement Policy/Date of Revival? If PED is noticed, mention the nature of disease/surgery and its duration with supported documents.				
4. Whether any treatment, tests prior to date of commencement of Policy, Date of Revival are noticed? If yes mention the same with supported documents.				
5. If the Insured was employed, obtain the particulars of leave availed by him/her on sickness/medical grounds before date of commencement of Policy/Date of Revival from the employer and ascertain, if there is any scheme of reimbursement for medical expenses available for the employees.				
6 a). Was the Insured a member of any Health Insurance Scheme/ Med claim? If so, the particulars of benefits availed by him under the scheme should be obtained from the Insurers. **b)** Whether the insured is having health insurance with any other Insurer, if so give details? **c)**Whether claim is made from any other insurer. If so give details?				

7. Whether the ailment and surgery performed are confirmed by the usual medical attendant?	
8. Whether the surgery shown in the claim forms and hospital reports are actually performed in the hospital?	
9. Whether any misrepresentation in the hospital records Submitted, is noticed? If so give details (Details of the claim to be mentioned)	
10. Any other information that you desire to give and your conclusion on the result of investigation	

Date: **Signature of the Investigating Official**

Name:

Address:

Designation:

PERIODICAL STATEMENTS ON CLAIMSTO BE SUBMITTED BY THIRD PARTY ADMINISTRATORS					
Sl.No	**Statement Identity**	**Statement Details**	**Office**	**Period**	**Date to be submitted**
1	Annexure C-1	Claims Performance Review of TPA (Consolidated Divisions)	CO	Monthly	Before 5th working day after month under review
2	Annexure C-2	Claims Performance Review of TPA for the Division	DO	Monthly	Before 5th working day after month under review
3	Annexure C-3	Statement of Claims Intimated/Processed	CO	Monthly	Before 5th working day after month under review
4	Annexure C-4	Statement of Claims Intimated/Processed for the Division	DO	Monthly	Before 5th working day after month under review
5	Annexure C-5	Statement of Outstanding Claims for all Divisions	CO	Daily on Website	
6	Annexure C-6	Statement of Outstanding Claims for the Division	DO	Daily on Website	
7	Annexure C-7	Summary of Claims Intimated/Processed	CO	Monthly	Before 5th working day after month under review
8	Annexure C-8	Statement of Claim Master data files sent to CO	CO	Monthly	Before 5th working day after month under review
9	Annexure C-9	Details of the Claim Investigation by TPA on policies of all Divisions	CO	Monthly	Before 5th working day after month under review
10	Annexure C-10	Details of the Claim Investigation by TPA on policies for the Division	DO	Monthly	Before 5th working day after month under review
11	Annexure C-11	Statement of Claims admitted- data Required for Actuarial Purposes (Principal Insured)	CO	Quarterly	Before 5th working day after Quarter under review
12	Annexure C-12	Statement of Claims admitted-data required for Actuarial Purposes (Spouse Insured)	CO	Quarterly	Before 5th working day after Quarter under review
13	Annexure C-13	Statement of Claims admitted- data required for Actuarial Purposes (Child Insured)	CO	Quarterly	Before 5th working day after Quarter under review
14	Annexure C-14	Statement of High amount of Claims paid for the Diseases	CO	Quarterly	Before 5th working day after Quarter under review

15	Annexure C-15	Statement of Claims Analysis (All Claims)	CO	Quarterly	Before 5th working day after Quarter under review
16	Annexure C-16	Statement of Repeated Utilization of Benefits by the same Claimant	CO	Quarterly	Before 5th working day after Quarter under review
17	Annexure C-17	Statement of Distribution of Claims Paid Band wise	CO	Quarterly	Before 5th working day after Quarter under review
18	Annexure C-18	State wise Analysis of the Number of Claims and Average Claim Paid	CO	Quarterly	Before 5th working day after Quarter under review
19	Annexure C-19	Age wise / Gender wise Analysis of Claim Paid, Average Claim	CO	Quarterly	Before 5th working day after Quarter under review
20	Annexure C-20	Statement of Pending Claims with specific requirements & contact details	CO	Weekly	Before next working day after Week under review
21	Annexure C-21	Statement of pending claims for IRDA	CO	Quarterly	Before 5th working day after Quarter under review

PERIODICAL STATEMENTS FROM THIRD PARTY ADMINISTRATORS – Other Than CLAIMS				
All Statements are to prepared separately for each Region				
S. No.	Statement Identity (Annexure)	Statement Details	To be sent to Claims Department, Divisional Office & Respective Zonal Office	To be sent to Zonal Office & Central Office
1	A - 1	Statement of Grievances received and disposed and Action taken Report on Grievances received by the TPA for the month	Before 5th of the following month	
2	A - 2	Statement of Scanned Images received from the Divisions for the month	Before 5th of the following month	
3	A - 3	Statement of Call Center Analysis for the month	Before 5th of the following month	
4	B - 1	Summary of Division-wise Statement of Grievances received and disposed and Action taken Report on Grievances received by the TPA for the month		Before 5th of the following month
5	B - 2	Summary of Division-wise Statement of Scanned Images received from the Divisions for the month		Before 5th of the following month
6	B - 3	Summary of Division-wise Statement of Call Center Analysis for the month		Before 5th of the following month
7	B - 4	Statement of Division-wise Issue of TPA Booklet for the month		CO