Letterhead of Referring ESI Hospital (P-I)

Referral Form (Permission letter)

Referral No	:	Insurance No/Staff Card No/ Pensioner Card No	:
Name of the Patient	:		
Address/Contact No	:	Age/Sex	:
Identification marks (if any)	:		
IP/Beneficiary/Staff	:		
Relationship with IP/Staff	:	F/M/S/D/Other	
Entitled for Speciality/Super Sp tt	:	Yes/No	
Diagnosis/clinical opinion/case summary	:		
Relevant Treatment given/ Procedure/ Investigation done in referring hospital	:		
Treatment/Procedure/Investigation for which patient is being referred (mention specific diagnosis for referral)	:		

Photograph Of Patient (optional)

I voluntarily choose _____ Hospital for treatment of self or my _____

Sign/Thumb Impression of IP/Beneficiary/Staff

Referred to _____ Hospital/Diagnostic Centre for _____

Date:

Sign & Stamp of Authorized Signatory **

** **In case of emergency, signature of referring doctor or Casualty Medical Officer. Record to be maintained in the register. New form duly filled will be sent after signature of the competent authority on the next working day.**

Mandatory Instructions for Referral Hospital:

- Referral hospital is instructed to perform only the procedure/treatment for which the patient has been referred to.
- In case of additional procedure/treatment/investigation is essentially required in order to treat the patient for which he/she has been referred to, the permission for the same is essentially required from the referring hospital either through e-mail, fax or telephonically (to be confirmed in writing at the earliest).

Contd ..2/-

- The referred hospital is requested to raise the bill as per the agreement on the standard proforma along with supporting documents within 6 days of discharge of the patient giving account number and RTGS number etc.

Checklist(Referring Hospital)

1. *Duly filled & signed referral proforma.*
2. *Copy of Insurance Card/Photo I card of IP.*
3. *Referral recommendation of the specialist/concerned medical officer.*
4. *Copy of entitlement evidence of Specialty/super specialty treatment.*
5. *Reports of investigations and treatment already done.*
6. *Photograph, if available*

Date:

Signature of the Competent Authority **
(With Stamp)

To be used by Tie-up hospital (for raising the bill) (P-II)

Letterhead of Hospital with Address & Email/Fax/Telefax number

(NABH accredited/ Superspeciality Hospital)

(Attach documentary proof)

Date of Submission:

Individual Case Format

Photograph Of the Patient verified by hospital authority

Name of the Patient : Referral S.No.(Routine) / Emergency/ through

Age/Sex : SSMC/SMC :

Address :

Contact No :

Insurance Number/Staff Card No/Pensioner Card no. :

Date of referral :

Diagnosis :

Condition of the patient at discharge :

(For Package Rates)

Treatment/Procedure done/performed :

I. Existing in the package rate list's

CGHS/other Code no/nos for chargable procedures :

S.No.	Chargeable Procedure	CGHS Code no with page no (1)	Other if not on (1) prescribed code no with page no	Rate	Amt. Claimed with date	Amount Admitted with date (X)	Remarks (X)

Charges of Implant/device used …….

Amount Claimed…….. Amount Admitted Remarks

(To be filled up by ESIC official(s))

II. (Non-package Rates) For procedures done (not existing in the list of packages rates)

S.No.	Chargeable Procedure	Amt. Claimed with date	Amount Admitted with date (X)	Remarks (X)

III. Additional Procedure Done with rationale and documented permission

S.No.	Chargeable Procedure	CGHS Code no with page no (1)	Other if not on (1) prescribed code no with page no	Rate	Amt. Claimed with date	Amount Admitted with Date (X)	Remarks (X)

Total Amount Claimed(I+II+III) Rs. ……..

Total Amount Admitted (X) (I+II+III) Rs. ……

Remarks

Certified that the treatment/procedure has been done/performed as per laid down norms and the charges in the bill has/ have been claimed as per the terms & conditions laid down in the agreement signed with ESIC.

Further certified that the treatment/ procedure have been performed on cashless basis. No money has been received /demanded/ charged from the patient/ his/her relative.

Sign/Thumb impression of patient with date **Sign & Stamp of Authorized Signatory with date**

(for Official use of ESIC)

Total Amt payable:
Date of payment :

Signature of Dealing Assistant Signature of Superintendent

Date: **Signature of ESIC Competent Authority (MS/SMC/SSMC)**

1. *Discharge Slip containing treatment summary & detailed treatment record.*
2. *Bill(s) of Implant(s) / Stent(s) /device along with Pouch/packet/invoice etc.*
3. *Photocopies of referral proforma, Insurance Card/ Photo I card of IP/ Referral recommendation of medical officer & entitlement certificate. Approval letter from SMC/SSMC in case of emergency treatment or additional procedure performed.*
4. *Sign & Stamp of Authorized Signatory.*
5. *Patient/Attendant satisfaction certificate.*
6. *Document in favour of permission taken for additional procedure/treatment or investigation.*

(X) to be filled by ESIC Official(s).

To be used by Tie-up hospital (P-III)

Letterhead of Hospital with Address & Email/Fax/Telefax

Consolidated Bill Format

Bill No …… Date of Submission……..

Bill Details (Summary)

SNo	Name of patient	Ref. No	Diag./Procedure for which referred	Procedure Performed/ treatment given	CGHS/other Code (with page) No/Nos/N.A	Other if not in CGHS rates list	Amount claimed with date	Amount entitled with date	Remarks

Total Claim.

Certified that the treatment/procedure has been done/performed as per laid down norms and the charges in the bill has/ have been claimed as per the terms & conditions laid down in the agreement signed with ESIC.

Further certified that the treatment/ procedure have been performed on cashless basis. No money has been received /demanded/ charged from the patient/ his/her relative.

The amount may be credited to our account no _____ RTGS no _____ and intimate the same through email/fax/hard copy at the address.

Date:

Signature of the Competent Authority of Tie-up Hospital.

Checklist

1. *Duly filled up consolidated proforma.*
2. *Duly filled up Individual Pt Bill .proforma.*

Certificate: It is certified that the drugs used in the treatment are in the standard pharmacopeia IP/BP/USP.

It is certified that total amount of Rs _____ has been credited to your account no. _____, RTGS no _____ on _____

Date:

Signature of the Competent Authority.

(To be filled up by ESIC official(s))

Letterhead of Referring ESI Hospital (P-IV)

Sanction Memo/Disallowance Memo

Name of Referral Hospital (Tie-up Hospital)

Bill No …… **Date of Submission……..**

SNo/Bill No	Name of the Patient & Reference No.	Amount Claimed with date	Amount Sanctioned/ admitted with date	Reasons(s) for Disallowance	Remarks

Date:

Signature of Competent Authority
With Stamp

(To be filled up by ESIC official(s))

Letterhead of Tie-up Hospital with Address details(P- V)

Monthly Bill Special Investigations For diagnosis centres/referral Hospitals

Bill No …… **Date of Submission……..**

SNo	Name of the Patient & Insurance /Staff no	Date of Reference	Investigation Performed	CGHS/ other code no with page no	**Charges not in package rates list**	Amount Claimed with date	Amount Admitted (entitled) with date	Remarks Disallowances with reasons

Certified that the procedure/investigations have been done/performed as per laid down norms and the charges in the bill has/ have been claimed as per the terms & conditions laid down in the agreement signed with ESIC.

Further certified that the procedure/investigations have been performed on cashless basis. No money has been received /demanded/ charged from the patient / his/her relative.

The amount may be credited to our account no _____ RTGS no _____ and intimate the same through email/fax/hard copy at the address.

Date: **Signature of the Competent Authority of Tie-up Hospital**

Checklist

1. Investigation Report of each individual/Pt.
2. Copy of Referral Document of each individual/Pt.
3. Serialization of individual bills as per the Sr. No. in the bill.

It is certified that total amount of Rs _____ has been credited to your account no. _____, RTGS no _____ on _____

Signature of Account department with stamp.

Signature of Competent Authority
Date: Referral Hospital.

(To be filled up by ESIC official(s))

Patient Referral No _____

PATIENT/ATTENDANT SATISFACTION CERTIFICATE (P-VI)

1. **I am satisfied/ not satisfied with the treatment given to me/ my patient and with the behavior of the hospital staff.**

2. **If not satisfied, the reason(s) thereof.**

3. **It is stated that no money has been demanded/ charged from me/my relative during the stay at hospital.**

Sign/Thumb impression of patient/Attendant

Date & Time :

Name of the Patient/attendant
Name of IP
Insurance No/Staff no
Date of Admission
Date of Discharge