Letter on consent from Hospital (Non-Network) to extend cashless

LETTER OF CONSENT

Ref No: - **Date: -**

Hospital Name:
Hospital Address:

Sub: Letter of Consent for extending Cashless to the beneficiaries of "Insurance Company Name"

"**Insurance Company Name**" (hereinafter referred to as "the company ") has agreed to enter into a business arrangement with **"Provider Name"** for providing cashless to beneficiaries of "**Insurance Company Name"** Health Policy. This letter contemplates that both the company and **Provider agrees** to abide by the terms as mentioned below

1. The Hospital undertakes to provide the service in a precise, reliable and professional manner to the satisfaction of "Insurance Company Name" and in accordance with additional instructions issued by "**Insurance Company Name"**

2. The Hospital shall allow "**Insurance Company Name"** to conduct audits of their systems policies, process as and when deemed necessary by "Insurance Company Name". Such audits shall be conducted by "**Insurance Company Name**" audit team or any independent third party appointedby "Insurance Company Name" with prior intimation to the Hospital for all cases those directly relate to the services under this agreement

3. The Hospital shall allow "**Insurance Company Name**" to conduct audits of the bills as and when necessary, by deemed "**Insurance Company Name**". Such audits shall be conducted by "**Insurance Company Name** "audit team without prior intimation to the Hospital.

4. Hospital will submit all the documents within 15 days from the date of the discharge of the patient/Insured Beneficiary and **Insurance Company Name** will make payment of eligible bills within 30 days from the date of receipt of such submission. However, if required, Insurance Company Name "can call for further document related to treatment to process the case, in which case the payment may be delayed beyond 30 days as contemplated herein (Depending on the query response received from the Hospital)
5. The Hospital also hereby indemnify and keep <**Insurer name**> Indemnified for its breach of any representations and warranties, or for its not obtaining license or registration under local, state or National Laws, and also registered with such agency/authority as prescribed IRIDAI, from time to time, as may be applicable and also for the doctors who treat the Members in Hospital are not duly qualified holding required Degree/qualifications from the authority competent to issue such Degree/qualifications or for any inadequate or deficiency of services/Health Checkup services, or for breach of confidentiality or for acts, commissions and omissions of the Hospital, its employees, Doctors, Nurses or other staff/persons who are

involved in the process of providing the Cashless Medical Treatment or healthcare services to the Members/Beneficiaries or for acts, commissions and omissions of Hospital, its staff, employees, doctors, agents etc., or for breach of this Agreement, resulting in any claims, damages, actions, proceedings suits [including the advocate fees incurred by our company, if any etc.,] against <**Insurer** name>. For all these obligations and indemnities, the Hospital shall also be liable to the Members who suffer due to various aspects mentioned in this clause".

6. All payments shall be made through direct electronic fund transfer subject to deduction of tax at source as applicable under the relevant laws.

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

8. All the claim documents shall be dispatched at the following address of Insurance

   Company Address:

This letter is being entered into to confirm the understanding of principal terms and our willingness to provide Cashless services in mutual good faith.

Provider name" to provide the documents as listed below along with this Letter of Consent for the payment of case

a. Original cancelled cheque
b. Duly filled and signed EFT Mandate form
c. Contact detail sheet
d. EFT terms & condition sheet
e. Payee name confirmation letter
f. PAN card photo copy

In case you are agreeable to the foregoing terms, please sign this Letter of Consent.

For Insurance Company **For "Provider Name"**

Authorized Signatory
Name:
Designation:

Authorized Signatory
Name:
Designation: