Process Flow for State Bank of India Staff Association (Bengal Circle) GMP

CLAIMS MANAGEMENT OPERATING PROTOCOL OF THE RESIDUAL POLICY OF BANK GMP

MEMBER SUBMITS CLAIM TO THE BANK

BANK SANCTIONS THE INITIAL PART AS PER BIPARTITE SETTLEMENT/BANK LEVEL AND LODGES THE CLAIM WITH FHPL.

All claims can be collected by FHPL from SBI Regional Local HO/ZO/RBO or will be send directly to TPA office

IN CASE THE CLAIM IS COMPLETE IN NATURE AND TENABLE PROCESSING WILL BE DONE

CONTACT DETAILS AND ESCALATION MATRIX OF FHPL:

FAMILY HEALTH PLAN TPA LTD
16/2, LAKEVIEW ROAD,
KOLKATA 700029
PHONE: 033-65503901/02/03
FAX: 033-24659377

Intimation can be provided by email/phone/fax

TOLL FREE – 18004254033
FOR INTIMATION: intimation@fhpl.net
Website: www.fhpl.net
FAX: 033-24659377

Helpdesk:

Mr. Anindya Mondal
anindya.mondal@fhpl.net
09230101116
Weekly Visit: Tuesday and Friday – 3 to 6 pm
Other ZO – Fortnightly
Siliguri - Monthly

Escalation 1: Mr. Arnab Roy, Dy. Manager Email id: arnabray@fhpl.net ,Mb: 09231001008

Escalation 2: Dr. Medha Ghugre, A.G.M., Email Id: drmedha@fhpl.net **,** Mb: 09231001001

CLAIMS CHECKLIST					
PLEASE TICK	*SL.NO.*	*IN CASE OF HOSPITALISATION CLAIM*	PLEASE TICK	*SL.NO.*	*IN CASE OF PRE & POST HOSPITALISATION CLAIM*
	1	COMPLETELY FILLED CLAIM FORM		1	COMPLETELY FILLED CLAIM FORM
	2	PHOTO COPY OF THE TPA CARD AND PHOTO ID		2	PHOTO COPY OF THE TPA CARD AND PHOTO ID
	3	BANK ATTESTED/CERTIFIED COPIES OF ALL THE BILLS/RECEIPTS/MEDICAL DOCUMENTS/INVESTIGATION REPORTS/PRESCRIPTION.		3	ATTESTED PHOTO COPY OF THE DISCHARGE SUMMARY
	4	ATTESTED COPY OF CASE SUMMARY AND DEATH CERTIFICATE OF THE HOSPITAL (IN CASE OF DEATH)/ /IN CASE OF ROAD TRAFFIC ACCIDENT/BURNS/POISIONING/OTHER ACCIDENTS-FIR COPY (MLC) AND TREATING DOCTORS CERTIFICATE STATING CAUSE OF INJURY		4	BANK ATTESTED/CERTIFIED COPIES OF BILLS/RECEIPTS/PRESCRIPTIONS/REPORTS etc.
MANDATORY: CANCELLED CHEQUE WITH IFSC CODE AND BANK ACCOUNT NO. FOR NEFT TRANSACTION HAS TO BE SUBMITTED					

INTIMATION FORMAT											
SL.No	**Date**	**UHID Card No. of Patient**	**Name of the patient**	**Relationship**	**Emp. Name**	**PF No**	**Designation**	**Mobile No**	**Hospital Name**	**Location & Address**	**Date of Admission**
1											

नेशनल इन्श्योरेन्स कम्पनी लिमिटेड
(भारत सरकार का एक उपक्रम)
'National Insurance Company Limited'
(A Govt. Of India undertaking)

FAMILY HEALTH PLAN (TPA)LIMITED

CLAIM FORM

To be filled by the Insured. UHID.NO._____

Policy No : _____

Name of the Proposer : **State Bank of India Staff Association (Bengal Circle)**

Name of the Employee : _____PF Index No_____

Name of the Patient : _____Relationship_____

Nature of Illness : _____

Treatment : _____

Confinement in Hospital : From _____ To _____

Name of the Hospital : _____

SCHEDULE OF EXPENSES INCURRED BY THE CLAIMANT:

Details of Expenses Claimed	Eligible Limited	Claimed Amount	Settled Amount	Not allowed Amount
Room Rent @ x days (Incl. Nursing Charges) Consultation Charges a) Surgeon Fees b) Anes. Fees c) Cons. Doctor Fees d) Asst Doctor Fee e) Medicines Supplied by Hospital f) Medicines from Shop g) Investigations h) Operation Theatre Charges, Blood, Oxygen. OT Com j) Others				
Total Rs.				

P.T.O

Date: _____

Contact Details: _____

Place: _____

NEFT Details (Cancelled Cheque is Mandatory):

Name of the Bank :	
Beneficiary Name :	
Address of Bank :	
City :	
State :	
Country :	
Account Number :	
IFSC Code :	

SIGNATURE OF THE INSURED