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[Cashless vs Reimbursement Hospital Claim: On health insurance, here is all you need to know](#)

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Owing to the rising medicare costs in recent years, the gap between healthcare costs and its affordability has also proportionately increased. An adequate health insurance cover is hence becoming crucial for bridging this gap. Due to significant rise in lifestyle diseases, health insurance is now seeing a gradual uptake among customers. However, many still remain unaware about availing insurance benefits during a claim scenario. This last-minute hustle can easily be resolved if you are well versed with the process and methods of filing health insurance claims.

There are two facilities that one can opt for while filing for health insurance claims, i.e. the cashless mode and the reimbursement mode.

Cashless Claims

Usually the cashless claims facility is used when medical treatment takes place in one of the network hospitals of your insurer. With this facility, the insured is not required to shell out any sum for the treatment except for the non-medical items. This is a direct mode of claims settlement where the insurance company settles the payment directly with the hospital depending on the insurance policy terms and conditions and the sum insured that the customer has opted for. One can avail the benefits of cashless claim facility for both planned and unplanned kind of medical treatments.

In order to avail the cashless claims benefit, a customer needs to follow below mentioned procedure:

1. In case the hospital admission is planned, a customer needs to take a pre-authorization from the insurer, which includes sharing treatment and its corresponding expense details with the insurance company through the hospital. Generally, this approval should be taken 4 – 7 days prior to the treatment, however, it may vary from insurer to insurer.

2. Once you connect with your insurance company, they will inform you about the documents that may be required. Post sharing these documents and medical details with the insurer, it evaluates the treatment details as per policy terms and conditions and informs the concerned hospital and insured.

3. The customer needs to produce following documents at the network hospital in addition to the documents that are specified by the insurer:

a) Pre-Authorization Letter

b) ID card issued by the insurance company

c) Health Insurance Policy

d) Aadhaar Card, Pan card / Form 60

4. Once the treatment is done and the customer has availed the cashless facility, the original bills and treatment evidence should be left with the hospital. The hospital shares these bills with your insurance company and accordingly payment is processed by the insurer to the hospital.

5. In case of any unplanned or emergency medical treatment, the policy holder can simply contact the insurer through its customer care center or chatbot facilities to know about the empanelled hospitals. Once at the hospital, the customer can request for cashless hospitalization by producing the insurance card provided by the insurers along with the policy copy.

6. Once the customer makes this request, hospital connects with the insurance company by filing the pre-authorized request form and consequently the insurer issues an authorization letter to the hospital and also shares details pertaining to the policy coverage of the customer.

7. Once the treatment is over, the insurer will then settle the payment of admissible claims.

Reimbursement Health Insurance Claims:

Another process that one can opt for settling a health insurance claim is the reimbursement mode. This situation mostly arises when a patient chooses the hospital as per his choice and convenience and the hospital is not empanelled with the insurer. In such scenarios, a policy holder has to make the payment for all the medical bills that are related to the said treatment and later on files the claim for reimbursement.

The reimbursement procedure is usually as follows:

1. The insurance company evaluates the documents and maps it against the policy coverage.
2. The customer is required to provide necessary documents along with the original medical bills to the insurer at the time of claim filing. These documents typically include a claim form, bank details, ID Cards, hospital discharge summary, investigation and diagnosis reports and bills, original hospital and pharmacy bills along with paid receipts and prescriptions. Additionally, in case of an accidental hospitalization, a copy of FIR also needs to be shared with the insurer.
3. Post the evaluation, the insurance company makes the payment to the beneficiary as per policy terms.
4. On non receipt of certain mandatory documents, the insurer can ask for these additional documents to take a decision on the claim.
5. In case of claim repudiation, the insurer provides the grounds on which the claim is non payable.

Health insurance is a stitch in time. However, to ensure that it is a backstitch, it is highly advised to be aware of what your policy offers at the time of purchase itself. A detailed understanding of what's covered and what's not helps you to avoid any last-minute ordeal.

(By Bhaskar Nerurkar, Head-Health Administration Team, Bajaj Allianz General Insurance)