

AYUSHMAN BHARAT - AROGYA KARNATAKA

Beneficiaries Declaration Form (Eligible patient)

1. This is to certify that we collected Rs. _____ (Rs. In words _____) towards Investigation charges from patient _____ (Name of patient) holding Ayushman Bharat-Arogya Karnataka Card (Eligible Patient-AB-ArK ID/Ration Card) Number _____. The amount of Rs. _____ (Rs. _____ in words) has been refunded to beneficiary through cash/cheque/DD the preauthorization is _____ (Preauth Number) has been approved to us.
2. This is also to certify that Rs. _____ (Rs. In words _____) has been paid to beneficiary towards travelling charges.

Signature/Thumb impression of
patient

Signature of Arogyamitra

Signature of SAMCO

**Ayushman Bharat-Arogya Karnataka (Eligible patient) Preauthorisation-Request
for cashless hospitalisation**

Date of Request:

Hospital name and city:		
District:	Date of referral:	Date of reporting to NWH:
If patient has already availed the treatment under Arogya Karnataka , furnish pre-auth/treatment details:		

Eligible patient card Details

AB-ArKID/Ration Card No.	Card issue date:
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Family Head Details:

First name:	Middle name:	Last name:
Gender (M/F):	Age:	Marital Status:
Caste: SC / ST / Minority / Others		
Address:	Village:	Taluk:
	Pin code:	Contact no:
District:		

Whether patient is covered under any other govt. schemes? If yes furnish the name of the scheme and ID card No. without fail: _____

Patient Details to be filled by network hospital Arogyamithra

First name:	Middle name:	Last name:
Gender (M/F)	Age:	DOB:
Relationship (with FH):		Marital status:
Source of registration:		

To be filled by SAMCO

Treating doctor name:	Doctor registration No:
Doctor qualification:	Specialty:
Mobile no:	
Past history of the patient:	
Present complaints:	
Final diagnosis:	
Disease main category:	Disease sub Category:
Surgery code:	
Plan of treatment:	
High risk consent remarks	
Complications description:	
Counselling doctor remarks:	
DOA:	Probable DOS:
Probable DOD:	Elective <input type="checkbox"/> Emergency <input type="checkbox"/>

Details of Diagnostics Protocol Followed:

Total Amount collected for investigation:
Special investigation (with reports) :
Routine investigation (with reports):

Clinical Data

Pulse	Temperature	CVS
BP	Respiratory	CNS

Estimated days of hospitalization

Expected no. of days hospital Stay :	Room type: general
Duration in ICU	Duration in room:
Estimated cost of surgery / Procedure:	

AM name and signature	Treating doctor Signature hospital Seal:	SAMCO name and Signature:	Patient /Family Head Signature / LTI
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ಆಯುಷ್ಮಾನ್ ಭಾರತ್ - ಆರೋಗ್ಯ ಕರ್ನಾಟಕ (ಅರ್ಹತಾ ರೋಗಿ)
ಅನಿಸಿಕೆ / ಪ್ರಯಾಣ ಭತ್ಯೆ / ಉಚಿತ ಆಹಾರ ಪಡೆದಿರುವ ಬಗ್ಗೆ ದೃಢೀಕರಣ ಪತ್ರ

ಶ್ರೀ/ಶ್ರೀಮತಿ/ಕುಮಾರ/ಕುಮಾರಿ.....ಗ್ರಾಮ

ತಾಲ್ಲೂಕು ಜಿಲ್ಲೆಯ.....

..... ನಿವಾಸಿಯಾಗಿದ್ದು, ನಾನು ಆಯುಷ್ಮಾನ್ ಭಾರತ್ ಆರೋಗ್ಯ ಕರ್ನಾಟಕ ಕಾರ್ಡ್

(AB-ArKID/ ಪಡಿತರ ಚೀಟಿ) ಸಂಖ್ಯೆಹೊಂದಿದ್ದು

..... ಆಸ್ಪತ್ರೆಯಿಂದ

ಆಯುಷ್ಮಾನ್ ಭಾರತ್ - ಆರೋಗ್ಯ ಕರ್ನಾಟಕ ಯೋಜನೆಯಡಿಯಲ್ಲಿ ಉಚಿತ ಚಿಕಿತ್ಸೆ ಪಡೆದು ದಿನಾಂಕ: ರಂದು

ಬಿಡುಗಡೆಯಾಗಿರುತ್ತೇನೆ.

1. ಪ್ರಯಾಣ ಭತ್ಯೆ ರೂ. _____ ಪಡೆದಿರುತ್ತೇನೆ / ಪಡೆದಿರುವುದಿಲ್ಲ.

2. ಆಸ್ಪತ್ರೆಯವರು ಉಚಿತ ಆಹಾರ ಒದಗಿಸಿರುತ್ತಾರೆ / ಒದಗಿಸಿರುವುದಿಲ್ಲ

3. ಆಸ್ಪತ್ರೆಯಿಂದ ಚಿಕಿತ್ಸೆ ಪಡೆದ ಬಗ್ಗೆ ನನ್ನ ಅನಿಸಿಕೆ ಈ ಕೆಳಗಿನಂತೆ ಇರುತ್ತದೆ.

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ದಿನಾಂಕ: ಫಲಾನುಭವಿಯ ಸಹಿ

ಆಯುಷ್ಮಾನ್ ಭಾರತ್ ಆರೋಗ್ಯ ಕರ್ನಾಟಕ
ಸುವರ್ಣ ಆರೋಗ್ಯ ಸುರಕ್ಷಾ ಟ್ರಸ್ಟ್‌ನ ವೈದ್ಯಕೀಯ
ಸಮನ್ವಯಾಧಿಕಾರಿಗಳ (SAMCO) ಸಹಿ ಮತ್ತು ಮುದ್ರೆ.

ಫೋನ್ ನಂ. ಆರೋಗ್ಯಮಿತ್ರನ/ಳ ಹೆಸರು ಮತ್ತು ಸಹಿ:

ದೂರವಾಣಿ ನಂ:

ಫಲಾನುಭವಿಯ ಪೂರ್ಣ ವಿಳಾಸ:

ಟಿಪ್ಪಣಿ: ಫಲಾನುಭವಿಯು ಅಪ್ರಾಪ್ತ ವಯಸ್ಸಿನಾಗಿದ್ದಲ್ಲಿ ಕುಟುಂಬದ ಪ್ರಧಾನ ಸದಸ್ಯರು ದೃಢೀಕರಿಸಬೇಕು.

AYUSHMAN BHARAT - AROGYA KARNATAKA PROCEDURE CLAIM FORM AND FEED BACK FORM

Hospital name :.....
Patient Name :.....
AB-ArKID/Ration card no. :.....
DOA:..... DOS:..... DOD:.....
Preauth issue date:..... Preauth no:.....
Preauth amount:..... Claimed amount:.....
Bill no:..... Bill date:..... Bill amount:.....

TREATMENT DETAILS

Procedure code approved:..... Procedure code done:.....
Name of the procedure:.....
Treating doctor name:..... Mobile no:.....
Diagnosis:.....

FEEDBACK AND REFUND

Shri/smt/Kum.....From:.....

Taluk:..... District:.....

having AB-ArKID/Ration card:..... having treated under

Ayushman Bharath - Arogya Karnataka Scheme was discharged on

1. Amount collected for Pre-operative investigation Rs.....
2. Amount refunded at the time of discharge Rs:.....
3. Travelling allowance Rs.....
4. Free food given: Yes No
5. Feedback from the patient.....

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Signature of the patient with mobile no.	Signature of the SAMCO with phone no.	Signature of the AM with phone no.
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AYUSHMAN BHARAT - AROGYA KARNATAKA

Beneficiaries Declaration Form (General patient)

3. This is to certify that we collected Rs. _____ (Rs. In words _____) towards Investigation charges from patient _____ (Name of patient) holding Ayushman Bharath - Arogya Karnataka Card (General patient-AB-ArKID/Ration Card) Number _____. The amount of Rs. _____ (Rs. _____ in words) has been refunded to beneficiary through cash/cheque/DD who's the preauthorization is _____ (Preauth Number) has been approved to us.
4. This is also to certify that Rs. _____ (Rs. In words _____) has been paid to beneficiary towards travelling charges.

Signature/Thumb Impression of
Patient

Signature of Arogyamitra

Signature of SAMCO

Ayushman Bharat - Arogya Karnataka (General patient) Preauthorisation-Request form

Date of Request:

Hospital name :		City:	District:
APL card no:		AB-ArKID no:	
If patient has already availed the treatment under Arogya Karnataka , furnish pre-auth/treatment details:			
Card no:		Card issue date:	

Family Head Details:

First name:		Middle name:	Last name:	
Gender (M/F):	Age:	Marital Status:	Caste: SC / ST / Minority / Others	
Address:	Village:		Taluk:	District:
	Pin code:		Contact no:	

Patient Details to be filled by network hospital Arogyamithra

First name:		Middle name:	Last name:	
Gender (M/F)	Age:	DOB:	Marital status:	
Relationship (with FH):			Source of registration:	

To be filled by SAMCO

Treating doctor name:		Doctor registration No:		
Doctor qualification:		Specialty:	Mobile no:	
Past history of the patient:				
Present complaints:				
Final diagnosis:				
Disease main category:		Disease sub Category:	Surgery code:	
Plan of treatment:				
High risk consent remarks				
Complications description:				
Counselling doctor remarks:				
DOA:	Probable DOS:	Probable DOD:	Elective <input type="checkbox"/> Emergency <input type="checkbox"/>	

Details of Diagnostics Protocol Followed:

Total amount collected for investigation:	
Special investigation (with reports) :	
Routine investigation (with reports):	

Clinical Data

Pulse		Temperature		CVS	
BP		Respiratory		CNS	

Estimated days of hospitalization

Expected no. of days hospital stay :	Room type: general
Duration in ICU	Duration in room:
Estimated cost of surgery / Procedure:	

Package rate info

General ward rate:	AK share amount:	Beneficiary share amount:	
AM name and signature	Treating doctor signature hospital Seal:	SAMCO name and signature:	Patient /Family head signature / LTI

Ayushman Bharat - Arogya Karnataka (General patient) Claim request form

Date of Request:

Hospital Name :	City:	District:
APL card no:	AB-ArKID no:	
If patient has already availed the treatment under Arogya Karnataka , furnish pre-auth/treatment details:		
Preauth no:	Preauth approved amount:	

Patient Details to be filled by network hospital Arogyamithra

First name:		Middle name:	Last name:
Gender (M/F):	Age:	DOB:	Marital status:
Relationship (with FH):		Source of registration:	

To be filled by SAMCO

Treating doctor name:		Doctor phone no:	
Investigation :			
Diagnosis:			
Broad speciality :			
Procedure name :		Procedure code:	
Disease main category:		Disease sub Category:	Surgery code:
Plan of treatment:			
High risk consent remarks			
Complications description:			
Counselling doctor remarks:			
DOA:	Probable DOS:	Duration of Stay:	DOD:

Details of Diagnostics Protocol Followed:

Total amount collected for investigation:			
Special investigation (with reports) :			
Routine investigation (with reports):			
Billing info			
	Amount approved	AK share amount	Beneficiary share amount
Preauth			
Claim			
AM name and signature	Treating doctor signature hospital Seal:	SAMCO name and signature:	Patient /Family head signature / LTI

ಆಯುಷ್ಮಾನ್ ಭಾರತ್ - ಆರೋಗ್ಯ ಕರ್ನಾಟಕ (ಸಾಮಾನ್ಯ ರೋಗಿ)
ಫಲಾನುಭವಿಯ ಅನಿಸಿಕೆ ಪತ್ರ

ಶ್ರೀ/ಶ್ರೀಮತಿ ರವರ ಮಗ/ಮಗಳ/ಹೆಂಡತಿಯಾದ
..... ಗ್ರಾಮ ತಾಲ್ಲೂಕು
..... ಜಿಲ್ಲೆಯ ನಿವಾಸಿಯಾಗಿರುವ ನಾನು
ಆಯುಷ್ಮಾನ್ ಭಾರತ್-ಆರೋಗ್ಯ ಕರ್ನಾಟಕ (ಸಾಮಾನ್ಯ ರೋಗಿ)/ಪಡಿತರ ಚೀಟಿ ಕಾರ್ಡ್‌ಸಂಖ್ಯೆ
ಹೊಂದಿದ್ದು ಆಸ್ಪತ್ರೆಯಿಂದ ಆಯುಷ್ಮಾನ್ ಭಾರತ್ -
ಆರೋಗ್ಯ ಕರ್ನಾಟಕ-(General patient) ಯೋಜನೆಯಡಿಯಲ್ಲಿ ಚಿಕಿತ್ಸೆ ಪಡೆದು ದಿನಾಂಕ ರಂದು
ಬಿಡುಗಡೆಯಾಗಿರುತ್ತೇನೆ.

1. ನನ್ನ ಕಡೆಯಿಂದ ಆಸ್ಪತ್ರೆಯವರು ಸಹಪಾವತಿ ಮೊತ್ತವಾದ ಅನ್ನು ಪಡೆದಿರುತ್ತಾರೆ ಮತ್ತು ಅವರು
ಅದಕ್ಕೆ ರಸೀದಿಯನ್ನು ಕೊಟ್ಟಿರುತ್ತಾರೆ.

2. ಆಸ್ಪತ್ರೆಯವರು ಚಿಕಿತ್ಸೆ ಪಡೆದ ಬಗ್ಗೆ ನನ್ನ ಅನಿಸಿಕೆ ಈ ಕೆಳಗಿನಂತೆ ಇರುತ್ತದೆ_

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ದಿನಾಂಕ:

ಫಲಾನುಭವಿಯ ಸಹಿ

<p>ಆಯುಷ್ಮಾನ್ ಭಾರತ್ - ಆರೋಗ್ಯ ಕರ್ನಾಟಕ ಯೋಜನೆಯ ವೈದ್ಯಕೀಯ ಸಮನ್ವಯಾಧಿಕಾರಿಗಳ (SAMCO) ಸಹಿ ಮತ್ತು ಮುದ್ರೆ</p>	<p>ಆರೋಗ್ಯಮಿತ್ರನ/ಳ ಹೆಸರು ಮತ್ತು ಸಹಿ</p>
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ಫಲಾನುಭವಿಯ ಪೂರ್ಣ ವಿಳಾಸ:

.....
.....

ದೂರವಾಣಿ ಸಂಖ್ಯೆ:.....

ಸೂಚನೆ: ಫಲಾನುಭವಿಯು ಅಪ್ರಾಪ್ತ ವಯಸ್ಸಿನಾಗಿದ್ದಲ್ಲಿ ಕುಟುಂಬದ ಪ್ರಧಾನ ಸದಸ್ಯರು ದೃಢೀಕರಿಸಬೇಕು

Ayushman Bharat - Arogya Karnataka

Referral to tie-up hospital

(Ayushman Bharat - Arogya Karnataka- pre-auth to be uploaded by the primary hospital only)

Primary hospital details	
Hospital Name & Place	
Available facilities & MoU signed for oncology	Surgery <input type="checkbox"/> RT <input type="checkbox"/> CT <input type="checkbox"/>
Name of treating doctor	
Patient details& Treatment provided	
Patient name	
Diagnosis	
Surgery details	
RT details	
CT details	
Pre-auth details	
Further treatment required	

Herewith referring the patient to the tie up _____ hospital.

Surgery RT CT

Specify details :

Kindly provide the required treatment for our patient.

Date :

Signature of the treating doctor

hospital seal

NOTE : This form should be uploaded at the time of Pre-auth and Claims also

SUVARNA AROGYA SURAKSHA TRUST

Hospital / Arogyamithra Daily patient Visit Chart

Hospital Name Location			
Arogyamitra/Hospital Representative Name		Pre-auth No.	
Date of Admission :	Date of Surgery :	Date of Discharge :	

Date of Visit	Visit Time	Food Provided	Any Complaints

To be filled During Discharge from Hospital

1. Free Food Provided during hospitalization (Yes/No) : _____
2. Rs. _____ was collected towards investigation charges and Rs. _____ amount refunded to patient.
3. Travel Allowance provided (Yes/No) : _____
4. Discharge Medicines provided(Yes/No) : _____
5. In case of death, ambulance facility provided (yes/No) : _____
6. Any Complaints / feedback:-

Signature of

Arogyamitra/ Hospital Representative

Patient/ Attender

SAMCO



PROFORMA FOR SURGICAL AND OTHER PROCEDURE CASES

Patient Name :	Name of the hospital:
Date of Approval of preauth	
Package code/s approved	
Amount approval	
Date of surgery/ Procedure performed	
O T note enclosed (Yes/No)	
Discharge summary (Yes/No)	
Post of investigations Yes/No (As per code book)	
Clinical photo showing scar/photo as requirement	
Amount claimed	
Remarks	

Name & Signature of claims executive
With contact number

Signature of the consultant