## AYUSHMAN BHARAT - AROGYA KARNATAKA

## **Beneficiaries Declaration Form (Eligible patient)**

This is to certify that v	we collected Rs.	(Rs. In words
		) towards Investigation
charges from patient		(Name of patient) holding
Ayushman Bharat-Arogya K	Karnataka Card (Eligible Patie	nt-AB-ArK ID/Ration Card
Number	The amount of Rs.	
(Rs	in wo	rds) has been refunded to
beneficiary through	cash/cheque/DD the	preauthorization is
	(Preauth Number) has been a	pproved to us.
This is also to certify that Rs	·	(Rs. In words
	) has been	paid to beneficiary towards
travelling charges.		
gnature/Thumb impression of patient	Signature of Arogyamitra	Signature of SAMCO

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

**Date of Request:** 

							Date 0	i Kequest:	
Hospital name and cit	ty:								
District:		Date	e of referra	al:		Date of	reportin	ng to NWH:	
If patient has already	availed the	treatme	nt under A	rogy	ya Karnat	aka, fur	nish pre-	-auth/treatm	ent details:
1 D 1 2220 (2 )	127	]	Eligible p	atien	t card Det			•	
AB-ArKID/Ration Ca	ard No.				15		rd issue	date:	
Einst manne.			Family Middle		ad Details:				
First name: Gender (M/F):	Age:	М	arital Stat		ne:		ast name		ority / Others
Address:	Age.	Villag		us.	Taluk:	Casic.		District:	only / Others
Tradross.		Pin co			Contact	10.			
L	red under a			emes			name o	f the scheme	e and ID card No
vithout fail:	ou unuoi ui		80 / 6. 5011		. 11 yes 141			i uno somonio	
	Patient D	etails to	be filled	by no	etwork ho	spital A	rogyam	ithra	
First name:			Middle					t name:	
Gender (M/F)	Age:	DOB:	L	M	arital statu	s:			
Relationship (with FI	H):	I		So	ource of re	gistratio	n:		
			To be fi	lled l	by SAMC	0			
Treating doctor name	:						ration N	o:	
Doctor qualification:			Spec	ialty:			Mobil	e no:	
Past history of the pat	tient:								
Present complaints:									
Final diagnosis:			1				1		
Disease main categor	y:		Di	sease	sub Categ	ory:		Surgery code	e:
Plan of treatment:	1								
High risk consent ren Complications descri									
Compleations descriptions Counselling doctor re									
DOA:		le DOS:		Prol	oable DOD	):		Elective	Emergency
					s Protocol		-d·		
Total Amount collect	ed for inves			USLICE	S I TOLOCOI	TOHOW	u.		
Special investigation									
1	` .								
Routine investigation (with reports):  Clinical Data									
Pulse		-	Temperatu		ı Data	CV	2		
BP			Respirator			CN	5		
Evenosted as -£ 1-	hoomital Cr				f hospitali				
Expected no. of days	nospital Sta	ay:			n type: ger				
Duration in ICU	many / Due : -	duma:		Dura	tion in roo	m:			
Estimated cost of surg			ootor		SAMCO	nome	ıd T	Dotiont /	Family Used
AM name and signatu		eating d Signatu ospital S	ire		SAMCO		iu		Family Head hture / LTI

# ಆಯುಷ್ಮಾನ್ ಭಾರತ್ – ಆರೋಗ್ಯ ಕರ್ನಾಟಕ (ಅರ್ಹತಾ ರೋಗಿ) ಅನಿಸಿಕೆ /ಪ್ರಯಾಣ ಭತ್ಯೆ / ಉಚಿತ ಆಹಾರ ಪಡೆದಿರುವ ಬಗ್ಗೆ ಧೃಢೀಕರಣ ಪತ್ರ

ಶ್ರೀ/ಶ್ರೀಮತಿ/ಕುಮಾರ/ಕುಷ	ರಾರಿ			ಗ್ರಾಮ					
ತಾಲ್ಲೂಕು				ස්	ಲ್ಲೆಯ				
		ನಿವಾಸಿಯ	ಾಗಿದ್ದು,	ನಾನು	ಆಯುಷ್ಮಾನ್	ಭಾರತ್	ಆರೋಗ್ಯ	ಕರ್ನಾಟಕ	ಕಾರ್ಡ್
(AB-ArKID/	ಪಡಿತರ	ಚೀಟ)	ಸಂಖ್ಯೆ					ಹೆ	ೂಂದಿದ್ದು
							••••••	ಆಸ್ಪ	ತ್ರೆಯಿಂದ
ಆಯುಷ್ಮಾನ್ ಭಾರತ್	– ಆರೋಗ್ಯ ಕನಾ	೯ಟಕ ಯೋಜನೆಯ	ಡಿಯಲ್ಲಿ ಅ	೧೦ಚಿತ ೭	ಕಿ <del>ಕಿ</del> ತ್ಸೆ ಪಡೆದು ದಿ	ುನಾಂಕ:			ರಂದು
ಬಿಡುಗಡೆಯಾಗಿರುತ್ತೇನೆ.									
1. ಪ್ರಯಾಣ ಭತ್ಯೆ ರೂ		ಪಡೆದಿರುತ್ತೇನೆ / ಕ	ಪಡೆದಿರು	ಶ್ರದಿಲ್ಲ.					
2. ಆಸ್ಪತ್ರೆಯವರು ಉಚಿತ	ಆಹಾರ ಒದಗಿಸಿಂ	ಯತ್ತಾರೆ / ಒದಗಿಸಿರ	ುವುದಿಲ್ಲ						
3. ಆಸ್ಪತ್ರೆಯಿಂದ ಚ	3ಕಿತ್ಸೆ ಪಡೆದ	ಬಗ್ಗೆ ನನ್ನ	ಅನಿಸಿಕೆ	ಈ	ಕೆಳಗಿನಂತೆ	ಇರುತ್ತದ	3		
				••••••					•••••••
							•••••		
ದಿನಾಂಕ:	ब	ಸಲಾನುಭವಿಯ ಸಹ <u>ಿ</u>			,	ອ		್ಯ ಕರ್ನಾಟಕ	
						-		್ಟ್ ನ ವೈದ್ಯಕಿ ಎಂ. ಎ.ಎ.	
					ಸಮನ್ವಯಾಧಿ	ಕಾ <b>೦</b> ೧೪ (3	AIVICO	ര്ക്ക് ബള്യ	ු කාದු.
ಘೋನ್ ನಂ. ಆರೋಗ್ಯವಿ	ುತ್ರನ/ಳ ಹೆಸರು <u> </u>	ಮತ್ತು ಸಹಿ:							
ದೂರವಾಣಿ ನಂ:									
ಫಲಾನುಭವಿಯ ಪೂರ್ಣ	ವಿಳಾಸ:								

ಟಿಪ್ಪಣಿ: ಫಲಾನುಭವಿಯು ಅಪ್ರಾಪ್ತ ವಯಸ್ಥನಾಗಿದ್ದಲ್ಲಿ 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:	Pro	eauth no:	
Preauth amount:		Claimed amount:	
Bill no:	Bill date:	Bill amount:	
	TREAT	MENT DETAILS	
Procedure code approved:	Procedu	ure code done:	
Name of the procedure:			
Treating doctor name:		Mobile no:	
Diagonsis:			
	FEEDBA	CK AND REFUND	
i/smt/Kum		From	
uk:		District:	
ing AB-ArKID/Ration card:			having treated under
shman Bharath - Arogya Kar	nataka Scheme was d	ischarged on	
Amount collected f	or Pre-operative inve	stigation Rs	
	•		
<ol><li>Travelling allowand</li></ol>	e Rs		
4. Free food given: Ye	s No		
5. Feedback from the	patient		
nature of the patient with bile no.	Signature of the S	AMCO with phone no.	Signature of the AM with phone no.

## AYUSHMAN BHARAT - AROGYA KARNATAKA

#### **Beneficiaries Declaration Form (General patient)**

3. This is to certify t	hat we collected Rs	(Rs. In words
		) towards Investigation
charges from patient		(Name of patient) holding
Ayushman Bharath - A	Arogya Karnataka Card (Gene	eral 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	s been approved to us.
4. This is also to certify the	nat Rs.	(Rs. In words
	) has	s been paid to beneficiary towards
travelling charges.		
Signature/Thumb Impression of Patient	f Signature of Arogyami	itra Signature of SAMCO

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

**Date of Request:** 

Hospital name:			(	City:			D	istrict	:		
APL card no: AB-ArKID no:											
If patient has already	ava	ailed the t	reatmer	nt under	Aro	gya Karnat	aka,	, furni	ish pre	-auth/treatm	nent details:
Card no:			Card	issue dat	te:						
Caru no.			Caru			ead Details	•				
First name:				Midd	_		•	Las	t name	2:	
Gender (M/F):		Age:	Ma	arital Sta		*****	Cas				ority / Others
Address:		Village:				Taluk:			]	District:	
		Pin code	:			Contact no	):		Į.		
	Pa	tient Det	tails to	be filled	l by	network ho	spita	al Arc	ogyam	ithra	
First name:				Middl	e nai	me:			Las	t name:	
Gender (M/F)	Age	÷:	DOB:	l	]	Marital statu	ıs:				
Relationship (with F	H):				;	Source of re	gistr	ation:			
				To be	filled	l by SAMC	O				
Treating doctor nam	e:			D	octo	r registratio	n No	:			
Doctor qualification				$S_{1}$	pecia	alty:			M	obile no:	
Past history of the pa	<u>atien</u>	<u>:t:</u>									
Present complaints:											
Final diagnosis:				15	. •	1.0				<u> </u>	
Disease main catego	ry:			D	oseas	se sub Categ	gory:			Surgery cod	<u>e:</u>
Plan of treatment: High risk consent re	morl	7.0									
Complications descr											
Counselling doctor r	_										
DOA:		Probable	DOS:		Pr	obable DOI	):			Elective	Emergency □
			)etails	of Diag	 nosti	ics Protocol	Foll	lowed	l <u>:</u>		
Total amount collect	ed f			01 2148			1011				
Special investigation											
Routine investigation	n (w	ith report	s):								
				C	linio	cal Data					
Pulse			Т	emperat	ure			CVS			
BP				Respirato				CNS			
			Esti	imated o	days	of hospital	izati	on			
Expected no. of days	s hos	pital stay	<i>'</i> :		Ro	om type: ge	neral	l			
Duration in ICU					Du	ration in roo	om:				
Estimated cost of sur	rgery	y / Proced	lure:		•						
				Pac	kag	e rate info					
General ward rate:			AK sh	nare amo	ount:			Benef	iciary	share amou	nt:
AM name and signa	ture	S	ating dosignatur	e		SAMCO sign	nam ature				/Family head ature / LTI
ì		1			1				J		

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

				e of Request:
(	City:	Dist	rict:	
		AB-ArKID no:		
vailed the treatment	t under A	Arogya Karnataka, fu	rnish p	re-auth/treatment details:
		Preauth approved am	nount:	
atient Details to b	e filled	by network hospital A	Arogya	mithra
	Middle	name:	L	ast name:
Age:	DOB:		Ma	rital status:
:		Source of registration	on:	
	To be fi	lled by SAMCO		
	Do	ector phone no:		
			Proce	edure code:
	Di	sease sub Category:	Su	rgery code:
	<u> </u>		I.	
rks				
ion:				
arks:				
Probable DOS:		Duration of Stay:		DOD:
Details o	f Diagn	ostics Protocol Follow	ved:	•
or investigation:				
h reports):				
th reports):				
Amount appro	ved	AK share amount		Beneficiary share amount
signature		SAMCO name and signature:	1	Patient /Family head signature / LTI
	rks fon: arks: Probable DOS: Details of rinvestigation: th reports): Treating doctor signature	Patient Details to be filled    Middle     Age:   DOB:     To be fi     Do     District     Dist	AB-ArKID no:  railed the treatment under Arogya Karnataka, fur  Preauth approved am  Age: DOB:  Source of registration  To be filled by SAMCO  Doctor phone no:  Disease sub Category:  rks  fon:  arks:  Probable DOS: Duration of Stay:  Details of Diagnostics Protocol Follow or investigation:  th reports):  Billing info  Amount approved AK share amount  Treating doctor signature  SAMCO name and signature:	City: District:  AB-ArKID no:  railed the treatment under Arogya Karnataka, furnish p  Preauth approved amount:  Preauth approved amount:  Age: DOB: Ma  Source of registration:  To be filled by SAMCO  Doctor phone no:  Proce  Disease sub Category: Su  Rks  con:  arks:  Probable DOS: Duration of Stay:  Details of Diagnostics Protocol Followed:  or investigation:  th reports):  th reports):  Billing info  Amount approved AK share amount  Treating doctor signature:  SAMCO name and signature:

# ಆಯುಷ್ಮಾನ್ ಭಾರತ್ – ಆರೋಗ್ಯ ಕರ್ನಾಟಕ (ಸಾಮಾನ್ಯ ರೋಗಿ) ಫಲಾನುಭವಿಯ ಅನಿಸಿಕೆ ಪತ್ರ

<u> </u>	ರವರ	ಮಗ/ಮಗಳ/ಹೆಂಡತಿಯಾರ
ಗ್ರಾಮ		ತಾಲ್ಲೂಕ
	ಜಿಲ್ <u>ಲೆ</u> ಯ	ನಿವಾಸಿಯಾಗಿರುವ ನಾನ
ಆಯುಷ್ಮಾನ್ ಭಾರತ್–ಆರೋಗ್ಯ ಕರ್ನಾಟಕ (ಸಾಮಾನ್ಯ ರೋಗಿ)/ತ	ಶಡಿತರ ಚೀಟಿ ಕಾರ್ಡ್ <sub>ಸಂಖೈ</sub>	
ಹೊಂದಿದ್ದು	ಆಸ್ಪತ್ರೆಯಿಂದ	ಆಯುಷ್ಮಾನ್ ಭಾರತ್ -
ಆರೋಗ್ಯ ಕರ್ನಾಟಕ–(General patient) ಯೋಜನೆಯಡಿಯ	ುಲ್ಲಿ ಚಿಕಿತ್ಸೆ ಪಡೆದು ದಿನಾಂಕ	ರಂದ
ಬಿಡುಗಡೆಯಾಗಿರುತ್ತೇನೆ.		
<ol> <li>ನನ್ನ ಕಡೆಯಿಂದ ಆಸ್ಪತ್ರೆಯವರು ಸಹಪಾವತಿ ಮೊತ್ತವಾದ ಅದಕ್ಕೆ ರಸೀದಿಯನ್ನು ಕೊಟ್ಟಿರುತ್ತಾರೆ.</li> </ol>	3 ಅನ್ನು ಪಡೆಂ	ನಿರುತ್ತಾರೆ ಮತ್ತು ಅವರು
2. ಆಸ್ಪತ್ರೆಯವರು ಚಿಕಿತ್ಸೆ ಪಡೆದ ಬಗ್ಗೆ ನನ್ನ ಅನಿಸಿಕೆ ಈ ಕೆಳ	ಗಿನಂತೆ ಇರುತ್ತದೆ	
ದಿನಾಂಕ:	<u> </u>	ಕಲಾನುಭವಿಯ ಸಹಿ
ಆಯುಷ್ಟಾನ್ ಭಾರತ್ – ಆರೋಗ್ಯ ಕರ್ನಾಟಕ ಯೋಜನೆಯ	ಆರೋಗ್ಯಮಿತ್ರನ/ಳ ಹೆಸರು	ಮತ್ತು ಸಹಿ
ವೈದ್ಯಕೀಯ ಸಮನ್ವಯಾಧಿಕಾರಿಗಳ (SAMCO) ಸಹಿ ಮತ್ತು ಮುದ್ರೆ		
·		
ಫಲಾನುಭವಿಯ ಪೂರ್ಣ ವಿಳಾಸ:		
ದೂರವಾಣಿ ಸಂಖ್ಯೆ:		
ಸೂಚನೆ: ಫಲಾನುಭವಿಯು ಅಪ್ರಾಪ್ತ ವಯಸ್ಕನಾಗಿದ್ದಲ್ಲಿ ಕುಟುಂಬ	ಬದ 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 RT CT
Name of treating doctor	
Patient details& Treatment provide	ded
Patient name	<del></del>
Diagnosis	
Surgery details	
RT details	
CT details	
Pre-auth details	
Further treatment required	
Herewith referring the patient to the tie u	p hospital.
Surgery RT	CT
Specify details:	
	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		Pre-auth	
Representative Name		No.	
Date of Admission :	Date of Surgery :	Date of Disch	arge :

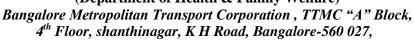
Date of Visit	Visit Time	Food Provided	Any Complaints

#### To be filled During Discharge from Hospital

10	be filled burning bischarge from frospital		
1.	Free Food Provided during hospitalization (	'es/No) :	
2.	Rs was collected towards investigation	ation charges and Rs.	amoun
	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:-		
Si	gnature of		
Ard	gyamitra/ Hospital Representative	Patient/ Attender	SAMCO

#### **Government of Karnataka** SUVARNA AROGYA SURAKSHA TRUST

(Department of Health & Family Welfare)





Phone: 080-22536200, Fax: 080-22536221, E-mail: directorsast@gmail.com

#### 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