

Website: [www.esichennai.org](http://www.esichennai.org)



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OFFICE OF STATE MEDICAL COMMISSIONER  
कर्मचारी राज्य बीमा निगम  
EMPLOYEES' STATE INSURANCE CORPORATION  
143, स्टर्लिंग रोड, चेन्नै-34  
143, STERLING ROAD, CHENNAI-34

Date : 19.12.2011

CIRCULAR

**Sub : CGHS rates to the Tie-up Hospitals.**

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Tie-up Hospitals are directed to follow the latest CGHS rate as found in the website [www.esichennai.org](http://www.esichennai.org). Further they are requested to use the under mentioned format as given in the said website.

1. The revised formats as given below have been prepared which must be used henceforth by all concerned.

P-I- Referral form to be used by ESI/ESIC hospitals while referring the patient to tie-up hospitals for treatment /investigation.

P-II- Individual bill format- Is meant for details of the charges for procedure for individual patients treated at tie-up hospitals to be filled for each patient by tie-up hospital while claiming the payment.

P-V- Bill claim format for special investigations(for diagnostic centre's/referral hospitals). Is meant for hospitals/diagnostics centre's, for the raising of bills for investigation of the patient for which he/she is referred to.

P-VI- Patient satisfaction certificate to be duly signed or thumb impression put by patient/attendant to be tie-up hospital while claiming the bill along with format P II & IV patient satisfaction certificate is meant for a statement by patient/attendant that they have received satisfaction treatment as well as statement that no money has been charged from him/her attendants during the stay in the hospital.

Contd..2



2. Packages rates for conditions/procedures where CGHS (Central Government Health Scheme) treatment rates are available, the same will be applicable. The latest CGHS rates as given on the website should be followed ([www.esichennai.org](http://www.esichennai.org)).

In general the Tie-up hospitals are directed to follow the non NABH rates while processing their bills. If the Tie-up Hospitals are NABH, they have to forward the documentary proof to this office for considering their bills under NABH rates.

3. Packages rates have been devised for the treatments/procedures not prescribed by CGHS. They will be called as ESIC rates, which are to be followed if not available in CGHS rate list. The list of ESIC rates is also available in the website ([www.esichennai.org](http://www.esichennai.org))

4. Certain discounts on Drugs/treatment/procedures/devices have been instructed by our ESI Headquarters which may also be followed. These are:

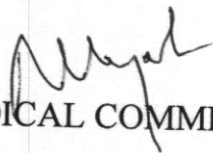
- a) 15% discount on hospital rates if there is no package procedure under CGHS/ESIC.
- b) For devices/stents etc, 15% discount on MRP (Maximum Retail Price).
- c) In case of drugs not available in the CGHS/ESIC package/procedure, 10% discount on the MRP.

5. Regarding the patient admitted in tie-up hospitals, the empanelled hospitals levy CGHS or ESIC approved rates for the procedures for which the tie-up hospitals are not empanelled. If no such rates are available, then there shall be a discount of 15% on normal scheduled rates of the hospitals.

6. A ESI Head Quarters circular regarding ceiling limit for coronary and vascular stent (forward by Govt of India) has also been displayed in above said website, which also to be followed for required cases.

These instructions may be followed for all patients being admitted henceforth.

Encl: As above

  
STATE MEDICAL COMMISSIONER

# Letterhead of Referring ESI Hospital (P-I)

## Referral Form (Permission letter)

Referral No : Insurance No/Staff Card No/  
Pensioner Card No :  
Name of the Patient :  
Address/Contact No : Age/Sex :  
Identification marks (if any) :  
IP/Beneficiary/Staff :  
Relationship with IP/Staff : F/M/S/D/Other  
Entitled for Speciality/Super Sp tt : Yes/No  
Diagnosis/clinical opinion/case :  
summary

Photograph  
Of Patient  
(optional)

Relevant Treatment given/ Procedure/  
Investigation done in referring hospital :

Treatment/Procedure/Investigation for  
which patient is being referred (mention  
specific diagnosis for referral) :

I voluntarily choose \_\_\_\_\_ Hospital for treatment of self or my \_\_\_\_\_

**Sign/Thumb Impression of IP/Beneficiary/Staff**

Referred to \_\_\_\_\_ Hospital/Diagnostic Centre for \_\_\_\_\_

Date:

**Sign & Stamp of Authorized Signatory \*\***

**\*\* In case of emergency, signature of referring doctor or Casualty Medical Officer. Record to be maintained in the register. New form duly filled will be sent after signature of the competent authority on the next working day.**

### **Mandatory Instructions for Referral Hospital:**

- Referral hospital is instructed to perform only the procedure/treatment for which the patient has been referred to.
- In case of additional procedure/treatment/investigation is essentially required in order to treat the patient for which he/she has been referred to, the permission for the same is essentially required from the referring hospital either through e-mail, fax or telephonically (to be confirmed in writing at the earliest).

:2:

- The referred hospital is requested to raise the bill as per the agreement on the standard proforma along with supporting documents within 6 days of discharge of the patient giving account number and RTGS number etc.

**Checklist(Referring Hospital)**

1. Duly filled & signed referral proforma.
2. Copy of Insurance Card/Photo I card of IP.
3. Referral recommendation of the specialist/concerned medical officer.
4. Copy of entitlement evidence of Specialty/super specialty treatment.
5. Reports of investigations and treatment already done.
6. Photograph, if available

**Date:**

**Signature of the Competent Authority \*\***  
**(With Stamp)**

**To be used by Tie-up hospital (for raising the bill) (P-II)**

**Letterhead of Hospital with Address & Email/Fax/Telefax number**

**(NABH accredited/ Superspeciality Hospital)**

(Attach documentary proof)

**Date of Submission:**

**Individual Case Format**

Name of the Patient : Referral S.No.(Routine) /  
 Age/Sex : Emergency/ through  
 Address : SSMC/SMC :  
 Contact No :  
 Insurance Number/Staff Card No/Pensioner :  
 Card no.  
 Date of referral :  
 Diagnosis :  
 Condition of the patient at discharge :

|  |
|--|
| Photograph<br>Of the Patient<br>verified by<br>hospital<br>authority |
|--|

**(For Package Rates)**

Treatment/Procedure done/performed :

**I. Existing in the package rate list's**

CGHS/other Code no/nos for chargeable procedures :

| S.No. | Chargeable Procedure | CGHS Code no with page no (1) | Other if not on (1) prescribed code no with page no | Rate | Amt. Claimed with date | Amount Admitted with date (X) | Remarks (X) |
|-------|----------------------|-------------------------------|---|------|------------------------|-------------------------------|-------------|
|       |                      |                               |   |      |                        |                               |             |

Charges of Implant/device used .....

Amount Claimed..... Amount Admitted      Remarks

(To be filled up by ESIC official(s))

:2:

**II. (Non-package Rates) For procedures done (not existing in the list of packages rates)**

| S.No. | Chargeable Procedure | Amt. Claimed with date | Amount Admitted with date (X) | Remarks (X) |
|-------|----------------------|------------------------|-------------------------------|-------------|
|       |                      |                        |                               |             |

**III. Additional Procedure Done with rationale and documented permission**

| S.No. | Chargeable Procedure | CGHS Code no with page no (1) | Other if not on (1) prescribed code no with page no | Rate | Amt. Claimed with date | Amount Admitted with Date (X) | Remarks (X) |
|-------|----------------------|-------------------------------|---|------|------------------------|-------------------------------|-------------|
|       |                      |                               |   |      |                        |                               |             |

Total Amount Claimed(I+II+III) Rs. ....

Total Amount Admitted (X) (I+II+III) Rs. ....

Remarks

Certified that the treatment/procedure has been done/performed as per laid down norms and the charges in the bill has/ have been claimed as per the terms & conditions laid down in the agreement signed with ESIC.

Further certified that the treatment/ procedure have been performed on cashless basis. No money has been received /demanded/ charged from the patient/ his/her relative.

**Sign/Thumb impression of patient with date                      Sign & Stamp of Authorized Signatory with date**

**(for Official use of ESIC)**

Total Amt payable:

Date of payment :

Signature of Dealing Assistant

Signature of Superintendent

**Date:**

**Signature of ESIC Competent Authority (MS/SMC/SSMC)**

1. Discharge Slip containing treatment summary & detailed treatment record.
2. Bill(s) of Implant(s) / Stent(s) /device along with Pouch/packet/invoice etc.
3. Photocopies of referral proforma, Insurance Card/ Photo I card of IP/ Referral recommendation of medical officer & entitlement certificate. Approval letter from SMC/SSMC in case of emergency treatment or additional procedure performed.
4. Sign & Stamp of Authorized Signatory.
5. Patient/Attendant satisfaction certificate.
6. Document in favour of permission taken for additional procedure/treatment or investigation.

**(X) to be filled by ESIC Official(s).**

**Letterhead of Tie-up Hospital with Address details(P- V)**

**Monthly Bill Special Investigations For diagnosis centres/referral Hospitals**

**Bill No .....**

**Date of Submission.....**

| SNo | Name of the Patient & Insurance /Staff no | Date of Reference | Investigation Performed | CGHS/ other code no with page no | <b>Charges not in package rates list</b> | Amount Claimed with date | Amount Admitted (entitled) with date | Remarks Disallowances with reasons |
|-----|---|-------------------|-------------------------|----------------------------------|--|--------------------------|--------------------------------------|------------------------------------|
|     |   |                   |                         |                                  |  |                          |                                      |                                    |
|     |   |                   |                         |                                  |  |                          |                                      |                                    |

Certified that the procedure/investigations have been done/performed as per laid down norms and the charges in the bill has/ have been claimed as per the terms & conditions laid down in the agreement signed with ESIC.

Further certified that the procedure/investigations have been performed on cashless basis. No money has been received /demanded/ charged from the patient / his/her relative.

The amount may be credited to our account no \_\_\_\_\_ RTGS no \_\_\_\_\_ and intimate the same through email/fax/hard copy at the address.

**Date:**

**Signature of the Competent Authority of Tie-up Hospital**

**Checklist**

1. Investigation Report of each individual/Pt.
2. Copy of Referral Document of each individual/Pt.
3. Serialization of individual bills as per the Sr. No. in the bill.

**It is certified that total amount of Rs \_\_\_\_\_ has been credited to your account no. \_\_\_\_\_, RTGS no \_\_\_\_\_ on \_\_\_\_\_**

Signature of Account department with stamp.

Date:

Signature of Competent Authority Referral Hospital.

(To be filled up by ESIC official(s))

Patient Referral No \_\_\_\_\_

**PATIENT/ATTENDANT SATISFACTION CERTIFICATE (P-VI)**

- 1. I am satisfied/ not satisfied with the treatment given to me/ my patient and with the behavior of the hospital staff.**
  
- 2. If not satisfied, the reason(s) thereof.**
  
  
  
  
  
  
  
  
  
  
- 3. It is stated that no money has been demanded/ charged from me/my relative during the stay at hospital.**

Date & Time :

**Sign/Thumb impression of patient/Attendant**

Name of the Patient/attendant

Name of IP

Insurance No/Staff no

Date of Admission

Date of Discharge