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 Arogya Karnataka Card (Eligible Patient-ARKID/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

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

ARKID/Ration 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:	

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:	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 ☐ Emergency ☐

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

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

ಶ್ರೀ/ಶ್ರೀಮತಿ/ಕುಮಾರ/ಕುಮಾರಿ.....ಗ್ರಾಮ .....

ತಾಲ್ಲೂಕು ..... ಜಿಲ್ಲೆಯ.....

..... ನಿವಾಸಿಯಾಗಿದ್ದು, ನಾನು ಆರೋಗ್ಯ ಕರ್ನಾಟಕ ಕಾರ್ಡ್ (ARKID/ ಪಡಿತರ ಚೀಟಿ) ಸಂಖ್ಯೆ .....ಹೊಂದಿದ್ದು .....

..... ಆಸ್ಪತ್ರೆಯಿಂದ 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. .....

.....

.....

.....

ದಿನಾಂಕ: ಫಲಾನುಭವಿಯ ಸಹಿ 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 ವಯಸ್ಕನಾಗಿದ್ದಲ್ಲಿ ಕುಟುಂಬದ ಪ್ರಧಾನ ಸದಸ್ಯರು ದೃಢೀಕರಿಸಬೇಕು.

AROGYA KARNATAKA PROCEDURE CLAIM FORM AND FEED BACK FORM

Hospital name :……

Patient Name :……

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:……

Diagonsis:……

FEEDBACK AND REFUND

Shri/smt/Kum……From:……

Taluk:…… District:……

having ARKID/Ration card:…… having treated under 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……

……

……

Signature of the patient with mobile no.	Signature of the SAMCO with phone no.	Signature of the AM with phone no.

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 Arogya Karnataka Card (General patient-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

Arogya Karnataka (General patient) Preauthorisation-Request form

Date of Request:

Hospital name :	City:	District:
APL card no:	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 ☐ Emergency ☐

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

Arogya Karnataka (General patient) Claim request form

Date of Request:

Hospital Name :	City:	District:
APL card no:	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 :			
Diagonsis:			
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

ಆರೋಗ್ಯ ಕರ್ನಾಟಕ (ಸಾಮಾನ್ಯ ರೋಗಿ)
ಫಲಾನುಭವಿಯ ಅನಿಸಿಕೆ ಪತ್ರ

ಶ್ರೀ/ಶ್ರೀಮತಿ ..... ರವರ ಮಗ/ಮಗಳ/ಹೆಂಡತಿಯಾದ

..... ಗ್ರಾಮ ..... ತಾಲ್ಲೂಕು

..... ಜಿಲ್ಲೆಯ ..... ನಿವಾಸಿಯಾಗಿರುವ

ನಾನು ಆರೋಗ್ಯ ಕರ್ನಾಟಕ (ಸಾಮಾನ್ಯ ರೋಗಿ)/ಪಡಿತರ ಚೀಟಿ ಕಾರ್ಡ್‌ಸಂಖ್ಯೆ .....

ಹೊಂದಿದ್ದು ..... ಆಸ್ಪತ್ರೆಯಿಂದ 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_.....

.....

.....

ದಿನಾಂಕ: ಫಲಾನುಭವಿಯ ಸಹಿ

ಆರೋಗ್ಯ ಕರ್ನಾಟಕ ಯೋಜನೆಯ ವೈದ್ಯಕೀಯ ಸಮನ್ವಯಾಧಿಕಾರಿಗಳ (SAMCO) ಸಹಿ ಮತ್ತು ಮುದ್ರೆ	ಆರೋಗ್ಯಮಿತ್ರನ/ಳ ಹೆಸರು ಮತ್ತು ಸಹಿ

ಫಲಾನುಭವಿಯ ಪೂರ್ಣ ವಿಳಾಸ:

.....

.....

ದೂರವಾಣಿ ಸಂಖ್ಯೆ:.....

ಸೂಚನೆ: ಫಲಾನುಭವಿಯು ಅಪ್ರಾಪ್ತ ವಯಸ್ಕನಾಗಿದ್ದಲ್ಲಿ ಕುಟುಂಬದ ಪ್ರಧಾನ ಸದಸ್ಯರು ದೃಢೀಕರಿಸಬೇಕು

Arogya Karnataka

Referral to tie-up hospital

(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 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

Government of Karnataka
SUVARNA AROGYA SURAKSHA TRUST
(Department of Health & Family Welfare)
Bangalore Metropolitan Transport Corporation , TTMC "A" Block,
4th Floor, shanthinagar, K H Road, Bangalore-560 027,
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