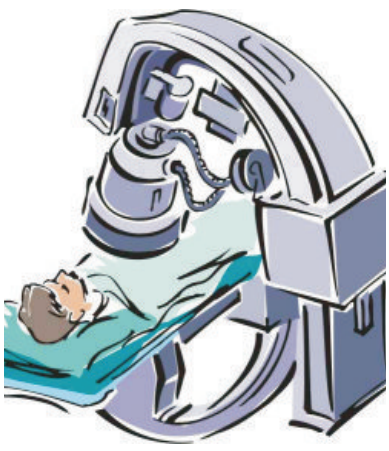
KNOWLEDGE SERIES 8

optima INSURANCE BROKERS

10 Questions About Health Insurance

You Always Wanted to Ask, But Didn't Know Whom To

1. Do we need to submit all the claim documents in original?



It is the standard practice in all mediclaim policies to release the payment against the original bills only. This prevents duplicacy of payments and even frauds. However certain medical records can be returned to the claimant on request.

2. Why pre-post hospitalization expenses are not covered for maternity?

Child birth is not a disease, illness or ailment and is therefore not covered under any standard medical insurance policy. However a maternity cover is granted in corporate policies as a value added benefit. But it is not treated at par with usual diseases treatment reimbursement parameters. Therefore insurers do not cover pre & post hospitalization expenses in the maternity cover.

3. What is the time limit for settlement of a reimbursement claim?

The standard time limit for settlement of any claim is 15 days from the date of submission of the documents to the approving authority or reply to last query raised whichever is later.

4. The insurance company deducted some amount from my reimbursement because a couple of reports were not submitted. Can this amount be recovered by submitting the reports now?

Yes, you can submit these reports and get the reimbursement for them but if they are submitted immediately after the settlement. The insurer will not reimburse if there is a delay of more than 15 days in submitting such reports from the day of the settlement of the claim.

5. Why has the insurer not reimbursed the bills for non medical items? They were prescribed by the doctor.

In a health insurance policy, the focus is on actual expenses made strictly towards treatment and other expenses are excluded under a written stipulation mentioned in the policy document. Expenses on non-medical items like Disposable Pads, Cotton, Baby Oil, Soap, Glucose, Foot Pad, Tissue Paper, Sanitary Paper etc. are not reimbursed by the insurers.

6. Certain tests were prescribed by the doctor before the operation. However I was not hospitalized because of favorable test reports. Why were the tests disallowed as 'Observation & Investigation' and not paid?

Expenses are generally made under following 3 categories:
(1) OPD Expenditure
(2) Tests for evaluation
(3) Hospitalization
The medical policy is mainly designed to cover 24 hour hospitalization and not those covered under point 1 & 2 above. However the tests for evaluation done within 30 days prior to hospitalization and within 60 days after discharge from the hospital are paid as pre & post hospitalization part of the claim. Tests which do not lead to hospitalization are not paid. This is a universal feature of the medical policy.

7. Why has the insurer not reimbursed the bills for medical instruments? They were a part of the treatment.

To keep the premium of the policy affordable insurers do not include medical instruments like thermometers, disposable syringes, insulin pump etc. for reimbursement. Accommodation of the cost of such items will increase the cost of the policy phenomenally and will make it beyond the reach of the common man.

8. Is it possible to re-claim a rejected cashless through reimbursement?

During a cashless approval the insurance company's (or TPA's) doctor has to evaluate the merits of the claim within an hour and send a response to the hospital. Sometimes the doctors are not able to decide in favour of the claimant due to lack of information or clarity of information. In such cases the cashless approval is not granted. However it does not mean a rejection of the claim. Such claims should be sent for reimbursement. When all the documents reach the insurer after hospitalization, they are able to take a well informed decision and such claims are generally paid on merits.

9. The insurer deducted some amount from the claim. The reason mentioned was 'Limit Exhaustion'. However there was sufficient balance in my sum insured. Why was the entire amount not reimbursed?

In addition to the overall limit of Sum Insured there are sublimits in the policy under different heads like room rent, doctor's fees, and medicines. Sub limits on sum insured are also enforced by the insurer on treatment of certain diseases like cataract, hernia etc. The insurer will not reimburse more than the sub-limited sum insured for such treatments. This is done to control the claims and also to ensure that the balance sum insured can be utilized for another treatment if required.

10. Why acknowledgement of payment on the letter pad of the hospital is not acceptable in absence of proper numbered bills or a receipt?

All financial transactions are governed by standard accounting practices which require numbered stationary in standard format. Such procedures also help the insurers in controlling frauds.

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