PROCEDURE FOR HOSPITAL admission using MEDICAL CARD

ARE you insured? Or over-insured? Or you're unsure of your life insurance situation? In this article, we provide frank insights on medical insurance, focusing on various types of critical illness insurance that could help to unravel your dilemma and discover solutions in medical insurance.

Q I have recently purchased a hospital policy and was given a medical card to be used if I am admitted to a hospital. What is the procedure for hospital admission and discharge when using this card?

A When you purchase hospital insurance, most insurance companies will give you a medical card together with the policy. This medical card allows you the convenience of getting admitted into hospitals that are in the insurance company's panel of hospitals.

On admission, you need not have to pay for admission deposits (except for small amounts as required by individual hospitals to cover for incidentals not covered by your insurance policy).

When you are discharged, you need not have to pay for your hospital expenses. This will be paid for by your insurance policy, provided the hospitalisation meets the terms and conditions of the policy.

With this arrangement, it removes the strain of having to withdraw your cash deposits or raise funds to pay for your hospital bills at a time when getting the illness treated is of primary concern.

Before getting admitted to the hospital, you will have to ascertain whether that hospital is one of your insurance company's panel of hospitals.

If it is not in the panel, it does not mean that you cannot be treated in that hospital. Just that you will have to pay for the hospital fee first and then make a claim for reimbursement later. A letter from the attending doctor, giving a brief description of diagnosis, the necessity for hospitalisation and the treatment given, together with the original bills and receipts will normally be required to make a claim.

If the hospital is in the panel, you can show your medical card for admission to the hospital. The hospital will communicate with your insurance company or the third party provider appointed by your insurance company for the issue of a "guarantee of payment" letter.

On discharge, you are required to go through your medical bills. Clarify with the hospital the charges for the treatment provided to ensure that the billing is correct. If they are correct, your insurance company may require you to sign off the bill and they will then pay the bill on your behalf. You will have to pay for the charges and incidentals that are not covered by your insurance policy. Do remember to get back the initial deposit from the hospital, too.

Q I was admitted to the hospital for dengue. On the day of discharge, I had to wait for 3 to 4 hours before I could leave the hospital. When I complained about the delay in discharging me to the hospital, I was told that the insurance company took a long time to approve my bill. This was also the experience my friend had when she was hospitalised. Why do insurance-companies cause such delays?

A The discharging procedure by the hospital usually takes some time as there is administrative work to be done before the settlement of the bills.The attending doctor has to complete his ward rounds and this may take some time if he has to attend to a number of patients. He will have to complete your medical report as required by the insurance company. Further, he may also need to review and write the necessary prescriptions for take-home medications for the discharging patients.

Once completed, the billing section will then be notified to prepare the bills. The billing section will also have to wait for the final bills from the various departments, including that from the pharmacy which has to dispense your take-home prescriptions.

Having done that, the hospital will finally fax the necessary discharged reports and the bills to the insurance company or third party provider for their assessment and approval.This assessment may usually take not more than an hour depending on the complexity of the claim and the volume of claims being handled at that time.

Q After being discharged from the hospital for an appendix operation, my uncle went back for follow-ups with the doctor. When he submitted his follow-up bills to the insurance company, they only reimbursed him the bills partially and not the full bills. Why is that so?

A Your uncle will have to check with the company on the actual reason for the partial payment. Probably the bills may not have fulfilled certain conditions under the post hospitalisation benefits.

Your uncle can check whether the follow-ups were done within the period of post hospitalisation allowed in the policy. Obviously, the insurance company will not pay for follow-ups done out of the benefit period.

The period of post hospitalisation may vary for different hospital policies.

Insurance companies may also not pay for follow-ups done by doctors who are not the treating doctors in the hospital unless these have been approved by them earlier.

From previous claims experience, excessive claims have been made under the post hospitalisation benefit and these include taking medications for other family members, requesting for a variety of multi-vitamins and supplements and taking large supply of medications for treatment of chronic medical conditions. Such abuses have detrimental effects for both the insured and the company.

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