

For category - A (for 901, 902, 903 & 904)
(Fixed Benefit Reimbursement Scheme)

The Role of TPA

The TPA shall hold a valid license as a third Party Administrator under the Third Party Administrator (Health Services) Regulations, 2001 framed under Sections 14 and 26 of the Insurance Regulatory and Development Authority Act, 1999.

Part A Customer Service at the Commencement of the Policy
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1. The TPA shall forward a user guidebook/brochure and related information to the Insured person within 5 working days of receipt of information regarding the issuance of policy to the Insured person from the Insurer, and the scanned image of the Photo Addendum which will be uploaded by the Divisions. (The TPA has to download the data of HCD/HCU and the uploaded scanned images from LIC's server on daily basis without fail.) The Guidebook shall inter-alia contain information regarding the following :
 - Information regarding the TPA and its address, fax number, website address, Toll free number of the Call Center Service and other contact information
 - Procedure to be adopted for reimbursement of hospitalization expenses in a Network or a Non-network Hospital
 - Any information that would be useful to the Insured which is agreed between the TPA and the Insurer

Part B Customer Service during the Policy Term

1. **Spread of Offices:** The TPA shall endeavor to open more offices or expand the Network of Providers to allow easy and convenient access to the Insured persons.
2. **Network Providers:** The TPA shall make available the list of Network Providers affiliated to the TPA to the Insured on their website.
3. **Changes in the Network Provider:** The TPA shall intimate from time to time any changes in the number and details of the Network Providers. The directory shall be updated regularly in the website of the TPA.
4. **Call Center services:** The TPA shall provide Call Center services for the guidance and benefit of the Insured Persons. The Call Center shall function for 24 hours a day, 7 days a

week, round the year. As part of the Call Center Service, the TPA shall provide the following :

- General guidance on the Service
- Information on Network Providers and contact numbers
- Claim status information to the Insured Person
- Advising the Insured Person regarding the deficiencies in the documents for a claim
- Any other information relevant & available to the Insured at the Call Center

5. Toll Free Number: The TPA shall operate a Toll Free number with a facility of minimum of 10 lines. In case of non-availability of the 10 line facility immediately, the TPA shall as soon as possible and in any case within 30 days provide for the facility and intimate the Insurer. The Toll Free numbers shall be restricted only to the incoming calls of the clients and outward facilities from those numbers shall be barred to prevent misuse.

6. Language: The TPA shall provide the information on services to the Insured Persons in English, Hindi and the regional language applicable to the region.

7. Website Services: The TPA shall have a Website for the benefit of all Insured Persons/Insurer. As part of the Website service, the TPA shall provide the following:

- General guidance on the Services
- Information on Network Providers and contact numbers
- Claim status information to the Insured Person
- Advising the Insured Person regarding the deficiencies in the documents for a full claim
- Any other relevant information required by the Insured Person

The information shall be updated dynamically or at least at the end of the day.

The system shall have facility which can be accessed by the Insured/Insurer and both.

8. Grievance handling : The TPA shall provide adequate services to the Policyholders and ensure that their grievances are resolved to the best of their satisfaction, under intimation to the Insurer.

9. Redressal Mechanism : The TPA shall act as a frontline for the redresser of Insured Person's grievances ; and shall attempt to solve the customer grievance at their end. The grievances shall be recorded by the TPA and the grievances so recorded shall be numbered consecutively and the Insured Person who records the grievance shall be provided the number assigned to the grievance. The TPA shall attempt to solve the customer grievance at their end at the earliest - as per the IRDA Regulations for "Protection of Policyholders' Interest."

10. Co-ordination with the Insurer : The TPA shall co-ordinate with the Insurer to solve the grievance of the Insured Person/s, as and when required depending upon the nature and circumstances of the grievance.

11. Confidentiality :

- The TPA shall maintain confidentiality of data collected by it from the Insurer and policies serviced and data of claims processed and shall not under any circumstances divulge any such data to any other person or entity unless authorized in writing by the Insurer
- The TPA shall not influence directly or indirectly the policyholders to shift their insurance portfolio from the Insurer with whom this agreement is entered into, to another Insurer
- The TPA shall not act or do anything which shall prejudice the interests of the Insurer or do anything that can create a conflict of interest
- The TPA or the Network provider shall keep such medical information / records of the Insured person as confidential as per guidelines / instructions of GOI in respect of certain ailments / diseases and shall not part with the information, unless duly authorized by IMA / concerned department of GOI or the courts

Part C Customer Service / Claim Settlement

Maintenance and Claims settlement consists of the following :

- a. General maintenance of the policy records including claim records if any
- b. TPAs shall provide recommendations as to claim admissibility as per terms and conditions of the policy and plan. Policy particulars shall be made available to them on Corporation's website. If further information is required, the TPA should obtain data from DHUs viz., proposal forms, endorsements, underwriting decision etc.
- c. The identity of the Insured as given in the Hospital Treatment Form is cross checked with the
 - a. photo addendum
- d. Putting up of claim status including specific requirements necessary for adjudication of claim
- e. Verifying of the identity of the claimant
- f. Verifying whether the hospitalization/treatment was actually availed
- g. Verifying whether the treatment for which the claim has been lodged has been medically necessary
- h. Verifying whether the duration of hospitalization was reasonable for the ailment as compared to the standard duration applicable for the ailment
- i. Verification whether the Insured's ailment precedes policy date
- j. Only MBBS doctors shall make note down the recommendation with justification for the same in the claim summary sheet
- k. Substantiating reasons for claim admission / rejection /disallowance of claim with regard to terms and conditions of the policy.
- l. In case of any excess payment made as a result of wrong recommendation, TPAs shall indemnify the Corporation to the extent of loss suffered by it
- m. Conducting of Claim Investigation Reports in case of frauds based on 'fraudulent triggers' and submission of reports where done. However the no. of such investigations shall not be less than the number mentioned below:

Sl. No	% of claims to be investigated	Amount
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1	10%	Admission and Rejection Cases not based on PED	Claims for treatment taken in Network Hospitals of TPA.
	100%	Claim Rejections for Pre Existence of Disease	
2.	20%	Admission and Rejection Cases not based on PED	Claims for treatment taken in Non Network Hospitals of TPA.
	100%	Claim Rejections for Pre Existence of Disease	
Note 1: The number of claims for deciding the % of the investigations shall be reckoned for each Division of the Insurer whose policies are being serviced by the TPA. However, such number of claims to be investigated shall be a minimum of 1 (One) per month per Division and fraction of the figure arrived has to be rounded to the next higher number. (This will be based on the number of claims processed) TPA has to report the details of the cases where claim investigation has been done, to LIC HI on a monthly basis in the format provided. If not reported, LIC HI will deem that the TPA has not investigated any case in that month.			
Note 2: 'Network Hospitals' means all those hospitals which are recognized as Preferred Provider Organizations / Preferred Provider Networks (PPOs/PPNs) by the TPA and with whom the TPA has entered into MOU/Agreements and includes all other reputed corporate Hospitals. The % of investigations mentioned in Sl. Nos. 1 above will be applicable for 'Recognized Hospitals'. 'Non Network Hospital' means those hospitals, the TPA has not recognized for various specified/ unspecified reasons. The % of investigations mentioned in Sl. No. 2 above will be applicable for 'Non Recognized Hospitals'.			

- n.** Furnishing MIS data in the format prescribed by the Insurer and at the frequency that is desired by LIC (Health Insurance)(List of formats and their frequency is provided)

TPA shall accept only those cases sent to it by LIC Divisional Offices with mandatory claim requirements. If not, they shall be returned to the Divisional Offices with appropriate remark. The Checklist as per which claim forms can be accepted from the Divisions is attached.

- o.** TPAs shall provide recommendation for intimated claims as per the following benchmarks :
- TPAs shall consider and recommend all claim cases within an average of three(3) days where further requirements (based on the submitted requirements and history

- provided)
- and / or investigations (based on investigation triggers/red alerts) are not required.
- b. TPAs shall consider and recommend all other claim cases within an average of 15 days in cases where additional requirements (based on the submitted requirements & history provided) and / or investigations (based on investigation triggers/red alerts) are required.
- c. No claim shall be kept pending beyond 45 days for want of requirements from claimants.

Where requirements are to be called for based on the information provided in the mandatory requirements, TPAs are required to send the first letter calling for requirement/s within 2 days of

receipt of claim forms. This shall be followed by reminders every 10th day till the requirements are

received. Telephone calls, emails/SMSs shall also be made/ sent, every 3rd day in addition to the

written reminder letter. TPAs shall endeavour to engage claimant and obtain all data necessary for adjudication of claim.

Once claims recommendations are ready, TPAs shall send claims data to CO/HID for processing. The format is provided.

After the claim is decided by the Corporation, TPAs are required to send communication of claim

admission / rejection after intimation of the same by the Corporation. Formats of the communication

to be sent to Claimants is provided.

The claim files are to be returned to the Divisional office within 5 days from the date decision is given by LIC.

The Corporation has the option to shift to online decision making. In such a scenario, TPAs shall scan

all the documents received by them and put them in the respective folders for convenient decision making. TPAs shall provide access to their website to the Corporation. It shall provide a

menu with separate options to enable to view

- i. Claim cases with their recommendation of admission
- ii. Claim cases with their recommendation of rejection
- iii. Claim cases pending for recommendation
- iv. Claim cases pending for want of requirements
- v. Claim cases pending for investigations

There shall be provision with pass word to capture the decision given by the Corporation.

There shall be a provision to view the reminder letters for requirements, MIS, investigation reports

- vi. Claim pending cases, claim decided cases etc. pertaining to the Corporation.

Quick Cash facility: Processing of claims submitted by the policyholders under the “Quick cash facility”

method shall be as under:

A. Requirements for “Quick Cash” facility

1. Admission in Hospital
2. Hospitalization only for Major Surgical treatment
3. Advance payment only for MSB component
4. Availability of Bank Account Number and information on IFCS code for making payment through NEFT
5. Availability of the Policy holder’s Bank on Core banking Solutions (CBS) enabling NEFT payment

B. Process for “Quick Cash” facility:

1. Day Zero:
Policyholders send the details of their hospitalization etc., to TPA/LIC HI through Scanned images of the documents/Fax or hand over through his Agent personally wherever feasible.
2. Day One:
TPA processes the request and advises LIC HI Division on admissibility or otherwise. Scanned copies of the claim forms will be sent to LIC CO HI Division and policy servicing LIC Divisional Office. If not permissible, TPA shall inform the policyholder accordingly under intimation to LIC HI.
3. Day Two:
LIC admits the request for advance payment through “Quick Cash” facility and uploads payment instructions to the Bank for crediting to the Policyholder’s Bank Account through NEFT.

C. Procedure for “Quick cash” in LIC HI policies.

1. The Term “ Quick Cash” denotes that money would be made available to the policyholder even during period of hospitalization instead of waiting for making a claim for the benefit after discharge
2. It is only an advance payment to the policy holder in the event of planned hospitalization for any defined major surgical treatment (MSB) defined in the surgeries listed and permissible under the policy conditions of the relevant product.
3. The policy holder has to give prior intimation of the surgery to be undergone, if it is a planned surgery.
4. As per our policy conditions, different surgeries under MSB are allowed varying % of Sum Assured as maximum benefit payable per year / per term. 50% of the notified benefit defined for the surgical treatment shall be paid as advance payment to the policy holder as soon as he is hospitalized (either planned or emergency due to accident). This is however, subject to approval from the TPA, and the advance amount will be adjusted from the final settlement of the hospitalization bill.

For example: If 100% MSB is allowed under the product for a defined surgery, the advance payable shall be the 50% of the MSB payable for the surgery or 50% of the balance MSB eligible for the policy year/policy term, whichever is less.

5. This facility of advance payment shall be available only to those policyholders who have submitted the Bank Account and correct IFSC code so that direct credit to the policy holder's account can be made. The amount of advance shall under no circumstances be paid to the TPA or the hospital.

D. Role of Policy holder:

The policyholder or his / her representative shall submit

1. Advance Claim intimation form in the prescribed format of LIC HI Division.
2. A statement with the following requirements from the hospital / doctor on the letter head of the hospital where the PI or beneficiary is admitted for surgical treatment.
 - a. Name of the patient & policy details
 - b. Address and other contact details
 - c. Date of hospitalization
 - d. Duration of the present ailment necessitating surgery, nature and Diagnosis of the problem
 - e. Treatment if any, taken in the past for this ailment preceding the current hospitalization – Whether it involved surgical treatment
 - f. Details of surgery done earlier along with diagnostic reports
 - g. Present Diagnostic reports and the details of surgery to be performed
 - h. Expected cost involved for the surgery.
3. Intimation about the Bank IFSC code and the Bank Account number along with the blank cancelled cheque leaf.
4. Undertaking from the PI that the advance amount shall be repaid by him, if it is found later that
 - i. there was a mistake in the claim
 - ii. that the intended surgery was not performed
 - iii. that the surgery performed does not fall under the categories defined in the terms and conditions of the policy.
 - iv. That the cause of present hospitalization is linked to pre existing diseases.
 - v. That the Surgery performed differs with the original plan or
 - vi. Any other reason which makes the PI/Beneficiary not eligible for the above advance.

In case the ailment is not covered for one or more of the above reasons, the PI shall refund the amount within a fortnight, failing which the rate of interest as applicable in Banks shall be charged.

5. The documents clearly scanned should be sent directly to the policy servicing Division. The documents can also be faxed either to the TPA or to the LIC Divisional office that in turn will send them to the TPA for processing.
6. Discharge voucher (in LIC's prescribed format) which shall be used against the

advance payment, if it is considered by LIC HI Division on the recommendation of the TPA.

It shall always be the endeavour of the TPA to try to obtain the cases and settle claims correctly and Quickly.

In case of non adherence to benchmarks in any areas of claim processing, extra charges will be levied, as given below , which shall be deducted from the service fee payable to the TPA.

Chart of Penalties

1) Penalty for not maintaining datelines (DL) in submission of statements:

- i. Weekly Statements: Rs. 500/- per lapse (DL-next working day of the following week)
- ii. Monthly Statements: Rs. 750/- per lapse (DL-5th working day of the following month)
- iii. Quarterly IRDA Statements: Rs. 1000/- per lapse (DL-5th working day of the following quarter)

2) Penalty for not maintaining benchmarks in claim settlement (Quarterly Review) - Qrts are from April to June, July to September, October to December and January to March. Pl. refer to Part "C" - sub-section "o":

- i. Deduction of 1% from the average monthly servicing charges payable for the Quarter
(Under Review)

3) Penalty for not conducting requisite % of investigations (pl. see point (B) above):

- i. Deduction of 3% from the average monthly servicing charges payable for the Quarter (UR) - for the first lapse in the Same Financial Year (FY starts from 1st April of the year and ends on 31st March of the following year)
- ii. Deduction of 5% from the average monthly servicing charges payable for the Quarter (UR) - for the second lapse in the Same Financial Year (FY)
- iii. Deduction of 7% from the average monthly servicing charges payable for the Quarter (UR) - for the third lapse in the Same Financial Year (FY)
- iv. Deduction of 9% from the average monthly servicing charges payable for the Quarter (UR) - for the fourth lapse in the Same Financial Year (FY)

Part D Coordination between the TPA and the Insurer
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1. Call Center Analysis : The TPA shall provide general call center statistics in a format to the Insurer on a monthly basis including the aspects of grievance redressed. Any specific format, if required, shall be intimated by the Insurer in advance to the TPA.

2. Management Information System : The TPA shall provide management information System reports whereby the Insurer can have access to the information regarding the enrolment, pre-authorization, claims settlement and reimbursement and such other information regarding the Services. The reports shall be submitted by the TPA to the Insurer on a regular basis preferably monthly or as agreed between the Parties. (Annexure enclosed)

3. TPA Charges : In consideration of the Services mentioned above, the Insurer shall pay to the TPA the Fees per Policy as agreed upon between the TPA and the Insurer.

- a. Any applicable taxes and other levies of the Government or any Governmental Authority in relation to the Fees payable, shall be borne by the Insurer provided the TPA is a regular payee of Service tax and they are having the Service tax Account with the concerned Dept. of the Govt. which shall be mentioned in the service charge bill raised by the TPA.
- b. The TPA charges shall be paid only as long as the policy is in force. In other terms, policies lapsed/ discontinued shall not be eligible for any TPA charge of payment.



(Health Insurance Division, II Floor, 'Oasis Plaza', Tilak Road, Abids, HYDERABAD - 500 001

Hospital Claim Adjudication Check List

Policy Number:**Name:****Inward Date:****Inward Register Entry No.****Letter sent to PH on:**

Please verify the following items in this check list before sending letter to the Policyholder.

A)

S. No.	Title	Please write YES / NO / Remarks
1	Claim Form is duly filled in	
2	Hospital Treatment Form is duly filled in & self attested (all questions to be answered; dots, dashes or blanks are not allowed)	
3	Xerox copy of Health Card / Photo-identity Card is pasted on the Hospital Treatment Form	
4	Hospital Treatment Form is signed by Hospital Authorities / Treating Doctor with seal	
5	Original / Attested copy of Hospital Discharge Summary, should be attested by the PI also	
6	Original / Attested copy of the Final Hospital Bill, should be attested by PI also	
7	Original / Attested copies of the pathological / USG / MRI reports if mentioned in the Discharge Summary , should be attested by the PI also	
8	Original / Attested copies of the Surgical reports/OT Notes in case surgery is performed , should be attested by the PI also	
9	Original / Attested copies of MLC / FIR reports in case of Road Traffic Accident , should be attested by the PI also	
10	Self Declaration explaining cause of Accident / Fall in case of accident other than RTA	
11	In case of any diseases/surgeries undergone , print-out of the EDMS /copy of proposal of the Insured to be attached or e-mailed -Question E (Health details and Medical information). In case of female insured, Question F also is required.	
12	Pl. mention Underwriting Decision at proposal / revival stage in the remarks column	
13	Are Contact (latest address, mobile no. and email id) and NEFT details of PI given	
14	Is NEFT Master & Address Master created / updated	
15	Is Delay Condoned if claim form is submitted beyond 30 days from date of discharge of hospital	

B) Claim Adjudication DHU shall send the claim documents to the TPA concerned, only if the answers are "YES" and ACTION is taken for all the questions (except Q.no.s 7,8,9,10,11, where the answers can be "Not Applicable") .

Certified that the requirements are checked against items in Check List. Created/ updated NEFT /Address Master.

Manager (HI)



Life Insurance Corporation of India
Divisional Office:

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CLAIM INVESTIGATION REPORT FORM
(for HEALTH INSURANCE POLICIES)

Part 'A'

(To be completed by the Divisional Health Unit before entrusting the Claim for investigation)

A. Policy Number		Date of Commencement of the policy	
B. Name and occupation of the Principal Insured			
C. Address of the Principal Insured			
D. Name of the Insured hospitalized		Age	
E. Name and address of the Hospital where the insured was hospitalized:			
F. Period of Hospitalization including ICU:			
G. Illness Diagnosed as per claim forms:			
H. Date of Surgery (if done):			
I. Surgery as per claim forms:			

Part 'B'

(to be completed by the Investigating Official)

	Sl.No.	Name of doctor/Hospital visited	Place of visit	Date of visit
1. Mention the details in the of enquiry				
2. (A) Are you satisfied with the identity of the Insured hospitalized and age? Pl. satisfy yourself that there is no overstatement or understatement of age.				
(B) Mention any critical information related to health & habits of the Insured gathered during the enquiries.				
3 - What was the exact occupation of the Principal Insured prior to hospitalization? Was it different from the answer given in the proposal form?				
4 - What was Principal Insured's monthly income? Was it affordable and adequate to the total amount of premiums payable under all the insurance policies on his/her life? (If the income mentioned in the proposal form is overstated, then efforts should be made to obtain evidences to establish his/her correct income by way of ITRs/salary slip/business proof etc.)				
5 - (a) If the Insured was employed, obtain particulars of leave availed by him on sickness/medical ground during last three years prior to date of proposal/revival. Also obtain certified copies of his leave applications along with enclosed medical certificates. If the treatment particulars/medical history reported is significant, efforts should be made to obtain further details from the Doctors issuing the certificates. (b) Ascertain from the Employer if there is any indoor medical/health facilities being provided/run by the Employer. Also enquire of any scheme of reimbursement for medical expenses is available for the employees. Certified copies of relevant documents giving information about medical treatment/sicknesses of the Insured prior to the proposal /revival date of the policy should be obtained. Efforts should be made to obtain the names of other doctors/hospitals also to whom the insured contacted.				
7 - Was the Insured a member of any Health Insurance Scheme/ Mediclaim? If so, the particulars of benefits availed by him under the scheme should				

be obtained from the Insurers.	
8 a- Whether the insured is having health insurance with any other insurer. If so give details? 8 b- Whether claim is made from any other insurer. If so give details?	
9 - Whether any treatment, tests prior to the date of the proposal which are not disclosed in the proposal? If so give details? Efforts should be made to obtain the names of usual medical attendant/other doctors/hospitals/pathology labs/diagnostic facilities etc. to whom the Insured might have referred to for consultation/ treatment/ special tests.	
10. Enquire of other doctors/hospitals/diagnostic facilities in the vicinity of the residential/business place of the Principal Insured to find out the possibility of any treatment/special tests undergone by the Insured, particularly prior to the date of proposal/revival. Report the result of your findings enclosing certified copies of the case sheets/discharge summary/ pathological reports etc. in the following format	
11. Whether the ailment and surgery performed are confirmed by the usual medical attendant?	
12. Whether the surgery shown in the claim forms and hospital reports is actually performed in the hospital?	
13. Whether any misrepresentation in the hospital records submitted, is noticed? If so give details (Details of the claim to be mentioned)	
14. Are any pre-existing illnesses/habits mentioned in the hospital record? Any other pertinent matter in relation to the health insurance claim made:	
15. Your recommendation as to rejection of claim	

Date:

Signature of the Investigating Official

Name:
Designation:

Address:

PERIODICAL MIS STATEMENTS FROM THIRD PARTY ADMINISTRATORS - CLAIMS					
S.N o	State ment Identity	Statement Details	Offic e	Period	Date to be submitted
1	Annexure C-1	Claims Performance Review of TPA (Consolidated Divisions)	CO	Monthl y	Before 5 th working day after month under review
2	Annexure C-2	Claims Performance Review of TPA for the Division	DO	Monthl y	Before 5 th working day after month under review
3	Annexure C-3	Statement of Claims Intimated/Processed	CO	Monthl y	Before 5 th working day after month under review
4	Annexure C-4	Statement of Claims Intimated/Processed for the Division	DO	Monthl y	Before 5 th working day after month under review
5	Annexure C-5	Statement of Outstanding Claims for all Divisions	CO	Daily on Websit e	
6	Annexure C-6	Statement of Outstanding Claims for the Division	DO	Daily on Websit e	
7	Annexure C-7	Summary of Claims Intimated/Processed	CO	Monthl y	Before 5 th working day after month under review
8	Annexure C-8	Statement of Claim Master data files sent to CO	CO	Monthl y	Before 5 th working day after month under review
9	Annexure C-9	Details of the Claim Investigation by TPA on policies of all Divisions	CO	Monthl y	Before 5 th working day after month under review
10	Annexure C-10	Details of the Claim Investigation by TPA on policies for the Division	DO	Monthl y	Before 5 th working day after month under review
11	Annexure C-11	Statement of Claims admitted- data Required for Actuarial Purposes (Principal Insured)	CO	Quarter ly	Before 5 th working day after Quarter under review
12	Annexure C-12	Statement of Claims admitted- data required for Actuarial Purposes (Spouse Insured)	CO	Quarter ly	Before 5 th working day after Quarter under review
13	Annexure C-13	Statement of Claims admitted- data required for Actuarial Purposes (Child Insured)	CO	Quarter ly	Before 5 th working day after Quarter under review
14	Annexure C-14	Statement of High amount of Claims paid for the Diseases	CO	Quarter ly	Before 5 th working day after Quarter under review
15	Annexure C-15	Statement of Claims Analysis (All Claims)	CO	Quarter ly	Before 5 th working day after Quarter under review
16	Annexure C-16	Statement of Repeated Utilization of Benefits by the same Claimant	CO	Quarter ly	Before 5 th working day after Quarter under review
17	Annexure C-17	Summary of Claims Paid for the Insured members (Classified)	CO	Quarter ly	Before 5 th working day after Quarter under review
18	Annexure	Statement of Type of Cover, Number of Claims (Individual and	CO	Quarter	Before 5 th working day after Quarter

PERIODICAL MIS STATEMENTS FROM THIRD PARTY ADMINISTRATORS – Other Than CLAIMS				
All Statements are to prepared separately for each Region				
S. No.	Statement Identity (Annexure)	Statement Details	to be sent to : Divisional Office (copy to Zonal Office)	to be sent to : Zonal Office (copy to Central Office)
1	A - 1	Statement of Grievances received and disposed and Action taken Report on Grievances received by the TPA for the month	DO/ copy to ZO	
2	A - 2	Statement of Scanned Images received from the Divisions for the month	DO/ copy to ZO	
3	A - 3	Statement of Call Center Analysis for the month	DO/ copy to ZO	
4	B - 1	Summary of Division-wise Statement of Grievances received and disposed and Action taken Report on Grievances received by the TPA for the month		ZO/ copy to CO
5	B - 2	Summary of Division-wise Statement of Scanned Images received from the Divisions for the month		ZO/ copy to CO
6	B - 3	Summary of Division-wise Statement of Call Center Analysis for the month		ZO/ copy to CO
7	B - 4	Statement of Division-wise Issue of TPA Booklet for the month		CO