कर्मचारी राज्य बीमा निगम
वरिष्ठ राज्य चिकित्सा आयुक्त कार्यालय,
पंचदीप भवन, नन्दा नगर, इंदौर-452011 म.प्र.
फोन/फ़ैक्स :0731-2572560, ई-मेल :smc-mp@esic.in

क.रा.बी.निगम मध्यप्रदेश क्षेत्र में द्वितीयक चिकित्सा उपचार प्रदाय करने हेतु प्रस्ताव का आमंत्रण

कर्मचारी राज्य बीमा निगम अपने हितग्राहियों को निम्नलिखित केन्द्रों में एक वर्ष के लिए द्वितीयक चिकित्सा उपचार सुविधाएं **(Secondary Medical Care)** उपलब्ध करवाने हेतु प्रतिष्ठित चिकित्सा संस्थाओं के साथ गठबंधन व्यवस्था **(Tie-up arrangement)** हेतु निम्नांकित जिला मुख्यालय केंद्रों में कार्यरत संस्थाओं से प्रस्ताव आमंत्रित करता है:-

केन्द्रः- 1. सीहोर 2. राजगढ़ 3. अनूपपुर 4. दतिया 5. नरसिंहपुर 6. छिंदवाड़ा 7. गुना 8. छतरपुर 9. अशोक नगर 10. शिवपुरी 11. हरदा 12. आगर मालवा 13. अलीराजपुर 14. बालाघाट 15. बड़वानी 16. बैतूल 17. दमोह 18. झाबुआ 19. मंडला 20. पन्ना 21. सिवनी 22. सिंगरौली 23. शाजापुर 24. श्योपुर 25. सीधी 26. टीकमगढ़ 27. उमरिया 28. विदिशा 29. डिंडौरी।

अनुबंधित चिकित्सालयों को द्वितीय चिकित्सा प्रदान करने हेतु निम्नानुसार निश्चित भुगतान किया जावेगाः.

अ. मरीज के डिस्चार्ज के समय रु 200/- प्रति मरीज औषधि के मूल्य एंव वितरण हेतु दिये जावेंगे। (द्वितीयक चिकित्सा हेतु भर्ती मरीज CGHS Package/Non-package दरों पर, यदि भर्ती मरीज को दिया गया उपचार CGHS लिस्ट में शामिल नहीं है, तो हॉस्पिटल पैकेज रेट का 15% कटौत्रा करने के उपरांत देय होगा। स्टेंट का 15% एंव दवाईयों का 10% कटौत्रा उपरांत भुगतान देय होगा)

ब. O.P.D. प्रकरणों में परामर्श, जाँच एंव उपचार (औषधि का मुल्य एंव वितरण सहित) रु.450/- प्रति विजिट, प्रति रोगी अनुबंधित चिकित्सकों को सेवा प्रदान करने हेतु दिया जावेगा।

उल्लेखनीय है कि Chronic illness जैसे- रक्तचाप, मधुमेह एंव ह्रदय रोग जैसी समस्याओं के लिए औषधियाँ कर्मचारी राज्य बीमा सेवाएं तंत्र से प्राप्त की जा सकेगी।

ऊपर वर्णित सभी केन्द्रों पर द्वितीयक चिकित्सा उपचार एवं निदान का प्रदाय सी.जी.एच.एस.दरों/कराबी निगम द्वारा समय-समय पर जारी दिशा निर्देशों पर उपलब्ध रहेगा। उक्त केन्द्रों पर अनुबंध हेतु इच्छुक चिकित्सालय, अपने प्रस्ताव सहित अस्पताल विवरण स्टाफ सुविधाएं संस्थागत चिकित्सा एवं पैकेज रेट तथा अन्य शासकीय संस्थानों से गठबंधन के विवरण आदि सहित निर्धारित प्रारूप में आवेदन समस्त आवश्यक संलग्नकों सहित वरिष्ठ राज्य चिकित्सा आयुक्त कार्यालय, कर्मचारी राज्य बीमा निगम, ''पंचदीप भवन'', नंदानगर, इन्दौर-452 011 को दिनांक 23.01.2017 की सायं 6.00 बजे तक स्वयं उपस्थित होकर अथवा रजिस्टर्ड डाक/स्पीड पोस्ट द्वारा भेजे जा सकते हैं। आवेदन-पत्र निम्नलिखित वेबसाईट्स पर उपलब्ध है: www.esic.nic.in, www.esicmp.in

नोटः- अपने आवेदन पत्र के लिफाफे पर "_____ केंद्र हेतु द्वितीयक चिकित्सा उपचार हेतु प्रस्ताव'' आवश्यक रूप से लिखें।

डॉ.के.के.पाल
वरिष्ठ राज्य चिकित्सा आयुक्त - म.प्र., इन्दौर

INSTRUCTION TO SERVICE PROVIDERS

(Please read all terms and conditions carefully before filling the application form and Annexure thereto)

1. Document Acceptance:

Duly filled application with all annexure and required documents/certificates may be sent to the SSMC Office, ESIC, Indore with subject line reading **"EOI FOR EMPANELMENT FOR HOSPITALS FOR SECONDARY CARE TREATMENT SERVICES AT _____ CENTRE IN THE STATE OF M.P.".**

The proposal received after the scheduled date and time shall be summarily rejected.

2. Submission of Request For Proposal:

Please ensure that application form with Annexure I,II & III is submitted in with each page signed by the Proprietor / Partner / Director / Legally Authorized Person (Due authorization to be enclosed, in case of Authorized Person).

The proposal will be out rightly rejected if any technical condition is not fulfilled.

Attested photocopy of necessary certificates (as per Annexure-I) should be attached with the Proposal. Hospitals will be informed about date and time of inspection if required by a duly Constituted Committee on the address given in Document Form.

3. Condition for Empanelment:

Only those applications will be considered for empanelment that fulfills all technical conditions along with satisfactory report of Inspection Committee.

Annexure-I, II & III should be duly filled and signed.

An agreement on stamp paper shall be signed after finalizing verification / physical verification of records / Institution and incidental charges related to agreement shall be borne by the Empanelled Hospital. Agreement will be effective w.e.f. date of signing of the agreement by the ESIC Authority.

APPLICATION FORM

(For empanelment of Hospitals for secondary care treatment)

To,

The Sr. State Medical Commissioner,
Employees' State Insurance Corporation,
Panchdeep Bhavan,
Nanda Nagar, Indore-452011 (M.P.)

Sub: Expression of Interest (EOI) for Empanelment for Secondary Care Treatment (including diagnostic) Services at_____ Centre (Distt.Hqrs) in the State of M.P.

Madam,

In reference to your advertisement in the news paper / website dated _____ , I/ We wish to offer secondary care treatment services for ESI Beneficiaries on cashless basis.

I / We pledge to abide by the terms and conditions as mentioned in advertisement and I / We also certify that the above information as submitted by me / us in Annexure I, II & III is correct and I / We fully understand the consequences of default on our part, if any.

(Name & Signature of the Proprietor/Partner/Director/

Legally authorized signatory)

Place :

Date :

Enclosures: Duly filled Annexure I, II & III.

ANNEXURE-I

Information about the Hospital/ Centre

(To be submitted duly filled along with supporting documents along with the application form for Secondary Care Treatment services)

<table>
<tr><td>1. Name of the Nursing Home/Hospital/Clinic</td><td colspan="4"></td></tr>
<tr><td>2. Registered Address of the Nursing Home/Hospital/Clinic</td><td colspan="4"></td></tr>
<tr><td>3. Contact Number</td><td colspan="4"></td></tr>
<tr><td>4. Email id</td><td colspan="4"></td></tr>
<tr><td rowspan="4">5. Registration Number of the Nursing Home/Hospital/Clinic</td><td>Name of Issuing Body</td><td>Reg No</td><td>Bed as per Reg. Certificate</td><td>Valid upto</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="2">Number of ICU Beds</td><td colspan="2">Number of Operation Theatres</td></tr>
<tr><td colspan="2"></td><td colspan="2"></td></tr>
<tr><td>6. Biomedical Waste Management</td><td>Name of Issuing Body</td><td colspan="2">Bed as per Reg. Certificate</td><td>Valid upto</td></tr>
<tr><td></td><td></td><td colspan="2"></td><td></td></tr>
<tr><td>8. AERB/PNDT Certificate</td><td colspan="2">Name of Issuing Body</td><td colspan="2">Valid upto</td></tr>
<tr><td></td><td colspan="2"></td><td colspan="2"></td></tr>
<tr><td colspan="5">9. Type of Firm(Tick √ wherever applicable & attach documentary proof)</td></tr>
<tr><td>Public Ltd</td><td></td><td>Partnership</td><td colspan="2"></td></tr>
</table>

Private Ltd		Society	
Proprietorship		Others (Please Specify)	
10. PAN number of the Hospital/Owner(Attach self attested copy of PAN card)			
11. TAN/CST/VAT number (Attach self attested copy)			

12. Key Person Details (Owner/Proprietor/Partners/Directors)

Name & Designation	Contact Number	Specimen Signature

13. Details of Authorised Person/Nodal officer (attach authority letter)

Name & Designation	Email id	Contact No.

14. Name of Existing Organisation with whom the Hospital is empanelled (attached relevant valid documents)		
15. NABH Accrideted (if yes attach certificate)		
16. Empanelled with CGHS/ State Govt. / Central Govt. / PSU (attached relevant valid documents)		

18. **Bank Details (Attach Cancelled Cheque)**

Name of Bank	
Name of Account Holder	
Account Number	
IFSC	

19. **Details of the Specialist Doctors-Full Time/Part Time (Attach separate sheet signed by the authorized person)**

Name of the Specialist	Specialty	Registration Number(Attach self attested PG Degree certificate)

20. **Documents to be submitted**	**Attached (Yes/No)**
1. Memorandum of Association and Articles of Association - Booklet (Public/Pvt. Ltd.)	
2. Proprietary Registration Certificate - Notarised (Proprietorship	

3. Partnership deed - Notarised (Partnership)	
4. Society Registration Act Certificate - Notarised (Society)	
5. Copy of PAN card (Self Attested)	
6. Copy of TAN/VAT/CST certificate (Self Attested)	
7. Self attested copy of PG degree certificate of all Specialist (Full Time/Part Time) attached with the Hospital	
8. Copy of Cancelled Cheque	
9. Valid Nursing Home registration Certificate (Self Attested)	
10. Self attested copy of AERB/PNDT Certificate	
11. Biomedical Waste Management Certificate **or** Undertaking on Rs.100 stamppaper that same will be complied within 4 months after signing the MOU **or** NOC from the Local Body	
12. Fire NOC/ Fire clereance Certificate **or** Undertaking on Rs.100 stamppaper that same will be complied within 4 months after signing the MOU **or** NOC from the Local Body	
13. List of available major equipments. **(Separate sheet to be attached).**	
14. Daily and monthly number of inpatients specialty wise (separate sheet to be attached)	

Date:

Place:

(Name and signature of proprietor/Partner/Director
Authorized person with office seal / rubber stamp)

Note 1: Enclosures should be attached in the order as per the information given above.

Note 2: Technical evaluation of the Hospital/diagnostic centers shall be based on information provided by them on the above mentioned points and they shall mandatorily provide documentary proof for the same. No future correspondence shall be entertained in this regard. An Inspection committee will visit these Hospitals/Diagnostics Centers for inspection if recommended by the Evaluation Committee constituted for the evaluation of proposals.

ANNEXURE-II

Specialties for Empanelment

(Tick the specialties in which empanelment are desired by Hospital/centre)
Name of the Hospital:

Specialty Treatment:

1. General Medicine
2. General Surgery
3. Obstetrics and Gynecology
4. Pediatrics
5. Orthopedics
6. ENT
7. Ophthalmology
8. Imaging and in-house diagnostic facilities
9. Dental Specialty
10. Blood Bank
11. Others, if any

Date:
Place:

(Name and signature of the proprietor /
authorized person with office seal / rubber stamp)

ANNEXURE- III

UNDERTAKING

I / We _____(name of proprietor/Owner/Legally authorized signatory) have carefully gone through and understood the contents of the Document form and I / We undertake to abide myself / ourselves by all the terms and conditions set forth. I / We are legally bound to provide services to ESIC Beneficiaries as per rates / terms and conditions of Tender documents failing which Sr. State Medical Commissioner, Regional Office, ESI Corporation, Indore is liable to take action as deemed fit. I / We undertake to provide uninterrupted services or alternative arrangement will be made at the risk of our institute.

I / We have gone through the CGHS rates, terms and conditions available on CGHS website and ESIC rates.

I / We undertake that the information submitted along with document and ANNEXURE I & II is correct and also fully understand that in case of default security money will be forfeited.

I / We certify herewith that my/our empanelled / Hospital / diagnostic centre has never been de-empanelled / black listed by ESIC / CGHS or any other Govt. Institution / PSUs in the last three years.

Dated:
Place:

Signatures (With seal/rubber stamp)
Name: