R KUSELAN Vs ORIENTAL INSURANCE CO LTD

Court: NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION

Date of Decision: May 4, 2007

Citation: 2008 4 CPJ 365

Hon'ble Judges: K.Sampath , PonGunasekaran J.

Advocate: Nageswaran , S.Kaithamalai Kumaran , T.Chidambaram

Judgement

1. -THE complainant in O. P. No. 262 of 2003 on the file of the District Forum, Chennai (North) is the appellant herein.

2. THE case of the complainant was as follows : He was a member of the Group Insurance Mediclaim of O. P. 1 company as per letter dated 12.

11. 1998. He was under treatment with O. P. 2 from 28. 6. 2000. He got admitted as an in-patient in O. P2"s Nursing Home on 4. 7. 2000 and

was discharged on 5. 7. 2000. The application for reimbursement of the medical expenses incurred by the complainant was rejected by the first

opposite party. Alleging defective and deficient service against the opposite parties, the complaint came to be filed.

Opposite party Nos. 1 and 3 filed a version to the following effect : The complainant had not submitted any certicicate from the hospital to the

effect whether it was registered with the local authorities as prescribed in the claim form itself. Murugan Hospital where the complainant got treated

was not a registered one. He had submitted an incomplete certificate issued by O. P. 2. O. P. 3"s representative visited Murugan Nursing Home

and had confirmed that the said hospital did not admit the complainant for any treatment. The complainant was requested to send a complete

certificate giving particulars at a timelimit. As there was no response, the file was closed. There was no deficiency in service.

Opposite party No. 2 filed a version stating that the complaint against him was not maintainable. It was barred by limitation as the complainant was

treated by the opposite party on 5. 7. 2000, the complainant would not expect O. P. 2 to issue false certificate to the whims and fancies of the

patient contrary to the actual situation.

3. BEFORE the District Forum on the side of the complainant. Ex. A1 to Ex. A33 were marked while on the side of the opposite parties Ex. B1

and Ex. B2 were marked.

The District Forum found that as per conditions of the Group Medical Scheme for E. P. F. Pensioner Association one has to submit a certificate

from the hospital or nursing home where he had taken treatment as to whether that hospital was registered with the local authorities or whether it

was provided with 15 bed facilities; that the complainant had not produced any evidence to show that he had submitted the relevant certificate or

complied with the requests. In that view of the matter, by order dated 3. 9. 2004, the District Forum dismissed the complaint.

4. IT is as against that the present appeal has been filed.

On behalf of the complainant/appellant, learned Counsel, Mr. T. Chidambaram, made the following submissions : When the hospital was not a

registered one, then a certificate had to be issued by the hospital as per Clause 6. 1 of the Mediclaim rules of O. P. 1. The complainant had

obtained and forwarded the required certificate issued by O. P. 2 and this had been overlooked by the District Forum. O. P. 2 had issued a

misleading and defective certificate twice in spite of the complainant''s representation and in spite of the fact that O. P. 2 fulfilled all the

requirements. A proper reading of the version filed by O. P. 1 would show that all the required conditions stipulated by O. P. 1 were satisfied. O.

P. 2 resided at the very next door of the hospital and he had attended the emergency case during night time and round the clock and this fulfilled

the condition that the hospital should have 24 hours emergency service. He had also admitted in his version that nurses were available round-the-

clock, as also himself. This satisfied the conditions required by O. P. 1. He had also said that considering the nature of treatment of the complainant

and the facilities in Nursing Home being sufficient had treated him. Only when any patient required surgery/the medical operation purposes, the

patient had to go to larger nursing home and District Forum was in error in holding on the basis of what O. P. 3 had furnished as report; that he

was not admitted or treated by O. P. 2. O. P. 2 had denial that he made any such statement and on the contrary he had in his version stated that he

indeed treated the complainant. There was also no dispute with regard to the actual expenses incurred by the complainant. The complainant had

asked merely for the refund of the money he had actually spent and O. P. 1 was under an obligation to reimburse the said amount as per the terms

of the policy.

Mr. Nageswaran, learned Counsel for O. Ps. 1 and 3 submitted as follows : Condition No. 6 of the Scheme contained a ''definition clause'' and

according to that hospital/nursing home meant any institution in India established for indoor care and treatment of sickness and injuries and which

either (a) has been registered as a hospital or nursing home with the local authorities and under the supervision of a registered and qualified medical

practitioner or (b) should comply with minimum criteria as under : (i) it should have at least 15 in-patients beds: (ii) fully equipped operation theatre

of its own wherever surgical operations are carried out; (iii) fully qualified nursing staff under its employment round-the-clock; (iv) fully qualified

Doctors should be in charge round-the-clock. The complainant did not attend a hospital eligible to be covered by the policy. He submitted his

claim on 11. 7. 2000, but did not submit any certificate from the hospital as to whether it was registered with the local authorities as prescribed in

the claim form. The complainant had taken treatment for Lumbosacral Rasiculopathy and Cerebrou Asculari Insufficiency at Murugan Nursing

Home, which was not a registered one. Under condition 6. 1 of the scheme, if the hospital was not registered with the local authorities a certificate

from the hospital/nursing home should be obtained where the treatment was taken. O. P. 1 vide letter dated 26. 7. 2000 informed the complainant

to produce the said certificate. A certificate from O. P. 2 was produced. O. P. 2 issued two different certificates. In one certificate item Nos. 2

and 3 were scored out and in another certificate dated 14. 8. 2001 except Item No. 1, all the three items were scored out. Those two certificates

were not sufficient for processing the claim of the complainant. Thereafter O. P. 1 requested O. P. 3 to investigate whether the complainant was

admitted in the hospital on 4. 7. 2000. The representative from O. P. 3 reported that he had confirmed that the said hospital did not admit the

complainant for any treatments as informed vide their letter dated 8. 2. 2002. O. P. 1 made a request to the complainant to give particulars by

letter dated 23. 10. 2000. It was followed by another letter dated 2. 8. 2001 and in that letter it was stated that if no reply was received within 15

days they would close the claim. The final reminder was sent on 31. 12. 2001. There was no compliance. The file was, therefore, closed. Finally

O. P. 1 sent a letter on 21. 1. 2002 stating that due to non-compliance of the request to forward the certificate the claim was being closed as ""no

claims"". The District Forum had rightly dismissed the complaint and the same had to be confirmed.

5. LEARNED Counsel for O. P. 2 submitted as follows : Since O. P. 2 lived in the adjoining premises, he provided round-the-clock cover for his

patients, and, therefore, had not employed any junior doctors to assist him, and the only assistance was from nurses, who were also available

round-the-clock. Patients who claimed reimbursement from their employers or Insurance Companies were advised before admission, to get

admitted into the nursing home satisfying the criteria laid down by their employer or Insurance Company. O. P. 2 treated the complainant on 27. 6.

2000 that Cerebrovasclar Insufficiency + Lumbosacral Rasiculopathy. He was treated as an out-patient. O. P. 2 gave him medicines,

physiotherapy including spinal tractions. The treatment was as an out-patient. It was continued till 1. 7. 2000. The complainant requested O. P. 2

to admit him in the nursing home, since he found relief from the on going treatment, but, found it very difficult to travel every day for his treatment

from his house in Madhavaram to Anna Nagar. Therefore, considering the nature of treatment of the complainant and the facilties in the nursing

home being sufficient in treating him, he was admitted in O. P. 2 nursing home on 4. 7. 2000. After taking treatment with good relief from the pain

complained of, he was discharged on 5. 7. 2000, and a discharge summary and a consolidated receipt for all the fees received issued. Neither at

the time of admission as an in-patient, nor at the time of discharge, did the complainant request for any certificate for reimbursement of the

expenses incurred under a Mediclaim Scheme. Subsequently the complainant met O. P. 2 and requested his counter-signature on a medical

insurance claim form for reimbursement of the expenses for the treatment undergone. O. P. 2 told the complainant that his nursing home did not

satisfy all the criteria laid down for such reimbursement, but to the extent of the facilities provided by O. P. 2''s nursing home, he filled up the

certificate, after deleting item Nos. 2 and 3 provided in the claim form relating to 24-hour emergency service and fully equipped operation theatre

since these facilities were not available with O. P. 2 and modifying serial item No. 4 to the extent it was met by O. P. 2''s nursing home. The

appellant received the certificate and after one year the complainant wrote a letter dated 10. 8. 2001 stating he was not able to get reimbursement

from the Insurance Company and asked for a fresh certificate without deleting any item as was done previously since the certificate was only a

formality and would have no adverse effect on anybody. However, O. P. 2 did not concede the request but gave a certificate as had been done by

him previously.

6. THE District Forum had dismissed the complaint against O. P. 2 and also against O. Ps. 1 and 3 finding that there was no deficiency in service.

We have gone through the materials on record. We are pained by the technicalities raised by O. Ps. 1 and 3. The fact remains that the complainant

did undergo treatment with O. P. 2 and in fact he was admitted in his hospital for two days as in-patient. That he had incurred the expenses is not

disputed. What O. P. 3 had reported that he was not an in-patient and that this information had been gathered by a representative of O. P. 3 from

O. P. 2 cannot be correct. As even according to O. P. 2 the complainant had undergone treatment as in patient for two days. It is not disputed that

O. P. 2 is a qualified registered practitioner. He had been practising for 40 years as a doctor. He had treated the complainant. He had received

fees. For the expenses paid by the appellant, he had passed a receipt which was also given to O. P. 1. Without considering the claim of the

complainant in the proper perspective, O. Ps. 1 and 3 had raised technical objections, which, in our view, was totally uncalled for. A person got

treatment. He was covered by the policy. He had paid the doctor who treated him. The doctor also had passed a receipt and to dispute the claim,

by raising some outdated clauses in the insurance policy to say the least is unethical. Consequently we do not agree with the conclusion reached by

the District Forum.

In the result, the appeal shall stand allowed; the complaint shall stand allowed. There will be a direction to the first opposite party to process the

medical claim application form and reimburse Rs. 6078. 30 with 12% interest from 1. 8. 2000 together with a cost of Rs. 2,000. Time for

payment: Two months. Appeal allowed.