Checklist for Medical Tourism Facilitator

PART –I

(Technical and infrastructure specifications of the Organization)

1. Name of the Organization:

……

2 A. Complete address of the registered office:

City/Town: **……..**

Locality: **……..**

District: **……..**

State: **……**

Website**……**

Pin code**……**

Landmark**……..**

2 B. Complete address of the operational office (*if different from the above*)

City/Town: **……..**

Locality: **……..**

District: **……..**

State: **……**

Website……

Pin code……

Landmark……

3. Contact person(s) details:

- Head of the Organization: (or equivalent) ☐

  Mr. /Ms. /Dr. _____

  Designation: _____

  Tel: _____ Mobile_____

  Fax: _____ E-mail: _____

- Coordinator: (For regular correspondence if other than the above) ☐

  Mr. /Ms. /Dr. _____

  Designation: _____

  Tel: _____ Mobile_____

  Fax: _____ E-mail: _____

- Contact details in case of emergency:

  Mr. /Ms. /Dr. _____

  Designation: _____

  Tel: _____ Mobile_____

  Fax: _____ E-mail: _____

4. Location of Organization:

A. I. Metro ☐ II. Non-Metro: Urban ☐ Rural ☐

B. Does organization have branches other than head office: Yes / No

If yes, then enlist them……..

C. Does organization have overseas branches: Yes / No

If yes, then enlist them……..

D. Does Organization have MOUs with any overseas affiliate: Yes / No

If yes, then enlist the name of the countries.

5. Ownership: (The organization working as a medical tourism facilitator shall be legally identifiable and registered in India)

☐ Sole proprietorship ☐ Partnership ☐ Private limited Company

☐ Limited liability Company ☐ Public Limited Company ☐ Society

☐ Trust

Others (describe)……

6. Name of the registering authority with the date of registration (dd/mm/yyyy)

……

Note: (Please attach a copy of the official certificate of registration)

7. Year and month in which operations started:

……

8. What are the normal business working hours?

……

9. Provide details of the following:

A. PAN Number ……

B. TAN Number ……

C. Service Tax Number ……

D. ITR of the latest financial year: Yes ☐ No ☐

If yes then please attach a copy of acknowledgement for filling

PART- II: Statuary Compliance Information

1. Legal Consultation: Provide the details for each of the following elements

A. Does facilitator provides legal consultation services: Yes ☐ No ☐

B. If yes then specify whether the facilitator has MOUs with legal consulting firms or individuals: Yes ☐ No ☐

PART-III: Organization Information

1. Whether Organization has its:

A. Vision: Yes ☐ No ☐

B. Mission: Yes ☐ No ☐

C. Objective: Yes ☐ No ☐

If yes then specify it

……

……

……

2. Organogram / Organizational chart available: Yes ☐ No ☐

If yes, then attach the Organogram

……

3. Business Promotional Activities/Plan:

A. Business marketing plan: Yes/No

If yes then provide details for each of the followings:

I. Overseas business plan: Yes ☐ No ☐

(If yes then attach copy of policy & procedures addressing business marketing)

II. Brand awareness by advertising for execution of business: Yes / No

4. Manpower details:

A. Total number of employees working in the Organization ……..

B. Number of Full time staff: ……..

C. Number of Part time (contractual & outsourced) staff: …….

D. Details of the above employees:

Name of the Employee	**Designation**	**Qualification**	**Relevant Experience (in Years)**	**Full Time/Part time**	**Foreign Languages Known if any**

Note 1: Minimum of 3 full time staffs are required, at least one person should be a graduate or equivalent with minimum 1 year experience in healthcare/tourism industry.

Note 2: Provide details of additional qualifications if any.

E. Facility for language translators: Yes/No

I. If yes then provide details: Empaneled ☐ Hired ☐

II. Mention details about the translators:

Sl. No.	Name of the Translator	Empaneled /hired	languages Known

Note: The facilitator should possess the MOUs signed between the organization & translator.

6. Staffs trained in: Tick whichever is applicable

A. Communication ☐

B. Etiquettes ☐

C. Foreign currency ☐

D. Visa Rules ☐

E. Basic Medical Terminology ☐

F. Basic Computer knowledge & skills ☐

(Note: Staff's training on the above mentioned topics relevant to the procedures/hospitals should depend on their assigned job responsibilities**)**

7. Facilities at office: Tick the appropriate option

A. Office Building: Owned ☐ Rented ☐

(*Note:* If rented provide a copy of rent agreement**)**

B. Office has help desk, reception, & separate space for storing client documents? ☐ ☐

Yes No

C. Office has Basic facilities like computer, Photocopy, Scanner and Fax:

Yes ☐ No ☐

D. Reception has waiting area for relatives and attendants: Yes ☐ No ☐

E. Availability of potable water: Yes ☐ No ☐

F. High speed Internet connectivity: Yes ☐ No ☐

G. All applicable software & application license: Yes ☐ No ☐

If yes then kindly attach the proof of the same.

PART-IV: Facilities Provided by the Organization

A. Mention list of hospitals that are empaneled with the Organization:

Sl No.	City	Name of the hospital	Accredited/Non Accredited	*Procedures being offered	Range of Procedural Package rate

*Facilitator should provide a list of 10 most common procedures for clients.

Note: Organization must possess MOUs with all the empaneled hospitals for their services

B. Does Organization has defined package rate for the following:

I. Treatment procedures being offered: Yes ☐ No ☐

II. Additional services as per the requirement of the clients: Yes ☐ No ☐

III. Any discount offered on whole package: Yes ☐ No ☐

If yes then provide details of the documented policies for the discount package offered.

C. Does the facilitator have a documented policy for recommendation about a hospital to the client? : Yes ☐ No ☐

D. Any rating criteria being used for recommendation: Yes ☐ No ☐

2. Travel facilitation services being offered: Yes / No

A. If yes then specify details:

I. Flight Tickets: Yes ☐ No ☐

II. Local Transport: Yes ☐ No ☐

III. Visa-assistance: Yes ☐ No ☐

IV. Privileged airport pick-up and drop off facility: Yes ☐ No ☐

V. Does facilitator provide vehicle for commuting, to the clients as per their requirements? Yes ☐ No ☐

If yes then specify whether the pre-determined vehicle hiring charges are available or not? Yes ☐ No ☐

VI. Provide facilities as per need of the patients: Yes / No

If yes then mention the services offered:

Ambulance: Yes ☐ No ☐

If yes then specify whether the trained staff for ambulance are available or not?
Yes ☐ No ☐

Wheelchair: Yes ☐ No ☐

Stretcher: Yes ☐ No ☐

B. Travel arrangements for clients made by:

☐ Owned travel agency ☐ Collaborated travel agency others ☐

C. Travel agency registered or not? Yes / No

If yes then specify the registering authority:

I. Transport Authority: Yes ☐ No ☐

II. If any other authority specify…….

(Attach a copy of registration certificate as an evidence)

(Note: Organization must possess MOUs with all the collaborated travel agencies for their services**)**

3. Patient Counselling Service: Tick whichever is applicable

A. Pre-appointment services with doctors: Yes ☐ No ☐

B. Accommodation services for the patients and attendants: Yes ☐ No ☐

If yes then mention the types of accommodation facilities offered:

☐ ☐

Registered Guest house: Yes No

Registered Paying Guest (PG): Yes ☐ No ☐

Registered Hotels: Yes ☐ No ☐

Others (describe): ……..

Note: (The facilitator organization should possess a copy of the registration certificate for the hotels/guest house/P.G with the local applicable authorities)

C. Provision of food arrangements as per the requirement of the clients:

Guest house: Yes ☐ No ☐ Paying Guest (PG): Yes ☐ No ☐

Hotels: Yes ☐ No ☐

Others (describe): ……..

Note: (The Organization shall assure that the quality of the food provided to the clients are certified by local food safety officer. For this organization must possess food safety approval certificate issued from concerned authority as per law of the state)

D. Follow up services upon return: Yes ☐ No ☐

4. Any other additional Services provided by the Agency:

A. Wellness center and Spa Facility: Yes ☐ No ☐

If yes then elaborate on services being offered
……..
……..
……..

B. Provide facilities for local sight-seeing excursions with staff/registered guide: Yes ☐ No ☐

PART V: Privacy Policy & Procedures

A. Organization has policy regarding confidentiality and privacy of client information: Yes ☐ No ☐

B. Does Organization provide details of the liabilities arising out of the facilitation service? Yes ☐ No

C. Disclaimer's policy: Yes ☐ No ☐

(***Note:*** Attach a copy of privacy policy and procedures**)**

PART VI: General Policy & Procedures

A. Whether the organization follows fair distribution principle for selecting most appropriate associated hospital for clients? Yes ☐ No ☐

If yes then specify the principle used

……
……
…….

B. Tick the factors most commonly used by the Organization for selection of most appropriate hospital:

A) Scope of service: Yes ☐ No ☐ B) Cost: Yes ☐ No ☐

C) City: Yes ☐ No ☐ D) Support facilities: Yes ☐ No ☐

E) Testimonials from the users: Yes ☐ No ☐

Any others (describe)…….

Note: At any time during the screening process, clients may decide to choose the desired hospital of his/her choice from available option and the facilitator should have documentary evidence of the same.

C) Payment Procedures:

1. Specify the mode of payment the organization accepts from the hospitals: Tick the appropriate one

A) Net Banking: Yes ☐ No ☐

B) Credit card/Debit card: Yes ☐ No ☐

C) Bank Transfer: Yes ☐ No ☐

D) Cheque: Yes ☐ No ☐

Note: (The organization must notify clients that cash payment for any services is not acceptable)

2. Does facilitator provide a detailed quotation of the package cost as per the requirement of the client? Yes ☐ No ☐

I. Does the package include cost incurred for the attendants? Yes ☐ No ☐

If yes then mention the payment method adopted for services offered:

A) **For hospital facilities**: Tick whichever is applicable

I. Directly between hospital & clients: Yes ☐ No ☐

II. Paid to hospital through facilitator: Yes ☐ No ☐

Note: (Kindly provide the details of the entire process in each of the above case)

B) **Lodging & other facilities**:

I. Details of advance payment **(in percentage)** accepted by the facilitator after client approval:

☐ 10-20 20-30 ☐ 30-40 ☐ 40-50 ☐

C. Does Organization have policy regarding payment settlement including service charge: Yes ☐ No ☐

I. If yes then provide details of Facilitation service charge (in percentage):

Sl No.	Types of services being offered	Approximate range of Service Charge (Percentage of gross bill)

PART VII: Organization Responsibilities

A. Website Requirements: Whether website contains following information.

1. Vision and Mission: Yes ☐ No ☐

2. Various services being provided: Yes ☐ No ☐

3. Information about extra services:

☐ Local Tours & sightseeing ☐ Spa & wellness ☐ Guide facilities

☐ Other recreational activities

4. User information manual: Yes ☐ No ☐

5. Availability of standard package rates for different types of services provided: Yes ☐ No ☐

6. Details of the payment mechanism options: Yes ☐ No ☐

7. Availability of help desk (24 x 7): Yes ☐ No ☐

8. Frequently asked questions (FAQs) and answer to all the queries raised by the visitors? Yes ☐ No ☐

9. Information regarding hospitals: Yes ☐ No ☐

10. Additional charges on account of complication if any: Yes ☐ No ☐

11. Information about the liabilities arising out of facilitation service:

Yes ☐ No ☐

B. Security, Archival & Retention Policy of Patient Documents & Records

1. Archival & Retention policy for all the records: Yes/No

2. The facilitator has a laid down policy & procedure for maintaining the confidentiality of the patient & their information: Yes ☐ No ☐

If yes then attach the copy of policy & procedures.

C. Complaint Redressal system:

1. Organization has Complaint redressal system: Yes ☐ No ☐

If yes, then specify the following:

A. Organizational policy and procedures for the resolution of complaints or feedback from clients & Companion: Yes ☐ No ☐

B. Available predefined format and content of complaint/feedback form:

Yes ☐ No ☐

D. Continual Quality improvement:

I. Records of processing time for each patient: Yes ☐ No ☐

II. Corrective action taken for complaints, feedback and nonconformance after root cause analysis: Yes ☐ No ☐

E. Internal audit/ Self-Assessment:

1. The organization has documented plan & procedures for internal audit of the services being offered (At least twice in 12 months): Yes ☐ No ☐

If yes then, name the person responsible for organizing and carrying out audit.

……..

2. The organization has documented plan & procedures for management review: (At least once in 12 months): Yes ☐ No ☐