+91 77805 06670
www.healthcarepartner.in
support@healthcarepartner.in

HOSPITAL NETWORK PARTNERSHIP MEMORANDUM OF UNDERSTANDING (MOU)

Date:____ / ____ / 20____

To,
The Management / Authorised Representative

Hospital Name: _____

Hospital Address: _____

Subject: Request for Hospital Network Partnership with HCP

Dear Sir/Madam,

We are pleased to request your esteemed hospital to associate with Healthcare Partner Network Private Limited (HCP) as a Network Hospital, for providing healthcare services and agreed benefits to eligible HCP members.

HCP aims to connect its members with reputed hospitals and healthcare providers and facilitate access to quality healthcare services at mutually agreed benefits.

1. PURPOSE

The purpose of this MOU is to establish a partnership between HCP and the Hospital, whereby eligible and active HCP members may avail the agreed healthcare services and benefits at the Hospital, subject to the terms of this MOU.

2. SERVICES & AGREED BENEFITS

The Hospital agrees to provide the following benefits to eligible HCP members:

Healthcare Service	HCP Member Benefit
Doctor Consultation	____ %
Diagnostics / Lab Services	____ %
Hospitalisation (IP)	____ %
Medical Bills / Pharmacy	____ %
Surgery / Procedures	____ %
Emergency Care	____ %
Other Services (if any)	_____

The final benefits may be mutually agreed and updated in writing by both Parties.

3. HCP MEMBER VERIFICATION

HCP members shall present a valid HCP Membership ID / Digital HCP Card / QR Code / OTP or other verification provided by HCP. Benefits shall be provided only to members having a valid and active HCP membership.

4. KEY TERMS & CONDITIONS

4.1 HCP benefits are applicable only to valid and active HCP members.
4.2 Benefits shall apply only to the services mentioned above and mutually agreed by both Parties.
4.3 Benefits shall not apply to insurance-covered cases, implants, consumables, outsourced services, statutory/government charges, special packages or other mutually agreed exclusions.
4.4 Hospital billing shall be directly between the Hospital and the patient/member. HCP membership fees are separate from Hospital medical bills.
4.5 The Hospital shall provide healthcare services in accordance with applicable laws, regulations and professional standards.
4.6 All medical decisions, diagnosis, treatment, surgery, prescriptions and clinical decisions shall remain solely under the independent professional judgment of the Hospital and its doctors.
4.7 HCP shall not be responsible for medical negligence, treatment outcomes, clinical decisions or medical services provided by the Hospital or its healthcare professionals.
4.8 Both Parties shall maintain confidentiality of member/patient information and use it only for lawful and authorised purposes.
4.9 HCP may identify and promote the Hospital as an "HCP Network Hospital / Partner Hospital" for member awareness, using the Hospital's approved name and logo.
4.10 No referral commission or percentage of Hospital billing shall be payable to HCP unless separately agreed in writing and permitted by applicable law.
4.11 This MOU shall be valid from _____ to _____.
4.12 Either Party may terminate this MOU by giving 30 days prior written notice to the other Party.
4.13 This MOU is non-exclusive. Both Parties are free to associate with other organisations/hospitals.
4.14 Any amendment to this MOU shall be made in writing and accepted by authorised representatives of both Parties.
4.15 Both Parties agree to cooperate in good faith for the benefit of HCP members.

5. ACCEPTANCE & AGREED

We hereby confirm our acceptance of the above terms and agree to partner with HCP.

For Healthcare Partner Network Private Limited (HCP)

Name: _____

Designation: _____

Signature: _____

Date: ____ / ____ / 20____

Company Seal:

Healthcare Partner Network Pvt. Ltd. Peddapalli

For Hospital

Hospital Name: _____

Legal Entity Name: _____

Authorised Signatory: _____

Designation: _____

Signature: _____

Date: ____ / ____ / 20____

Hospital Seal

HOSPITAL CONTACT DETAILS

Contact Person: _____
Designation: _____
Mobile: _____
Email: _____

HCP CONTACT DETAILS

Healthcare Partner Network Private Limited
H.No. 3-237, Peddapalli Main Road,
Manthani, Peddapalli, Telangana, India.
+91 77805 06670
support@healthcarepartner.in www.healthcarepartner.in

Note: _____