

PART – A CLAIM FORM
TO BE FILLED IN BY THE INSURED

The issue of this Form is not to be taken as an admission of liability
(To be filled in block letters)

DETAILS OF PRIMARY INSURED																								
a) Policy No.										b) Sl. No./Certificate No.														
c) Company/TPA ID No.																								
d) Name																								
e) Address																								
City																								
State																				Pin Code				
Ph. No.																				Email ID				

DETAILS OF INSURANCE HISTORY																																		
a) Currently covered by any other Medicaclaim/Health Insurance																				Yes		No												
b) If yes, Company Name																																		
Policy No.																				Sum Insured ()														
c) Date of commencement of first Insurance without break															DD / MM / YYYY					(Copies of Policies to be attached)														
d) Have you been hospitalized in the last 4 years? (since inception of the contract)															Yes		No		Date		DD / MM / YYYY													
															Diagnosis																			
e) Have you been covered by any other Medicaclaim/Health Insurance in last 4 years																				Yes		No												
f) If yes, Company Name																																		

DETAILS OF INSURED PERSON HOSPITALIZED																																							
a) Name																																							
b) Gender					Male					Female					c) Age					years					months					d) Date of Birth					DD / MM / YYYY				
e) Relationship to Primary insured										Self					Spouse					Child					Father					Mother									
										Other					(Please Specify)																								
f) Occupation										Service					Self-Employee					Homemaker					Student					Retired									
										Other					(Please Specify)																								
Address (if different from above)																																							
City																																							
State																				Pin Code																			
Ph. No.																				Email ID																			

DETAILS OF HOSPITALIZATION																																												
a) Name of Hospital where Admitted																																												
b) Room Category occupied										Day Care					Single occupancy					Twin sharing					3 or more beds per room																			
c) Hospitalization due to										Injury					Illness					Maternity																								
d) Date of Injury/Date of Disease first detected/Date of Delivery																																												
e) Date of Admission										DD / MM / YYYY					f) Time					HH / MM					g) Date of Discharge					DD / MM / YYYY					h) Time					HH / MM				
i) If injury give cause										Self-inflicted					Road Traffic Accident																													
Substance Abuse/Alcohol consumption										i. if Medico legal															Yes		No																	
ii. Reported to police										Yes		No			iii. MLC Report & Police FIR attached										Yes		No																	
j) System of Medicine																																												
k) Date of Surgery										DD / MM / YYYY					l) Claim Intimated										Yes		No																	
i. Intimated to whom										SBU					Intermediaries					Call Centre					Health Claims Team																			
ii. Intimation No. & date																									DD / MM / YYYY																			
iii. If not Intimated, reason?																																												

DETAILS OF CLAIM																								
a) Details of the treatment expenses claimed																								
i. Pre-hospitalization Expenses										ii. Hospitalization Expenses														
iii. Post-hospitalization expenses										iv. Health-Checkup Cost														

v. Ambulance Charges										vi. Others (code)										
vii. Pre-hospitalization period	Days																			
										viii. Post hospitalization period	days									
b) Claim for Domiciliary Hospitalization	Yes	No	(If yes, provide details in annexure)																	
c) Details of Lump sum/cash benefit claimed																				
i. Hospital Daily Cash										ii. Surgical Cash										
iii. Critical Illness Benefit										iv. Convalescence										
v. Pre/Post hospitalization Lump sum benefit										vi. Others										
										Total										
Claim Documents Submitted - Check List										Operation Theatre Notes										
Claim Form Duly signed										ECG										
Copy of the claim intimation										Doctor's request for investigation										
Hospital Main Bill										Investigation Reports (CT/MRI/USG/HPE)										
Hospital Break - up Bill										Doctor's Prescriptions										
Hospital Bill Payment Receipt										Pre-Hosp. Bills										
Hospital Discharge Summary										Post-Hosp. Bills										
Pharmacy Bill										Others										

DETAILS OF BILLS ENCLOSED									
Sl. No.	Bill No.	Date	Issued by	Towards (Hospitalization/Pre-hospitalization/Post-hospitalization)	Amount (₹)				
1		<u>DD / MM / YYYY</u>							
2		<u>DD / MM / YYYY</u>							
3		<u>DD / MM / YYYY</u>							
4		<u>DD / MM / YYYY</u>							
5		<u>DD / MM / YYYY</u>							
6		<u>DD / MM / YYYY</u>							
7		<u>DD / MM / YYYY</u>							
8		<u>DD / MM / YYYY</u>							
9		<u>DD / MM / YYYY</u>							
10		<u>DD / MM / YYYY</u>							

Do you want to opt for Automatic Reinstatement of Sum Insured in the event of a claim? If, Yes, applicable premium at short period rates would be deducted from the claim amount due to you. This reinstated sum will not be available for the same hospitalization. It will be available for treatment (other than certain chronic diseases) including the same illness or disease but separate independent case of hospitalization which are not case of relapse within 45 days of first hospitalization. Please contact the agent/our office for further details:

Yes ☐ No ☐

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT (Please submit a cancelled cheque copy for NEFT)																				
a) PAN										b) Account Number										
c) Bank Name and Branch																				
d) Cheque/DD Payable details										e) IFSC Code										

I hereby declare that the information furnished in this claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent & authorize TPA/Insurance company, to seek necessary medical information/documents from any hospital/Medical Practitioner who has attended on the person against whom this claim is made. I hereby declare that I have included all the bills/receipts for the purpose of this claim & that I will not be making any supplementary claim except the pre/post-hospitalization claim, if any.																			
DECLARATION BY THE INSURED																			

Place: _____

Date: DD / MM / YYYY

Signature of the Insured

Important:

1. Please submit copy of valid Photo ID.
2. For claimed amount above 1 lac, it is mandatory to submit the KYC (Know your customer) form.

CLAIM FORM – PART B
TO BE FILLED IN BY THE HOSPITAL
The issue of this Form is not to be taken as an admission of liability
Please include the original preauthorization request form in lieu of PART A

(To be filled in block letters)

DETAILS OF HOSPITAL

a) Name of the hospital:
b) Hospital ID: c) Type of Hospital: Network ☐ Non Network ☐ (If non network fill section E)
d) Name of the treating doctor:
e) Qualification: f) Registration No. with State Code: g) Phone No.

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient:
b) IP Registration Number: c) Gender: Male ☐ Female ☐ d) Age: Years Months e) Date of birth: :
f) Date of Admission: g) Time: : h) Date of Discharge: i) Date of Delivery:
j) Type of Admission: Emergency ☐ Planned ☐ Day Care ☐ Maternity ☐ k) If Maternity ☐ ii. Gravida Status:
l) Status at time of discharge: Discharge to home ☐ Discharge to another hospital ☐ Deceased ☐ m) Total claimed amount

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a)	ICD 10 Codes	Description	b)	ICD 10 PCS	Description
i. Primary Diagnosis:	<input type="text"/>	<input type="text"/>	i. Procedure 1:	<input type="text"/>	<input type="text"/>
ii. Additional Diagnosis:	<input type="text"/>	<input type="text"/>	ii. Procedure 2:	<input type="text"/>	<input type="text"/>
iii. Co-morbidities:	<input type="text"/>	<input type="text"/>	iii. Procedure 3:	<input type="text"/>	<input type="text"/>
iv. Co-morbidities:	<input type="text"/>	<input type="text"/>	iv. Details of Procedure:	<input type="text"/>	<input type="text"/>

d) Pre-authorization obtained: ☐ Yes ☐ No e) Pre-authorization Number:
f) If authorization by network hospital not obtained, give reason:
g) Hospitalization due to Injury: ☐ Yes ☐ No i. If Yes, give cause Self-inflicted ☐ Road Traffic Accident ☐ Substance abuse / alcohol consumption ☐
ii. If Injury due to Substance abuse / alcohol consumption, Test Conducted to establish this: ☐ Yes ☐ No (If Yes, attach reports) iii. If Medico legal: ☐ Yes ☐ No iv. Reported to Police: ☐ Yes ☐ No
v. FIR no. vi. If not reported to police give reason:

CLAIM DOCUMENTS SUBMITTED - CHECK LIST

- | | |
|--|--|
| <input type="checkbox"/> Claim Form duly signed | <input type="checkbox"/> Investigation reports |
| <input type="checkbox"/> Original Pre-authorization request | <input type="checkbox"/> CT/MR/USG/HPE investigation reports |
| <input type="checkbox"/> Copy of the Pre-authorization approval letter | <input type="checkbox"/> Doctor's reference slip for investigation |
| <input type="checkbox"/> Copy of photo ID card of patient verified by hospital | <input type="checkbox"/> ECG |
| <input type="checkbox"/> Hospital Discharge summary | <input type="checkbox"/> Pharmacy bills |
| <input type="checkbox"/> Operation Theatre notes | <input type="checkbox"/> MLC report & Police FIR |
| <input type="checkbox"/> Hospital main bill | <input type="checkbox"/> Original death summary from hospital where applicable |
| <input type="checkbox"/> Hospital break-up bill | <input type="checkbox"/> Any other, please specify |

DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)

a) Address of the Hospital:
City: State:
Pin Code: b) Phone No. c) Registration No. with State Code:
d) Hospital PAN: e) Number of Inpatient beds f) Facilities available in the hospital: i. OT : ☐ Yes ☐ No ii. ICU : ☐ Yes ☐ No
iii. Others :

DECLARATION BY THE HOSPITAL

(PLEASE READ VERY CAREFULLY)

We hereby declare that the information furnished in this Claim Form is true & correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited.

Date:

Place:

Signature and Seal of the Hospital Authority:

GUIDANCE FOR FILLING CLAIM FORM – PART B (To be filled in by the hospital)		
DATA ELEMENT	DESCRIPTION	FORMAT
SECTION A - DETAILS OF HOSPITAL		
a) Name of Hospital	Enter the name of hospital	Name of hospital in full
b) Hospital ID	Enter ID number of hospital	As allocated by the TPA
c) Type of Hospital	Indicate whether In network or non network hospital	Tick the right option
d) Name of treating doctor	Enter the name of the treating doctor	Name of doctor in full
e) Qualification	Enter the qualifications of the treating doctor	Abbreviations of educational qualifications
f) Registration No. with State Code	Enter the registration number of the doctor along with the state code	As allocated by the Medical Council of India
g) Phone No.	Enter the phone number of doctor	Include STD code with telephone number
SECTION B – DETAILS OF THE PATIENT ADMITTED		
a) Name of Patient	Enter the name of hospital	Name of hospital in full
b) IP Registration Number	Enter insurance provider registration number	As allotted by the insurance provider
c) Gender	Indicate Gender of the patient	Tick Male or Female
d) Age	Enter age of the patient	Number of years and months
e) Date of Birth	Enter date of admission	Use dd-mm-yy format
f) Date of Admission	Enter date of admission	Use dd-mm-yy format
g) Time	Enter time of admission	Use hh:mm format
h) Date of Discharge	Enter date of discharge	Use dd-mm-yy format
i) Time	Enter time of discharge	Use hh:mm format
j) Type of Admission	Indicate type of admission of patient	Tick the right option
k) If Maternity		
Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format
Gravida Status	Enter Gravida status if maternity	Use standard format
l) Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
m) Total claimed amount	Indicate the total claimed amount	In rupees (Do not enter paise values)
SECTION C – DETAILS OF AILMENT DIAGNOSED (PRIMARY)		
a) ICD 10 Code		
Primary Diagnosis	Enter the ICD 10 Code and description of the primary diagnosis	Standard Format and Open text
Additional Diagnosis	Enter the ICD 10 Code and description of the additional diagnosis	Standard Format and Open text
Co-morbidities	Enter the ICD 10 Code and description of the co-morbidities	Standard Format and Open text
b) ICD 10 PCS		
Procedure 1	Enter the ICD 10 PCS and description of the first procedure	Standard Format and Open text
Procedure 2	Enter the ICD 10 PCS and description of the second procedure	Standard Format and Open text
Procedure 3	Enter the ICD 10 PCS and description of the third procedure	Standard Format and Open text
Details of Procedure	Enter the details of the procedure	Open text
c) Pre-authorization obtained	Indicate whether pre-authorization obtained	Tick Yes or No
d) Pre-authorization Number	Enter pre-authorization number	As allotted by TPA
e) If authorization by network hospital not obtained, give reason	Enter reason for not obtaining pre-authorization number	Open text
f) Hospitalization due to injury	Indicate if hospitalization is due to injury	Tick Yes or No
Cause	Indicate cause of injury	Tick the right option
If injury due to substance abuse/alcohol consumption, test conducted to establish this	Indicate whether test conducted	Tick Yes or No
Medico Legal	Indicate whether injury is medico legal	Tick Yes or No
Reported To Police	Indicate whether police report was filed	Tick Yes or No
FIR No.	Enter first information report number	As issued by police authorities
If not reported to police, give reason	Enter reason for not reporting to police	Open Text
SECTION D – CLAIM DOCUMENTS SUBMITTED-CHECK LIST		
Indicate which supporting documents are submitted		
SECTION E – DETAILS IN CASE OF NON NETWORK HOSPITAL		
a) Address	Enter the full postal address	Include Street, City and Pin Code
b) Phone No.	Enter the phone number of hospital	Include STD code with telephone number
c) Registration No. with State Code	Enter the registration number of the doctor along with the state code	As allocated by the Medical Council of India
d) Hospital PAN	Enter the permanent account number	As allotted by the Income Tax department
e) Number of Inpatient beds	Enter the number of inpatient beds	Digits
f) Facilities available in the hospital	Indicate facilities available in the hospital	Tick the right option. If others, please specify
SECTION F - DECLARATION BY THE HOSPITAL		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign and stamp		