

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) SI. 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 Mediclaim/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 Mediclaim/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												
Ph. No.						Pin Code						
						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										DD / M M / YYYY			
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 / M M / 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			Total									
							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</u>	<u>/ MM</u>	<u>/ YYYY</u>									
2		<u>DD</u>	<u>/ MM</u>	<u>/ YYYY</u>									
3		<u>DD</u>	<u>/ MM</u>	<u>/ YYYY</u>									
4		<u>DD</u>	<u>/ MM</u>	<u>/ YYYY</u>									
5		<u>DD</u>	<u>/ MM</u>	<u>/ YYYY</u>									
6		<u>DD</u>	<u>/ MM</u>	<u>/ YYYY</u>									
7		<u>DD</u>	<u>/ MM</u>	<u>/ YYYY</u>									
8		<u>DD</u>	<u>/ MM</u>	<u>/ YYYY</u>									
9		<u>DD</u>	<u>/ MM</u>	<u>/ YYYY</u>									
10		<u>DD</u>	<u>/ MM</u>	<u>/ 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
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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) Type of Admission: Emergency Planned Day Care Maternity k) If Maternity 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="checkbox"/>	<input type="text"/>	i. Procedure 1: <input type="checkbox"/>	<input type="text"/>
ii. Additional Diagnosis: <input type="checkbox"/>	<input type="text"/>	ii. Procedure 2: <input type="checkbox"/>	<input type="text"/>
iii. Co-morbidities: <input type="checkbox"/>	<input type="text"/>	iii. Procedure 3: <input type="checkbox"/>	<input type="text"/>
iv. Co-morbidities: <input type="checkbox"/>	<input type="text"/>	iv. Details of Procedure: <input type="checkbox"/>	<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:

SECTION A

SECTION B

SECTION C

SECTION D

SECTION E

SECTION F

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		