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																				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	DD / MM / 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 / MM / YYYY		l) Claim Intimated		Yes		No																								
i. Intimated to whom	SBU		Intermediaries		Call Centre		Health Claims Team																								
ii. Intimation No. & date																															
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

SI. No.	Bill No.	Date	Issued by	Towards (Hospitalization/Pre-hospitalization/ Post-hospitalization	Amount (`)
1		DD / MM / YYYY			
2		DD / MM / YYYY			
3		DD / MM / YYYY			
4		DD / MM / YYYY			
5		DD / MM / YYYY			
6		DD / MM / YYYY			
7		DD / MM / YYYY			
8		DD / MM / YYYY			
9		DD / MM / YYYY			
10		DD / MM / YYYY			

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)

SECTION A | SECTION B | SECTION C | SECTION D | SECTION E | SECTION F

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: SURNAME FIRST NAME MIDDLE NAME

e) Qualification: f) Registration No. with State Code: g) Phone No.

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient: SURNAME FIRST NAME MIDDLE NAME

b) IP Registration Number: c) Gender: Male ☐ Female ☐ d) Age: Years YY Months MM e) Date of birth: DD i) Time: :

f) Date of Admission: DD MM YY g) Time: HH : MM h) Date of Discharge: DD MM YY HH MM

j) Type of Admission: Emergency ☐ Planned ☐ Day Care ☐ Maternity ☐ k) If Maternity i. Date of Delivery: DD MM YY MM YY

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:			i. Procedure 1:		
ii. Additional Diagnosis:			ii. Procedure 2:		
iii. Co-morbidities:			iii. Procedure 3:		
iv. Co-morbidities:			iv. Details of Procedure:		

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

- ☐ Claim Form duly signed
- ☐ Original Pre-authorization request
- ☐ Copy of the Pre-authorization approval letter
- ☐ Copy of photo ID card of patient verified by hospital
- ☐ Hospital Discharge summary
- ☐ Operation Theatre notes
- ☐ Hospital main bill
- ☐ Hospital break-up bill
- ☐ Investigation reports
- ☐ CT/MR/USG/HPE investigation reports
- ☐ Doctor's reference slip for investigation
- ☐ ECG
- ☐ Pharmacy bills
- ☐ MLC report & Police FIR
- ☐ Original death summary from hospital where applicable
- ☐ 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: DD MM YY

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			