CLAIM FORM - PART A' to 'CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT - PART A

TO BE FILLED BY THE INSURED

The issue of this Form is not to be taken as an admission of liablity

(To be Filled in block letters)

SECTION A

DETAILS OF PRIMARY INSURED:

a) Policy No.: b) Sl. No/ Certificate no.

c) Company/ TPA ID No:

d) Name: SURNAME FIRST NAME MIDDLE NAME

e) Address:

City: State:

Pin Code Phone No: Email ID:

SECTION B

DETAILS OF INSURANCE HISTORY:

a) Currently covered by any other Mediclaim / Health Insurance: ☐ Yes ☐ No b) Date of commencement of first Insurance without break: D D M M Y Y Y Y

c) If yes, company name: Policy No.

Sum insured (Rs.) d) Have you been hospitalized in the last four years since inception of the contract? ☐ Yes ☐ No Date: M M Y Y

Diagnosis:

f) If yes, company name: e) Previously covered by any other Mediclaim /Health insurance : : ☐ Yes ☐ No

SECTION C

DETAILS OF INSURED PERSON HOSPITALIZED: :

a) Name: SURNAME FIRST NAME MIDDLE NAME

b) Gender Male ☐ Female ☐ c) Age years Y Y Months M M d) Date of Birth D D M M Y Y Y Y

e) Relationship to Primary insured: Self ☐ Spouse ☐ Child ☐ Father ☐ Mother ☐ Other ☐ (Please Specify)

f) Occupation Service ☐ Self Employed ☐ Home Maker ☐ Student ☐ Retired ☐ Other ☐ (Please Specify)

g) Address (if diffrent from above) :

City: State:

Pin Code Phone No: Email ID:

SECTION D

DETAILS OF HOSPITALIZATION: :

a) Name of Hospital where Admited:

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 Disease first detected /Date of Delivery: D D M M Y Y Y Y

e) Date of Admission: D D M M Y Y f) Time H H M H g) Date of Discharge: D D M M Y Y h) Time: H H : M H

I) If injury give cause: Self inflicted ☐ Road Traffic Accident ☐ Substance Abuse / Alcohol Consumption ☐ I) If Medico legal ☐ Yes ☐ No

ii) Reported to Police ☐ ☐ iii. MLC Report & Police FIR attached ☐ Yes ☐ No j) System of Medicine:

SECTION E

DETAILS OF CLAIM:

a) Details of the Treatment expenses claimed

I. Pre -hospitalization expenses Rs. ii. Hospitalization expenses Rs.

iii. Post-hospitalization expenses Rs. iv. Health-Check up cost: Rs.

v. Ambulance Charges: Rs. vi. Others (code): Rs.

Total Rs.

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: Rs. ii. Surgical Cash: Rs.

iii. Critical Illness benefit: Rs. iv. Convalescence: Rs.

v. Pre/Post hospitalization Lump sum benefit: Rs. vi. Others: Rs.

Total Rs.

Claim Documents Submitted - Check List:

- ☐ Claim form duly signed
- ☐ Copy of the claim intimation, if any
- ☐ Hospital Main Bill
- ☐ Hospital Break-up Bill
- ☐ Hospital Bill Payment Receipt
- ☐ Hospital Discharge Summary
- ☐ Pharmacy Bill
- ☐ Operation Theater Notes
- ☐ ECG
- ☐ Doctor's request for investigation
- ☐ Investigation Reports (Including CT / MRI / USG / HPE)
- ☐ Doctor's Prescriptions
- ☐ Others

SECTION F

DETAILS OF BILLS ENCLOSED:

Sl. No.	Bill No.	Date	Issued by	Towards	Amount (Rs)
1.		D D M M Y Y		Hospital main Bill	
2.		D D M M Y Y		Pre-hospitalization Bills: Nos	
3.		D D M M Y Y		Post-hospitalization Bills: Nos	
4.		D D M M Y Y		Pharmacy Bills	
5.		D D M M Y Y			
6.		D D M M Y Y			
7.		D D M M Y Y			
8.		D D M M Y Y			
9.		D D M M Y Y			
10.		D D M M Y Y			

SECTION G

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT::

a) PAN: b) Account Number:

c) Bank Name and Branch:

d) Cheque / DD Payable details: e) IFSC Code:

(IMPORTANT: PLEASE TURN OVER)

DECLARATION BY THE INSURED:

I hereby declare that the information furnished in the claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealent of any material fact with respect to questions asked in relation to this claim, my right to claim reimbrusement 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.

SECTION H

Date D D M M Y Y Y Y Place: Signature of the Insured

GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled in by the insured)		
DATA ELEMENT	**DESCRIPTION**	**FORMAT**
SECTION A - DETAILS OF PRIMARY INSURED		
a) Policy No.	Enter the policy number	As allotted by the Insurance Company
b) Sl. No/ Certificate No.	Enter the social Insurance number or the certificate number of social health insurance scheme	As allotted by the oraganization
c) Company TPA ID No.	Enter the TPA ID No.	Licence number as allotted by IRDA and printed in TPA documents.
d) Name	Enter the full name of the policyholder	Surname, First name, Middle name
e) Address	Enter the full postal address	Include Street, City and Pin code
SECTION B -DETAILS OF INSURANCE HISTORY		
a) Currently covered by any other Mediclaim / Health Insurance?	Indicate whether currently covered by another Mediclaim / Health Insurance	Tick Yes or No
b) Date of commencement of first Insurance without break	Enter the date of commencement of first Insurance	Use dd-mm-yy-forrmat
c) Company Name	Enter the full name of the Insurance Company	Name of the organization in full
Policy No.	Enter the policy number	As allotted by the Insurance Company
Sum insured	Enter the total sum insured as per the policy	In rupees
d) Have you been Hospitalized in the last four years since Inception of the contract?	Indicate whether hospitalized in the last four years	Tick Yes or No
Date	Enter the date of Hospitalization	Use mm-yy format
Diagnosis	Enter the diagnosis details	Open Text
e) Previously covered by any other Mediclaim / Health Insurance?	Indicate whether previously covered by another mediclaim / Health Insurance	Tick Yes or No
f) Company Name	Enter the full name of the Insurance Company	Name of the organization in full
SECTION C -DETAILS OF INSURED PERSON HOSPITALIZED		
a) Name	Enter the full name of the patient	Surname, First name, Middle name
b) Gender	Indicate Gender of the patient	Tick Male or Female
c) Age	Enter age of the patient	Number of years and months
d) Date of Birth	Enter Date of Birth of patient	Use dd-mm-yy format
e) Relationship to primary Insured	Indicate relationship of patient with policyholder	Tick the right option, if others, please specify
f) Occupation	indicate occupation of patient	Tick the right option. If others, please specify.
g) Address	Enter the full postal address	Include Street, City and Pin code
h) Phone No	Enter the phone number of patient	Include STD code with telephone number
1) E-mail ID	Enter e-mail address of patient	Complete e-mail address
SECTION D - DETAILS OF HOSPITALIZATION		
a) Name of Hospital where admited	Enter the name of hospital	Name of hospital in full
b) Room category occupied	indicate the room category occupied	Tick the right option
c) Hospitalization due to	indicate reason of hospitalization	Tick the right option
d) Date of injury/Date Disease first detected / Date of Delivery	Enter the relevant date	Use dd-mm-yy format
e) Date of admission	Enter date of admission	Use dd-mm-yy format
f) Time	Enter time of admission	Use hh-mm- format
g) Date of discharge	Enter date of discharge	Use dd-mm-yy format
h) Time	Enter time of discharge	Use hh-mm- format
I) If injury give cause	indicate cause of injury	Tick the right option
If 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
MLC Report & Police FIR attached	indicate whether MLC report and Police FIR attached	Tick Yes or No
j) System of Medicene	Enter the system of medicine followed in treating the patient	Open Text
SECTION E - DETAILS OF CLAIM		
a) Details of Treatment Expences	Enter the amount claimed as treatment expences	In rupees (Do not enter paise values)
b) Claim for Domiciliary Hospitalization	indicate whether claim is for domiciliary hospitalization	Tick Yes or No
c) Details of Lump sum/ Cash benifit claimed	Enter the amount claimed as lump sum / cash benefit	In rupees (Do not enter paise values)
d) Claim documents Submitted-Check List	indicate which supporting documents are submitted	Tick the right option
SECTION F - DETAILS OF BILLS ENCLOSED		
Indicate which bills are enclosed with the amount in rupees		
SECTION G - DETAILS OF PRIMARY INSURED's BANK ACCOUNT		
a) PAN	Enter the permanent account number	As allotted by the Income Tax Department
b) Account Number	Enter the Bank account number	As allotted by the Bank
c) Bank Name and Branch	Enter the Bank name along with the branch	Name of the Bank in full
c) Cheque/ DD payable details	Enter the name of the beneficiary the cheque / DD should be made out to	Name of the individual / organization in full
c) IFSC Code	Enter the IFSC code of the Bank branch	IFSC code of the Bank branch in full
SECTION H - DECLARATION BY THE INSURED		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.		

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

SECTION A

a) Name of the hospital:

a) Hospital ID:

c) Type of Hospital: Network : ☐ Non Network : ☐ (if non network fill section E)

c) 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

SECTION B

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 MM YY

f) Date of Admission: DD MM YY

g) Time: HH MM

h) Date of Discharge: DD MM YY

i) Time: HH MM

j) Type of Admission: Emergency ☐ Planned ☐ Day Care ☐ Maternity ☐

k) If Maternity i) Date of Delivery: DD 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)

SECTION C

a)

	ICD 10 Codes	Description
I. Primary Diagnosis		
ii. Additional Diagnosis:		
iii. Co-morbidities:		
iv. Co-morbidities:		

b)

	ICD 10 PCS	Description
i. Procedure 1:		
ii. Procedure 2:		
iii. Procedure 3:		
iv. Details of Procedure:		

c) Pre-authorization obtained: ☐ Yes ☐ No d) Pre-authorization Number:

e) If authorization by network hospital not obtained, give reason:

f) 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

SECTION D

- ☐ 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 reports & Police FIR
- ☐ Original death summary from hospital where applicable
- ☐ Any other, please specify

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

SECTION E

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

SECTION F

(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: