



Medi Assist

## REIMBURSEMENT CLAIM FORM

TO BE FILLED 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 (MA ID)No:										
d) Name:	S U R N A M E	F I R S T N A M E	M I D D L E N A M E							
e) Address:										
City:						State:				
Pin Code						Phone No:				
					Email ID:					

DETAILS OF INSURANCE HISTORY:													
a) Currently covered by any other Mediclaim / Health Insurance:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	b) Date of commencement of first Insurance without break:	D	D	M	M	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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:	M	M	Y	Y
Diagnosis:										e) Previously covered by any other Mediclaim /Health insurance ::	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
f) If yes, company name:													

DETAILS OF INSURED PERSON HOSPITALIZED:																
a) Name:	S U R N A M E	F I R S T N A M E	M I D D L E N A M E													
b) Gender	Male <input type="checkbox"/>	Female <input type="checkbox"/>	c) Age years	Y	Y	Months	M	M	d) Date of Birth	D	D	M	M	Y	Y	
e) Relationship to Primary insured:	Self <input type="checkbox"/>	Spouse <input type="checkbox"/>	Child <input type="checkbox"/>	Father <input type="checkbox"/>	Mother <input type="checkbox"/>	Other <input type="checkbox"/>	(Please Specify)									
f) Occupation	Service <input type="checkbox"/>	Self Employed <input type="checkbox"/>	Home Maker <input type="checkbox"/>	Student <input type="checkbox"/>	Retired <input type="checkbox"/>	Other <input type="checkbox"/>	(Please Specify)									
g) Address (if different from above):										City:						
										State:						
Pin Code						Phone No:					Email ID:					

DETAILS OF HOSPITALIZATION:																								
a) Name of Hospital where Admitted:																								
b) Room Category occupied:	Day care <input type="checkbox"/>	Single occupancy <input type="checkbox"/>	Twin sharing <input type="checkbox"/>	3 or more beds per room <input type="checkbox"/>																				
c) Hospitalization due to:	Injury <input type="checkbox"/>	Illness <input type="checkbox"/>	Maternity <input type="checkbox"/>	d) Date of injury / Date Disease first detected /Date of Delivery:						D	D	M	M	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	:	N	H
i) If injury give cause:	Self inflicted <input type="checkbox"/>	Road Traffic Accident <input type="checkbox"/>	Substance Abuse / Alcohol Consumption <input type="checkbox"/>	i) If Medico legal						<input type="checkbox"/> Yes	<input type="checkbox"/> No													
ii) Reported to Police <input type="checkbox"/>	iii. MLC Report & Police FIR attached						<input type="checkbox"/> Yes	<input type="checkbox"/> No	j) System of Medicine:															

DETAILS OF CLAIM:																					
a) Details of the Treatment expenses claimed										Claim Documents Submitted - Check List:											
I. Pre-hospitalization expenses	Rs.	<input type="checkbox"/>					ii. Hospitalization expenses Rs.					<input type="checkbox"/>					<input type="checkbox"/> Claim form duly signed				
iii. Post-hospitalization expenses	Rs.	<input type="checkbox"/>					iv. Health-Check up cost: Rs.					<input type="checkbox"/>					<input type="checkbox"/> Copy of the claim intimation, if any				
v. Ambulance Charges:	Rs.	<input type="checkbox"/>					vi. Others (code): <input type="checkbox"/>					<input type="checkbox"/> Hospital Main Bill									
	Total						Rs.					<input type="checkbox"/> Hospital Break-up Bill									
vii. Pre-hospitalization period:	days	<input type="checkbox"/>					viii. Post-hospitalization period: days					<input type="checkbox"/> Hospital Bill Payment Receipt									
b) Claim for Domiciliary Hospitalization:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(If yes, provide details in annexure)								<input type="checkbox"/> Hospital Discharge Summary										
c) Details of Lump sum / cash benefit claimed:										<input type="checkbox"/> Pharmacy Bill											
i. Hospital Daily cash:	Rs.	<input type="checkbox"/>					ii. Surgical Cash:					Rs.	<input type="checkbox"/> Operation/Theater Notes								
iii. Critical Illness benefit:	Rs.	<input type="checkbox"/>					iv. Convalescence:					Rs.	<input type="checkbox"/> ECG								
v. Pre/Post hospitalization Lump sum benefit: Rs.	<input type="checkbox"/>					vi. Others:					<input type="checkbox"/>	<input type="checkbox"/> Doctors request for investigation									
	Total						Rs.					<input type="checkbox"/> Investigation Reports (Including CT / MRI /USG / HPE)									
												<input type="checkbox"/> Doctors Prescriptions									
												<input type="checkbox"/> Others									

DETAILS OF BILLS ENCLOSED:																			
Sl. No.	Bill No.	Date	D	D	M	M	Y	Y	Issued by	Towards					Amount (Rs)				
1.										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											

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT:											
a) PAN:	<input type="checkbox"/>					b) Account Number:	<input type="checkbox"/>				
c) Bank Name and Branch:	<input type="checkbox"/>					e) IFSC Code:	<input type="checkbox"/>				
d) Cheque / DD Payable details:	<input type="checkbox"/>					<input type="checkbox"/>					

## 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 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.

Date D D M M Y Y Y Place: \_\_\_\_\_

Signature of the Insured

(IMPORTANT: PLEASE TURN OVER)

SECTION A

SECTION B

SECTION C

SECTION D

SECTION E

SECTION F

SECTION G

SECTION H

GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled in by the insured)		
DATA ELEMENT	DESCRIPTION	FORMAT
<b>SECTION A - DETAILS OF PRIMARY INSURED</b>		
a) Policy No.	Enter the policy number	As allotted by the Insurance Company
b) SI. No/ Certificate No.	Enter the social Insurance number or the certificate number of social health insurance scheme	As allotted by the organization
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
<b>SECTION B - DETAILS OF INSURANCE HISTORY</b>		
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-format
c) Company Name Policy No.	Enter the full name of the Insurance Company Enter the policy number	Name of the organization in full 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
<b>SECTION C - DETAILS OF INSURED PERSON HOSPITALIZED</b>		
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
i) E-mail ID	Enter e-mail address of patient	Complete e-mail address
<b>SECTION D - DETAILS OF HOSPITALIZATION</b>		
a) Name of Hospital where admitted	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/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
<b>SECTION E - DETAILS OF CLAIM</b>		
a) Details of Treatment Expenses	Enter the amount claimed as treatment Expenses	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
<b>SECTION F - DETAILS OF BILLS ENCLOSED</b>		
Indicate which bills are enclosed with the amount in rupees		
<b>SECTION G - DETAILS OF PRIMARY INSURED's BANK ACCOUNT</b>		
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
<b>SECTION H - DECLARATION BY THE INSURED</b>		
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**

a) Name of the hospital:  b) Hospital ID:  c) Type of Hospital: Network :  Non Network :  (if non network fill section E)

c) Name of the treating doctor:  f) Registration No. with State Code:  g) Phone No.

e) Qualification:

**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) Time:

j) Type of Admission: Emergency  Planned  Day Care  Maternity  k) If Maternity  l) Date of Delivery:       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"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>	i. Procedure 1:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>
ii. Additional Diagnosis:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>	ii. Procedure 2:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>
iii. Co-morbidities:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>	iii. Procedure 3:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>
iv. Co-morbidities:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>	iv. Details of Procedure:	<input type="text"/>	

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**

- |  |  |
|--|--|
| <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 reports & 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                             |

**ADDITIONAL 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
<b>SECTION A - DETAILS OF HOSPITAL</b>		
a) Name of the hospital:	Enter the name of hospital	Name of the 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
c) Name of treating doctor	Enter the name of the treating doctor	Name of doctor in full
e) Qualification	Enter the qualification 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
<b>SECTION B - DETAILS OF THE PATIENT ADMITTED</b>		
a) Name of Patient	Enter the name of patient	Name of patient 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 birth	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		
i. Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format
ii. 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)
<b>SECTION C - DETAILS OF AILMENT DIAGNOSED (PRIMARY)</b>		
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 Code and description of the first procedure	Standard Format and Open text
Procedure 2	Enter the ICD 10 Code and description of the second procedure	Standard Format and Open text
Procedure 3	Enter the ICD 10 Code 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
<b>SECTION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST</b>		
Indicate which supporting documents are submitted		
<b>SECTION E - DETAILS IN CASE OF NON NETWORK HOSPITAL</b>		
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 Hospital obtained from local body like City Corporation / Municipality	As allocated by the City Corporation / Municipality
d) Hospital PAN	Enter the permanent account number	As allocated 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
<b>SECTION F - DECLARATION BY THE HOSPITAL</b>		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign. and stamp		