STAR HEALTH AND ALLIED INSURANCE COMPANY LTD
Corporate Office - Claims Dept. : No.15, Balaji Complex,
Whites Lane, 1st Floor, Royapettah, Chennai - 600 014
www.starhealth.in | support@starhealth.in

9876543210

Reimbursement Claim Form - Part A

All reimbursement claims have to be intimated to us immediately (before discharge). Claim documents should be submitted within 30 days from the date of discharge. Please answer all the questions. Use additional sheets, if required and attach the documents as indicated. Please note that the list of documents mentioned is an indicative list, we may ask for any other documents to process the claim. The issuance of this form does not imply Admission of Liability.

Claim Number	

Claim Type (Tick Appropriate Box)

- ☐ In-Patient Treatment
- ☐ OPD Treatment
- ☐ Health Checkup
- ☐ Hospital Cash
- ☐ Pre-Hospitalization Expenses
- ☐ Day Care Procedures
- ☐ Domiciliary Hospitalization
- ☐ EMI Protect
- ☐ Post-Hospitalization Expenses
- ☐ Maternity Cover
- ☐ Critical Illness

Details of Proposer

Policy Number		Policy Period	
Proposer Name	SH123456789	Customer ID	
Employee Name (in case of Group Policy)	John Doe	Employee ID No (in case of Group Policy)	
ID Proof Type		ID Proof No. (Last 4 Digits if Aadhaar)	
CKYC Number		PAN Card No.	
Address		City	
Registered email ID		District	
Registered Mobile No.		State	
WhatsApp Number		Pin code	

Details of Insured Patient in respect of whom claim has been made

Insured Patient Name			Gender		
Date of Birth/Age			Relationship with Proposer / Employee		
ABHA ID No.			ID Proof Type		
Star Health / TPA ID Card No.			ID Proof No. (Last 4 Digits if Aadhaar)		
Hospitalisation Due to	☐ Illness ☐ Maternity ☐ Injury		Date (if accident)	DD/MM/YYYY	Time
Place of Accident			Reported to Police (if Accident)	☐ Yes	☐ No
If not reported to Police give reasons					

Details of Insurance History

Currently are you insured by any other COMPANY's Health Insurance Policy or by any other Star Health Insurance Policy

☐ Yes ☐ No

If Yes, INSURER Name		Policy Number	
Policy Period		Sum Insured	

Has this hospitalisation bill been Claimed with any other Insurance Company or Insurance Schemes? If Yes, please enclose settlement letter

☐ Yes ☐ No

IRDAI Regn. No: 129
CIN : L66010TN2005PLC056649
Toll free Phone No: 1800 425 2255 | 1800 102 4477

Details of Treatment Expenses Claimed with STAR Health Insurance

Details of Expenses Claimed	Amount	Details of Expenses Claimed	Amount
Hospitalization Expenses	18000	Ambulance Charges	
Pre-Hospitalization Expenses		Lump-Sum Benefit	
Post - Hospitalization Expenses		Critical Illness Benefit	
Health Checkup Expenses		Others	
Total		**Total**	

Details of Bill Enclosed

Sl. No.	Bill No.	Date	Issued by	Details of Expenses Claimed	Amount

Note: In case of more details, please attach separate sheets

Please submit the required Mandatory Documents listed in the checklist for prompt claim settlement, wherever applicable

List of Mandatory Documents to be submitted	Yes / No	List of Mandatory Documents to be submitted	Yes / No
Duly filled and signed Claim Form		Doctor's Prescription for Admission, Medicine, investigations, Surgery (Originals)	
Discharge Summary (Originals)		Investigation / Diagnostic Reports Including CT / MRI / USG / HPE / ECG etc.,) (Originals)	
Hospital Final Bill with breakup and Receipts (Originals)		Invoice / Sticker for the implants used in the treatment.	
Doctor Consultation Bills (Originals)		Proposer's Bank Account Details-Cancelled Cheque Leaf / Passbook / Bank Statement - Self Attested	
Pharmacy / Investigation / Diagnostic Bills (Originals)		Death Certificate	
Sonography Report - in case of Maternity Claim (Originals)		Legal Heir / Succession Certificate if Nominee is not Registered under the Policy (in case of Proposer's Death)	
USG / X-Ray / MRI / CT Films (Original)		Affidavit-NOC from Legal Heirs in Stamp Paper certified by Notary Public (In case of settlement to Legal Heir)	
Pre & Post - Hospitalisation Bills (Originals)		Nominee / Legal Heir Bank Account Details-Cancelled Cheque Leaf / Passbook / Bank Statement (in case of Proposer's Death) - Self Attested	
Proposer's ID Proof, Address Proof, PAN Card & Photo (If CKYC not registered) Self Attested		Medico Legal Case (MLC) / Accident Report (AR) / (In case of Accident)	
ID Card issued by Employer (in case of Group Policy) Self Attested		First Information Report (FIR) in case of Accident	

Proposer's Bank Account Details

Bank Name		**Bank Account Holder Name**		**IFSC Code**	
Bank Branch Name		**Account Type**		**Account Number**	

☐ I / We understand that any payment related to Premium Refund / Claim Amount will be directly deposited to my aforesaid Bank Account. Verification of Bank Account Details is a mandatory requirement for NEFT transactions. Please enclose either a Cheque Leaf or Bank Passbook

Declaration by the Proposer / Claimant

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 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 hospitalisation claim, if any. I / We authorise Star Health Insurance Company / TPA to contact me / us through SMS / Email / WhatsApp for any update on this claim

I/we agree that the PAN details and other information provided by me/us in the proposal form may be used by the Company to download/ verify / modify / add my/our KYC documents from the CERSAI* CKYC portal for processing this application. I/We understand that only the acceptable officially valid documents would be relied upon for processing this application. (*Central Registry of Securitization and Asset Reconstruction and security Interest of India) I hereby consent to receiving information from Central KYC Registry through SMS / email on the above registered number/ email address. The list of acceptable documents can be referred from website (Download > AML/KYC).

I hereby authorize Star Health & Allied insurance Co to use any information/data provided in any of the documents submitted for this claim for the purpose of research/training/analytics/ investigations/case studies and to ensure that such information/data do not go outside the insurer and its authorized representatives and also to be compliant under the relevant laws and regulations and without prejudice to my Personal data privacy.

Date		**Signature of the Proposer / Claimant**	

Reimbursement Claim Form - Part B

(To be Filled by the Hospital)

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

Treating Doctor's & Hospital Details					
Name of the Hospital				**City**	
Facilities available in the hospital (Provide the details in Nos.)	Beds	OT	ICU	**Hospital Address**	
Type of Hospital	☐ Network	☐ Non Network		**District**	
If Network Hospital, Star HOS Code				**State**	
Hospital Registration No. with state code				**Pincode**	
Hospital Rohini ID				**Phone No. / Mobile No.**	
Hospital PAN No.				**GST No.**	
Treating Doctor Name					
Treating Doctor Qualification				**Treating Doctor Registration No.**	

Details of the Patient Admitted							
Name of the Patient				**IP Registration No.**			
Gender / Age				**ABHA ID No.**			
Date of Admission	2024-01-15		**Time**		**Date of Discharge**	**Time**	
Type of Admission	☐ Emergency	☐ Planned	☐ Day Care	☐ Maternity	**Date of Childbirth**		
Type of Management	☐ Medical		☐ Surgical		**Duration of Illness**		
Diagnosis							
Co-Morbidities							
Name of the Treatment / Procedure							
Past Medical / Surgical History							

Details in case of Accident				
Cause of Accident	☐ Self Inflicted	☐ Road Accident	☐ Substance Abuse	☐ Alcohol Consumption
Reported to Police	☐ Yes / ☐ No	**FIR NO.**		
Medico Legal / AR				

Declaration by the Hospital

We affirm the accuracy and truthfulness of the details provided in this Claim Form to the best of our knowledge and belief. We understand that any misrepresentation, withholding and omission of patient information, or concealment of material facts may lead to the forfeiture of the claim. Star Health or its authorized representatives are hereby authorized to verify, inspect, or collect any records related to this claim. The insured's signature is obtained on this form after we complete Claim Form B.

Date **Place** **Signature of Proposer / Claimant** **Signature & Seal of the Hospital Authority**

Authorisation to Star Health and Allied Insurance Co. Ltd

To:

Hospital Name: Apollo Hospital Place: _____

Dear Sir,

Claim No:		Patient Admission No / IP No / MRD No:	

I have undergone treatment for _____ from ____/____/____ to ____/____/____ in your Hospital. I hereby authorize M/s. Star Health and Allied Insurance Co. Ltd and its representatives, who is my Health Insurer to seek any medical information/records from you or from the Medical Practitioners who have attended on me in connection with the above ailment and the treatment given. In case they seek any such information/ records / indoor case papers, kindly oblige.

Thanking you,

Place: Yours Faithfully,

Date:

Address: **(Signature of the Proposer / Claimant)**