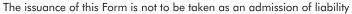




Toll Free No. 1800 266 3202

| SECTION A - DETAILS                              | OF     | PRI    | IM/           | ٩RY   | 'IN      | ISU        | REI   | D: (T  | o be  | e fil    | led  | in   | ı bla    | oc  | k le  | tter  | s)   |       |        |       |        |        |        |        |        |        |           |               |           |               |          |           |           |           |
|--|--------|--------|---------------|-------|----------|------------|-------|--------|-------|----------|------|------|----------|-----|---|-------|------|-------|--------|-------|--------|--------|--------|--------|--------|--------|-----------|---------------|-----------|---------------|----------|-----------|-----------|-----------|
| a) Policy No:                                    |        |        |               |       |          |            |       |        |       |          |      |      |          |     | b) :  | SI. N | Vo/  | Cer   | tific  | ate   | No     | : [    |        |        |        |        |           |               |           |               |          |           |           |           |
| c) Company/ TPA ID No:                           |        |        |               |       |          |            |       |        |       |          |      |      |          |     |   |       |      |       |        |       |        |        | •      | •      |        |        |           |               |           |               |          |           |           |           |
| d) Name:   |        |        |               |       |          |            |       |        |       |          |      |      |          |     |   |       |      |       |        |       |        |        |        |        |        |        |           |               |           |               |          |           |           |           |
| e) Address:                                      |        |        |               |       |          |            |       |        |       |          |      |      |          |     |   |       |      |       |        |       |        |        |        |        |        |        |           |               |           |               |          |           |           |           |
| City:  |        |        |               |       |          |            |       |        |       |          |      |      |          |     |   | Stat  | e:   |       |        |       |        |        |        |        |        |        |           |               |           |               |          |           |           |           |
| Pin Code:  |        |        |               |       |          |            |       |        |       |          | L    | .an  | dlin     | е   | (Wit  | h ST  | TD ( | Code  | e):    |       |        |        |        |        |        |        |           |               |           |               |          |           |           |           |
| Mobile No:                                       |        |        |               |       |          |            |       |        |       |          |      |      |          |     |   |       |      |       |        |       |        |        |        |        |        |        |           |               |           |               |          |           |           |           |
| [PLEASE PROVIDE ACTIVE EM                        | AIL    | ID (   | INC           | ΥΑ    | S C      | LAI۸       | AS C  | CORR   | SPC   | DNC      | ENG  | CE   | WILI     | L B | BE SE   | NT    | TO T | ΓHIS  | EMA    | AIL I | D.]    |        |        |        |        |        |           |               |           |               |          |           |           |           |
| Email ID:  |        |        | Ш             |       |          |            |       |        |       |          |      |      |          | L   |   |       |      | Ш     |        |       | 1      | 1      | _      | _      |        |        | _         | ightharpoonup |           | $\square$     | _        | _         |           |           |
| Alternate Email ID:                              |        |        |               |       |          |            |       |        |       |          |      |      |          |     |   |       |      |       |        |       |        |        |        |        |        |        |           |               |           | Ш             |          |           |           |           |
| CECTION B DETAILS                                | `      | EU     | ıcı           | I ID  | 4 h L    | <u>С</u> Г | 1 110 | `TOI   | V     |          |      |      |          |     |   |       |      |       |        |       |        |        |        |        |        |        |           |               |           |               |          |           |           |           |
| SECTION B - DETAILS                              | _      |        | _             | _     | _        | _          | _     |        |       |          |      | 1    |          |     | 7.  |       |      |       |        |       |        |        |        |        | 1      |        |           |               |           |               |          | 7         |           |           |
| a) Currently covered by any                      | oth    | ier Λ  | Λed           | licla | im ,     | / He       | ealth | n Insu | rand  | e:       | L    | Ye   | es       | L   | \   | lo    |      |       | b) I   |       |        |        |        | Гур    | e:     | _      | In        | divi          | du        | al            | 느        | <u> </u>  | Gro       | up        |
| Company Name:                                    |        |        |               |       |          |            |       |        | _     |          |      |      |          |     |   |       |      | Щ     |        |       | cy l   |        | _      |        | _      |        |           |               |           |               |          | $\perp$   | $\perp$   | _         |
| c) Date of commencement of                       | of fir | rst Ir | ารบา          | and   | e w      | vitho      | out k | oreak  |       |          |      |      |          |     |   |       |      |       | d) :   | Sun   | n In   | sur    | ed     | (Rs    | .):    |        |           |               |           |               |          |           |           |           |
| Have you been hospitalise                        | d ir   | 1 the  | e la          | ıst f | our      | yeo        | ars : | since  | ince  | epti     | on c | of t | the c    | 01  | ntra  | ct?   |      | Ш     | Yes    | 5     | Ļ      | \      | 10     |        |        |        |           |               |           |               |          |           |           |           |
| Diagnosis:                                       |        |        |               |       |          |            |       |        |       |          |      | L    |          | L   | $\perp$   |       |      |       |        |       |        |        |        |        |        |        | $\Box$    |               |           | Ш             | $\Box$   |           | $\Box$    |           |
| f) Previously covered by any                     | oth    | er M   | Λed           | icla  | im /     | / He       | alth  | Insu   | ranc  | e:       |      | ١    | Yes      |     | N   | lo    |      |       |        |       |        |        |        |        |        |        |           |               |           |               |          |           |           |           |
| g) If yes, Company Name:                         |        |        |               |       |          |            |       |        |       |          |      |      |          |     |   |       |      |       |        |       |        |        |        |        |        |        |           |               |           |               |          |           |           |           |
| SECTION C - DETAIL                               | s c    | )F I   | NS            | UR    | ED       | PEI        | RSC   | NC     | 109   | SPIT     | ALI  | SE   | D:       |     |   |       |      |       |        |       |        |        |        |        |        |        |           |               |           |               |          |           |           |           |
| a) Name:   |        |        |               |       |          |            |       |        | T     |          |      |      |          | Γ   | Т   |       |      |       |        |       | T      | T      | Т      | П      |        |        | $\exists$ | $\exists$     | $\Box$    |               | П        | $\exists$ | $\exists$ | $\exists$ |
| b) Gender:                                       |        | M      | ale           |       |          | Fer        | nale  | е      | c) A  | ge:      | Yeo  | ars  | Υ        | Υ   | 1   | Μ     | lont | hs    | M      | M     | ď      | ) D    | ate    | of     | Bir    | th:    | D         | D             | Μ         | M             | Υ        | Υ         | Υ         | Υ         |
| e) Relationship to Primary In                    | sure   | ed:    | $\neg$        | Sel   | f        |            | Spc   | use    |       | С        | hild |      | П        | Fc  | <br>ather                                       | r [   |      | Mot   | her    | Ī     |        | Oth    | er (   | Ple    | ase    | Sp     | eci       | fy)           | =         | _             | =        | =         | =         | ヿ         |
| f) Address (if different from                    | n ak   | JOV:   | e):           |       |          |            |       |        | T     |          |      |      | T        |     |   | Τ     | Π    |       |        | Ī     | _      |        | T      | П      |        |        | $\neg$    | Ī             | $\exists$ |               | $\equiv$ | $\exists$ | $\exists$ | ョ         |
| City:  |        |        |               |       |          | Ī          |       | Ť      | İ     | İ        |      |      | İ        | St  | ate:  |       | İ    |       | Ť      | İ     | İ      | İ      | Ť      | Ť      | Ì      | Ì      | 寸         | T             | T         | Ī             | Ħ        | Ħ         | Ħ         | 一         |
| Pin Code:  |        |        | П             |       |          |            |       |        |       |          |      | Р    | _<br>hon | е   | No:   |       |      |       | T      | Ì     | İ      | İ      | Ť      | T      |        |        | Ħ         | T             | Ħ         | Ħ             | T        | Ħ         | Ħ         | ī         |
| Email ID:  |        |        |               |       |          |            |       |        |       |          |      |      |          |     |   |       |      |       |        | T     | Ť      | Ť      | Ť      | T      | Ī      |        | Ħ         | Ī             | T         | T             | T        | Ħ         | Ħ         | Π         |
| g) Occupation:                                   |        | Se     | rvic          | e     |          | Self       | Em    | ploye  | ed [  |          | Hon  | ne   | mak      | er  | - <u>                                      </u> | Stu   | Jdei | nt    | R      | Retir | ed     |        | 10     | the    | er (   | Plec   | <br>se    | spe           | cify      | /)            |          | _         |           | 一         |
| h) Name of Employer/<br>Firm's Name:             |        |        |               |       |          |            |       |        |       |          |      |      |          |     | Ī   |       |      |       |        |       |        | Ι      |        |        |        |        |           | <u>.</u>      |           |               |          |           |           |           |
| i) Address of the<br>Employer/Firm:              |        |        |               |       |          |            |       |        |       |          |      |      |          |     |   |       |      |       |        |       |        |        |        |        |        |        | $\Box$    | $\Box$        |           |               |          |           |           |           |
| SECTION D - DETAIL                               | s C    | \F I   | 10            | CDI   | <b>T</b> | IC /       | TI    | 271    |       |          |      |      |          |     |   |       |      |       |        |       |        |        |        |        |        |        |           |               |           |               |          |           |           |           |
|  | 3 C    | ו דע   |               | SPI   | IAI      | _13/       | 1110  | JIN:   | _     |          |      |      |          |     |   |       |      |       |        |       | _      | _      |        |        |        |        |           | =             |           |               | =        | =         | =         |           |
| a) Name & Address of<br>Hospital where Admitted: |        |        | <u></u>       |       |          | _          |       |        |       |          |      |      |          |     |   |       |      | Ш     |        | _     |        |        | _      | _      | _      | _      | <u> </u>  | <u> </u>      |           | <u> </u>      | <u> </u> | <u> </u>  | <u>니</u>  |           |
| City:  |        | Ш      | $\sqsubseteq$ |       |          |            |       |        |       |          |      |      |          | L   |   | Sto   | ıte: | Щ     |        | _     | _      | 4      | _      | _      |        | _      | ᆜ         | ightharpoonup |           | $\sqsubseteq$ | _        | ᆜ         | ᆜ         | _         |
| Pin Code:  |        | Ш      |               |       |          |            |       | Lan    | dmo   | ırk:     | L    |      |          |     |   |       | L    | Ш     |        |       |        |        |        |        |        |        | $\Box$    | $\Box$        |           | Ш             | $\Box$   | $\Box$    | $\Box$    |           |
| b) Room Category occupied:                       |        | Do     | ау с          | are   |          | S          | ing   | le oc  | cupo  | anc      | У    |      | Twir     | n s | shari   | ing   |      | 3     | or r   | nor   | e b    | eds    | ре     | er ro  | oor    | n      |           |               |           |               |          |           |           |           |
|  |        | Ot     | ther          | r (Pl | eas      | e s        | oec   | ify)   |       |          |      |      |          |     |   |       |      |       |        |       |        |        |        |        |        |        |           |               |           |               |          |           |           |           |
| c) Hospitalisation due to:                       |        | lnj    | ury           |       | I        | llne       | SS    |        | Mate  | erni     | ty   |      |          |     |   |       |      |       |        |       |        |        |        |        |        |        |           |               |           |               |          |           |           |           |
| d) Date of Injury / Date Di                      | isea   | ıse f  | first         | de    | tect     | ed /       | / Do  | ate o  | De    | live     | ry:  |      | D        | D   | M   | M     | Υ    | ΥY    | Y      |       |        |        |        |        |        |        |           |               |           |               |          |           |           |           |
| e) Date of Admission:                            | D      | D      | M             | M     | Υ        | Υ          | f)    | Time   | Н     | Н        | : /  | M    | M        | (   | g) D  | ate   | of [ | Discl | narg   | je:   | D      | D      | M      | M      | Υ      | Υ      | ]         | n) Ti         | ime       | ::  -         | 1  -     | 1:        | M         | M         |
| i) In case of maternity,                         | I) D   | ate    | of            | De    | live     | ry:        | D     | D N    | M     | Υ        | Υ    |      | II) C    | 3r  | avid  | a St  | atu  | s:    |        |       |        |        |        |        |        |        |           |               |           |               |          |           |           |           |
| j) If injury give cause:                         |        | Se     | lf-ir         | nflic | ted      | Ì          |       | Road   | d Tro | affic    | Ac   | cid  | lent     |     |   | Su    | bst  | ance  | e Ab   | use   | e / A  | Alco   | ho     | l C    | ons    | sum    | ıptic     | on            |           |               |          |           |           |           |
|  | I) If  | Me     | edic          | o L   | ega      | ı: [       | ī     | Yes    | Г     | \<br>\   | lo   | I    | I) Re    | epo | orted   | d to  | ро   | lice: |        | Ye    | es     |        | \<br>\ | Ю      |        |        |           |               |           |               |          |           |           |           |
|  |        |        |               |       | _        |            | lice  | FIR    | atta  | _<br>che | d:   |      | Ye       |     |   | No    |      |       |        | _     |        |        | _      |        |        |        |           |               |           |               |          |           |           |           |
| k) System of Medicine:                           |        |        |               | Ė     |          |            |       |        | Т     |          |      |      | <u>.</u> | Г   | T   | ,<br> |      |       | $\neg$ | Т     | $\top$ | $\top$ | $\top$ | $\neg$ | $\neg$ | $\neg$ | $\neg$    | $\neg$        | $\neg$    | $\Box$        | $\neg$   | $\neg$    | $\neg$    | $\neg$    |





### **SECTION E - DETAILS OF CLAIM:**

| ď | Details 1 | of the | other | treatment | avnancac | claimed | i  |
|---|-----------|--------|-------|-----------|----------|---------|----|
| a | Delalis   | or me  | omer  | ireaimeni | expenses | ciaimea | i. |

| S.N. | Cover Name  | Amount (in Rs) | S.N. | Cover Name  | Amount (in Rs) |
|------|---|----------------|------|---|----------------|
|      | Pre Hospitalization Expenses                                |                |      | Green channel benefit claim against<br>Health wearable device |                |
|      | Post Hospitalization Expenses                               |                |      | Compassionate Visit in case of CI                             |                |
|      | Ambulance Cover   |                |      | Vaccination for new born                                      |                |
|      | Organ Donor Expenses  |                |      | Out-patient Cover   |                |
|      | Green channel benefit claim against<br>Non payable expenses |                |      | Air Ambulance   |                |

#### b) Details of Lump sum / cash benefit claimed

| S.N. | Cover Name                                   | Claimed | S.N. | Cover Name  | Claimed |
|------|--|---------|------|---|---------|
|      | Hospital Cash                                | Yes No  |      | Companion Benefit   | Yes No  |
|      | Loss of income benefit                       | Yes No  |      | Convalescence Benefit                                       | Yes No  |
|      | Enhanced Daily cash benefit                  | Yes No  |      | Benefit under Critical Illness optional Cover, if opted     | Yes No  |
|      | Home treatment additional daily Cash benefit | Yes No  |      | Benefit under Personal Accident optional<br>Cover, if opted | Yes No  |
|      | I delle ille dille elle elle                 |         |      |   |         |

Amount as per above covers, if claimed by you, will be paid as per the terms and conditions of the Policy plan.

| Check List of | t Claim Docu | ments to be su  | Jbmitted (In  | original)* - P | 'lease (√ ) ticl | k relevant box |
|---------------|--------------|-----------------|---------------|----------------|------------------|----------------|
| (For Hospital | Cash benefit | , photocopies c | of claim docu | ments are ac   | ceptable)        |                |

| ` | ,                                 | . ,                                      |   |   |
|---|---|--|---|---|
|   | Claim Form duly filled and signed                                       | Copy of the Claim Intimation, if any     | Hospital Bill Payment receipt   |   |
|   | Hospital Main Bill  | Hospital Break-up Bill                   | Doctor's request for investigation  |   |
|   | Hospital Discharge Summary  | Pharmacy Bill                            | Operation Theatre Notes   |   |
|   | Investigation Reports (Including CT                                     | / MRI / USG / HPE / ECG)                 | Test report and prescription relating to first consultation for the Illness                             |   |
|   | Doctor's prescription for medicines investigation done outside hospital | purchased outside the hospital and       | FIR / MLC in case of accident injury and Englis translation of the same if it is in any other language. |   |
|   | KYC document (Address proof, ID p                                       | proof only for claims exceeding ₹1 Lakh) | Original Death Summary (Wherever applicable   | ) |
|   | Cancelled cheque leaf of the bank                                       | account held in the name of the          | Any Other   |   |

### SECTION F - DETAILS OF BILLS ENCLOSED:

| SI. No | Bill No | Date | Issued by | Towards                         | Amount (Rs) |
|--------|---------|------|-----------|---------------------------------|-------------|
| 1.     |         |      |           | Hospital Main Bill              |             |
| 2.     |         |      |           | Pre-hospitalisation Bills: Nos  |             |
| 3.     |         |      |           | Post-hospitalisation Bills: Nos |             |
| 4.     |         |      |           | Pharmacy Bills                  |             |
| 5.     |         |      |           |                                 |             |
| 6.     |         |      |           |                                 |             |
| 7.     |         |      |           |                                 |             |
| 8.     |         |      |           |                                 |             |
| 9.     |         |      |           |                                 |             |
| 10.    |         |      |           |                                 |             |

Note: If there are more bills, please attach additional sheets with this claim form giving the bill details in same format as below.

Hospital Main Bill Payment Receipts only

| Receipt No. | Date | Amount (Rs) | Please (✓) Tick Relevant Box  |
|-------------|------|-------------|-------------------------------|
|             |      |             | Advance Receipt Final Receipt |
|             |      |             | Advance Receipt Final Receipt |
|             |      |             | Advance Receipt Final Receipt |
|             |      |             | Advance Receipt Final Receipt |

Note: Please attach separate sheet if necessary

<sup>•</sup> For new born baby cover, separate claim form to be filled & submitted. • For Fitness Reward points, please fill separate form "Fitness reward earning claim form" available on our website. • Benefits under Cumulative Bonus, Early joining Benefit, Restoration of Sum Insured will be provided automatically. You need not file a claim separately for these.

<sup>\*</sup>Please retain copy of complete set of claim documents for your records

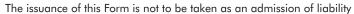


The issuance of this Form is not to be taken as an admission of liability IF THE CLAIM IS FOR ACCIDENTAL INJURIES, PLEASE PROVIDE DETAILS OF DATE, TIME AND CIRCUMSTANCES OF ACCIDENT EVENT AND OTHER DETAILS AS RELEVANT: Date: Circumstances of Accident event and other details: SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT: PLEASE PROVIDE YOUR BANK DETAILS: (PLEASE ATTACH CANCELLED CHEQUE LEAF OF BANK ACCOUNT IN THE NAME OF PRIMARY INSURED WITHOUT FAIL) a) PAN: b) Account Number: c) Bank Name and Branch: d) IFSC Code: e) Cheque/DD Payable Details: SECTION H - DECLARATION BY THE INSURED: 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, suppressed or concealed any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent & authorise TPA / insurance company to seek necessary medical information / documents from any hospital / Medical Practitioner who has attended the person for 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 pre/post hospitalization claim and for additional covers, if any. Date: Place: Signature of the Insured: Please send this duly filled and signed claim form to our TPA at below address: Family Health Plan Insurance TPA Limited Srinilaya - cyber spazio suite, 101,102,Ground Floor, Road No. 2, Banjara Hills, Hyderabad, Telangana 500034 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) SI. No/ Certificate No. Enter the social insurance number or the certificate As allotted by the organisation number of social health insurance scheme c) Company TPA ID No. Enter the TPA ID No. License number as allotted by IRDA and printed in TPA documents. Enter the full name of the policyholder Surname, First name, Middle name d) 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 / Indicate whether currently covered by another Tick Yes or No Health Insurance? Mediclaim / Health Insurance b) i. Company Name Enter the full name of the insurance company Name of the organisation in full b) ii. Policy No. Enter the policy number As allotted by the insurance company c) Date of Commencement of first Insurance Enter the date of commencement of first Use dd-mm-yy format without break insurance d) Sum Insured Enter the total sum insured as per the policy In rupees Have you been Hospitalised in the last four years Indicate whether hospitalised in the last four years Tick Yes or No since inception of the contract? f) Date Enter the date of hospitalisation Use mm-yy format g) Diagnosis Enter the diagnosis details Open Text h) Previously Covered by any other Mediclaim/ Indicate whether previously covered by another Tick Yes or No Mediclaim / Health Insurance Health Insurance?

Name of the organisation in full

Enter the full name of the insurance company

i) Company Name





| GUIDANCE FOR FILLING CLAIM FORM                                      | - PART A (To be filled in by the insured)                     |  |
|--|---|--|
| DATA ELEMENT   | DESCRIPTION   | FORMAT   |
| SECTIO   | DN C - DETAILS OF INSURED PERSON HOSPITA                      | ALIZED   |
| 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) Address   | Enter the full postal address                                 | Include Street, City and Pin Code                |
| Phone No.  | Enter the phone number of patient                             | Include STD code with telephone number           |
| E-mail ID  | Enter e-mail address of patient                               | Complete e-mail address                          |
| g) Occupation  | Indicate occupation of patient                                | Tick the right option. If others, please specify |
| i) Address of the Employer   | Complete address of the employer of the Insured               | Include Street, City and Pin Code                |
| SECTION D  | - DETAILS OF HOSPITALISATION FOR CLAIM B                      | BEING FILED                                      |
| 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) Hospitalisation due to  | Indicate reason of hospitalisation                            | Tick the right option                            |
| d) Date of injury / Date disease first detected/<br>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 ) In case of maternity   |   |  |
| I. Date of delivery  | Enter date of delivery  | Use dd-mm-yy format                              |
| ii. Gravida Status   | Enter Gravida Status  | Use standard format                              |
| j) If Injury give cause  | Indicate cause of injury                                      | Tick the right option                            |
| i. If Medico Legal   | Indicate whether injury is Medico Legal                       | Tick Yes or No                                   |
| ii. Reported to Police   | Indicate whether police report was filed                      | Tick Yes or No                                   |
| iii. MLC Report & Police FIR attached                                | Indicate whether MLC report and Police FIR attached           | Tick Yes or No                                   |
| k) System of Medicine  | Enter the system of medicine followed in treating the patient | Open Text  |
|  | SECTION E - DETAILS OF CLAIM                                  |  |
| a) Details of Treatment Expenses                                     | Enter the amount claimed as treatment expenses                | In rupees (Do not enter paise values)            |
| b) Claim for Domiciliary Hospitalisation                             | Indicate whether claim is for domiciliary hospitalization     | Tick Yes or No                                   |
| c) Details of Lump sum/ Cash Benefit 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 amounts                   | n rupees  |  |
| SECTION  | i<br>  G - Details of Primary Insured's bank ac               | CCOUNT   |
| 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                         |
| d) 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.                   |  |



The issuance of this Form is not to be taken as an admission of liability Please include the original pre-authorisation request form in lieu of PART A

Toll Free No. 1800 266 3202

| SEC  | CTION A - DETAILS                                | OF I     | HOS      | PITAI          | L (To   | be       | filled  | ni k     | blc      | ock I     | ette | ers)       | 1         |     |          |       |        |      |      |          |      |       |      |       |      |      |     |           |               |               |       |          |           |
|--|--|----------|----------|----------------|---------|----------|---------|----------|----------|-----------|------|------------|-----------|-----|----------|-------|--------|------|------|----------|------|-------|------|-------|------|------|-----|-----------|---------------|---------------|-------|----------|-----------|
| a) N   | lame of the hospital:                            |          |          |                |         |          |         |          |          |           |      |            |           |     |          |       |        |      |      |          |      |       |      |       |      |      |     |           |               |               |       |          |           |
| b) H   | lospital ID:                                     |          |          |                |         | Ī        |         | Ī        | Ī        |           | <br> | c)         | Тур       | e c | of Ho    | osp   | oital: | : [  |      | Net      | wo   | rk    |      | No    | n-N  | Vetv | vor | k (Fo     | or o          | ffice         | use   | onl      | y)        |
| d) N   | lame of the treating d                           | octor    | r:       | П              |         |          |         |          |          |           |      |            |           |     |          |       |        |      |      |          |      |       |      |       |      |      |     |           |               |               |       |          |           |
| e) G   | Qualification:                                   |          |          | П              |         | I        | Щ       | $\perp$  | L        |           |      |            |           | _   |          |       |        |      |      |          |      |       |      |       |      |      |     |           | $\Box$        | $\prod$       |       |          |           |
| f) Re  | egistration No. with Sto                         | ate C    | lode:    |                | $\perp$ | $\perp$  | $\prod$ | $\perp$  | $\prod$  |           |      |            |           | _   |          |       |        |      | g    | ) Ph     | on   | e N   | lo.: |       |      |      |     |           | $\Box$        | $\prod$       |       |          |           |
| SE   | CTION B - DETAILS                                | OF       |          | PAT            | IENT    | LAI      | TIMC    | IFD      |          |           |      |            |           |     |          |       |        |      |      |          |      |       |      |       |      |      |     |           |               |               |       |          |           |
|  | lame of the Patient:                             |          |          |                |         |          |         |          |          |           |      |            |           |     |          |       |        |      |      |          |      |       |      |       |      |      |     |           |               |               |       |          |           |
| •  | Registration Number:                             | . 🗀      | $\pm$    | $\pm \pm$      | $\pm$   | $\pm$    | +       | $\pm$    | 十        | $\pm \pm$ | 一    | 〓          | $\exists$ | _   | $\dashv$ |       | ]      | c)   | Ge   | L<br>end | er:  |       | 1    |       | Mo   | ıle  |     | $\exists$ | Fer           | male          | خ<br> |          |           |
| d) A   |  | $\vdash$ | $\dashv$ | Years          | +       | $\pm$    | Mor     | <br>nths |          |           |      |            |           | _   | —        |       | J      | ,    |      |          | of b | oirth | 1:   | D     | D    | M    | M   | Υ         | Y             | Y             | Y     |          |           |
|  | ate of Admission:                                | D        | D N      | M              | YY      | Y        | ΙΥ      |          |          |           |      |            |           |     |          |       |        |      |      | ne:      |      |       |      | Н     | Н    | : N  | \\  | 1         |               |               |       |          |           |
| •  | ate of Discharge:                                | D        | DN       | M              | YY      | Y        | Υ       |          |          |           |      |            |           |     |          |       |        |      |      | ne:      |      |       |      | Н     | Н    | : N  | 1   | 1         |               |               |       |          |           |
|  | pe of Admission:                                 | П        | Eme      | rgenc          | У       | $\vdash$ | Plan    | ned      |          |           | Do   | ау С       | Care      | 3   |          |       | Mc     |      |      |          |      |       |      | الللا |      |      |     |           |               |               |       |          |           |
| k) If  | Maternity:                                       | i. D     | ate o    | f Deli         | very:   | : D      | DV      | A M      | Y        | Y         | Υ    | Υ          |           |     | _        |       | 1      | ii.  | Gr   | avi      | da : | Stat  | tus: |       |      |      |     |           |               |               |       |          |           |
| I) Sto   | atus at time of dischar                          | rge:     |          | Discha         | ırge '  | to h     | ome     | T        | 70       | Disch     | arg  | e tc       | o an      | otl | her l    | hos   | spito  | ıl   |      |          | D    | ece   | ase  | d     |      |      |     |           |               |               |       |          | _         |
| m) T   | Total amount claimed:                            |          |          |                |         |          |         |          | Ī        |           |      |            |           |     |          |       |        |      |      |          |      |       |      |       |      |      |     |           |               |               |       |          |           |
| SE   | CTION C - DETAILS                                | S OF     | AIL      | MEN.           | T DI    | AG       | NOS     | ED (     | (PR      | IMA       | RY)  |            |           |     |          |       |        |      |      |          |      |       |      |       |      |      |     |           |               |               |       |          |           |
| a)   |  | ICD      | 10 (     | Codes          | 3       |          | De      | scrip    | otion    | <br>n     |      |            | a)        |     |          |       |        |      |      |          | ICE  | ) 1   | 0 P  | CS (  | Coc  | les  |     |           | )esc          | cript         | ion   |          |           |
| 1  | Primary Diagnosis:                               |          |          |                |         |          |         |          |          |           |      |            | 1         | +   | Proce    | edu   | re 1   | :    |      |          |      |       |      |       |      |      |     |           |               |               |       |          | $\exists$ |
| 2  | Additional Diagnosis:                            |          |          |                | +       |          |         |          |          |           |      |            | 2         | +   | Proce    | edu   | ıre 2  | :    |      |          |      |       |      |       |      |      |     |           |               |               |       |          | _         |
| 3  | Co-morbidities:                                  |          |          |                | +       |          |         |          |          |           |      |            | 3         | +   | Proce    | edu   | re 3   | :    |      |          |      |       |      |       |      |      |     |           |               |               |       |          | $\exists$ |
| 4  | Co-morbidities:                                  |          |          |                | +       |          |         |          |          |           |      |            | 4         | +   | Deta     | ils ( | of Pr  | осе  | edur | e:       |      |       |      |       |      |      |     |           |               |               |       |          | $\dashv$  |
|  |  | •        | Lite     | 1              | $\perp$ |          |         |          |          | .1\       |      |            | <u> </u>  |     |          |       |        |      |      |          |      |       | 1    |       |      |      |     |           | $\overline{}$ | $\overline{}$ |       | <u> </u> | $\exists$ |
|  | hether pre-authorisat                            |          |          |                | ا ا     | Yes      |         | No       |          |           |      | ies,       | pre       | )-a | utho     | oris  | Satio  | n i  | NUr  | nbe      | er:  |       |      |       |      |      |     |           |               | $\perp$       |       |          |           |
| e) II  | authorisation by netw                            | Ork i    | nospi    | fai no         | UO IK   | tam      | ea, gi  | ve re    | eas      | on.       |      |            |           |     |          |       |        |      |      |          |      |       |      |       |      |      |     |           |               |               |       |          | —         |
| f) H   | ospitalisation due to ir                         | niurv    |          | Yes            |         | <br>7    | 10 If   | f Yes,   | . ai     | ive c     | ans  | e:         |           |     |          |       |        |      |      |          |      |       |      |       |      |      |     |           |               |               |       |          | _         |
| .,   |  | i. [     |          | oo<br>lf-infli |         |          |         | Road     |          |           |      |            | ent       |     | ∃s       | Sub   | stan   | ice  | ab   | use      | / c  | ılco  | hol  | cor   | ısur | npt  | ion | Γ         | $\neg$        | Oth           | er    |          |           |
|  |  |          |          |                |         |          | unce a  |          |          |           |      |            |           | _   | _        |       |        |      |      |          |      |       |      |       |      | Ye   | Г   |           | —<br>No       |               |       |          |           |
|  |  |          |          | ,<br>ttach     |         |          |         |          |          |           |      |            |           |     |          |       |        |      |      |          |      |       |      |       |      |      | L   |           |               |               |       |          |           |
|  |  | iii. If  | f Med    | dico L         | .egal   | : [      | Yes     |          | \<br>  N | 10        |      | iv.        | . Re      | ро  | rted     | to    | the    | ро   | lice | :: [     |      | Ye    | S    |       | No   | )    |     |           |               |               |       |          |           |
|  |  | v. Fl    | IR No    | ).:            |         | Ī        |         | Ί        | İ        |           |      | vi.        | . If r    | not | rep      | ort   | ed t   | o tl | he   | pol      | ice, | giv   | e re | easc  | on:  |      |     |           |               |               |       |          |           |
|  |  |          |          |                |         |          |         |          |          |           |      |            |           | _   |          |       |        |      |      |          |      |       |      |       |      |      |     |           |               |               |       |          |           |
| g) W   | Vhen did the patient st                          | lart s   | ufferi   | ing of         | the     | com      | nplain  | ıt:      |          |           |      |            |           |     |          |       |        |      |      |          |      |       |      |       |      |      |     |           |               |               |       |          |           |
|  |  | Date     | e of f   | first co       | onsul   | ltatio   | on:     | D        | D        | M         | 1    | / <u>}</u> | Y         |     | Υ        |       |        |      |      |          |      |       |      |       |      |      |     |           |               |               |       |          |           |
| h) Pl  | lease give previous m                            | edico    | al his   | tory o         | of the  | pat      | ient:   |          |          |           |      |            |           | _   |          |       |        |      |      |          |      |       |      |       |      |      |     |           |               |               |       |          | _         |
| I) Is  | the patient suffering f                          | rom      | any c    | of the         | follo   | win      | g dise  | eases    | s\$ I    | lf "Ye    | s" P | 'lea       | ise r     | ne  | ntio     | n tl  | he d   | luro | atio | n b      | elo  | w.    |      |       |      |      |     |           |               |               |       |          |           |
|  |  |          |          |                |         |          |         |          |          |           |      |            |           | Y   | es / l   | No    |        |      |      |          |      |       | ı    | Dur   | atio | n in | yea | ır & ı    | mor           | nths          |       |          |           |
| 1  | High or low blood pre                            | ssure    | , che    | st pair        | 1, or 0 | any d    | other c | ardic    | ac       |           |      |            |           |     |          |       |        |      |      |          |      |       |      |       |      |      |     |           |               |               |       |          |           |
| 2  | Tuberculosis, asthma,                            | bron     | chitis   | or any         | y othe  | er lur   | ng / re | spirc    | notr     | у         |      |            |           |     |          |       |        |      |      |          |      |       |      |       |      |      |     |           |               |               |       |          |           |
| 3  | Ulcer (stomach / duoc<br>any other digestive tra |          |          |                | old Ilc | adde     | r diso  | rder (   | or       |           |      |            |           |     |          |       |        |      |      |          |      |       |      |       |      |      |     |           |               |               |       |          | _         |
| 4  | Kidney failure, stone in                         | n kidr   | ney or   | r urina        |         |          |         | e        |          |           |      |            |           |     |          |       |        |      |      |          |      |       |      |       |      |      |     |           |               |               |       |          | _         |
| disorder or any other kidney / urinary tract disorder  5 Stroke, epilepsy (fits), paralysis or any other nervous system (brain, spinal cord, etc) disorder |  |          |          |                |         |          |         |          |          |           |      |            |           |     |          |       |        |      |      |          |      |       |      |       |      |      |     |           |               |               |       |          |           |

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|        |   | Yes / No Duration in year & months   |
|--------|---|--|
| 6      | Diabetes, Impaired glucose tolerance (Pre-diabetes), Thyroid/Pituitary Disorder or any other endocrine disorder |  |
| 7      | Tumor (swelling)-benign or malignant, any external ulcer / growth / cyst / mass anywhere in the body            |  |
| 8      | Arthritis, spondylosis or any other disorder of the muscle / bone / joint                                       |  |
| 9      | Diseases of the ear / nose / throat / teeth / eye (please mention dioptres in case of refractory error)         |  |
| 10     | HIV / AIDS or sexually transmitted diseases or any immune system disorder                                       |  |
| 11     | Anaemia, leukaemia, lymphoma or any other blood / lymphatic system disorder                                     |  |
| 12     | Psychiatric / mental illnesses or sleep disorder  |  |
| 13     | Uterine fibroid, fibroadenoma breast or any other gynaecological (female reproductive system) / breast disorder |  |
| 14     | Any other illness or injury not mentioned above (other than common cold)  |  |
| g) Is  | the ailment a complication / sequel of a pre-existing disease o   | or condition? Yes No   |
| If Yes | s, please give details:   |  |
| h) Hi  | story of alcoholism Yes No If yes: No of years:   | Quantity consumed per day  |
| I) Hi  | story of smoking / tobacco chewing: Yes No If Yes   | s: No of years: Units consumed per day   |
| SEC    | CTION D - CLAIM DOCUMENTS SUBMITTED - CHECK   | LIST   |
|        | Claim Form duly signed  | Investigation reports  |
|        | Original pre-authorisation request  | CT/MR/USG/HPE investigation reports  |
|        | Copy of the pre-authorisation approval letter   | Doctor's reference slip for investigation  |
|        | Copy of photo ID card of patient verified by hospital   | ECG  |
|        | Hospital discharge summary  | Pharmacy bills   |
|        | Operation theatre notes   | MLC report & Police FIR  |
| Щ      | Hospital main bill  | Original death summary from hospital where applicable  |
|        | Hospital break-up bill  | Other, please specify  |
| SEC    | CTION E - ADDITIONAL DETAILS IN CASE OF NON-NET   | WORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)  |
| a) Ad  | Idress of the hospital:   |  |
| City:  |   | State:   |
| Pinco  | ode: b) Phone No:   |  |
| c) Re  | gistration No. with State Code:   | d) Hospital PAN:   |
| e) Nu  | umber of Inpatient beds:  |  |
| f) Fac | cilities available in the hospital: i. OT: Yes Mo ii. IC  | CU: Yes No iii. Round the clock Doctor / Nurses: Yes No  |
|        | iv. Maintains daily record of po  | atients: Yes No v. Others:   |
| SEC    | CTION F - DECLARATION BY THE HOSPITAL (PLEASE F   | READ VERY CAREFULLY)   |
|        |   | m is true & correct to the best of our knowledge and belief. If we have material fact, our right to claim under this claim shall be forfeited. |
|        |   |  |
| Date   |   |  |
| Place  | D:  | Signature and Seal of the Hospital Authority:  |
|        | ease send this duly filled and signed claim form to our TPA at be<br>mily Health Plan Insurance TPA Limited     | elow address:  |

Srinilaya - cyber spazio suite, 101,102,Ground Floor, Road No. 2, Banjara Hills, Hyderabad, Telangana 500034

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| Authorisation Letter (Mandatory)                    |  | Date: DDMMYYYYY                                      |
|---|--|--|
| From:   |  |  |
| To:<br>The Manager / Medical Superintendent, Medica | l Records  |  |
| Dear Sir  |  |  |
|   | Reg: Authorisation Letter.   |  |
| Name of the Patient:                                |  |  |
| IP Number   | (First admission) in   | Hospital   |
| IP Number   | (Second admission) in  | Hospital   |
| IP Number   | (Third admission) in   | Hospital   |
| hospital and share copies of indoor case sheets     | ral Insurance Co. Limited and their Authorised Service and such other relevant medical records and / or medical records a | eet / obtain statement from the Medical Practitioner |
| Thanking you,                                       |  |  |
| Yours sincerely,                                    |  |  |
|   |  |  |
| Signature of the Proposer                           | Siç  | gnature of the Patient                               |

| orginatore of the Proposer   | J.8   | digital of the falletin                      |  |  |
|--|---|--|--|--|
| 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 ADMITTE                            | I<br>ED                                      |  |  |
| 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  | Tick the right option   | Tick the right option                        |  |  |
| Date of Delivery   | Enter Date of Delivery if maternity                                   | Use dd-mm-yy format                          |  |  |
| Gravida Status   | Enter Gravida Status if maternity                                     | Use standard format                          |  |  |
| I) Status at time of discharge   | Indicate status of patient at time of discharge                       | Tick the right option                        |  |  |
| m) Total amount claimed  | Indicate the total amount claimed                                     | In rupees (Do not enter paise values)        |  |  |

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| SECTION C - DETAILS OF AILMENT DIAGNOSED   PRIMARY   Primary Diagnosis   Enter the ICD 10 Code and description of the primary diagnosis    Additional Diagnosis   Enter the ICD 10 Code and description of the odditional diagnosis    Co-morbidities   Enter the ICD 10 Code and description of the comorbidities    Enter the ICD 10 Code and description of the comorbidities    Enter the ICD 10 PCS and description of the first procedure    Procedure 1   Enter the ICD 10 PCS and description of the first procedure    Procedure 2   Enter the ICD 10 PCS and description of the second procedure    Procedure 3   Enter the ICD 10 PCS and description of the second procedure    Details of Procedure   Enter the ICD 10 PCS and description of the third procedure    Details of Procedure   Enter the ICD 10 PCS and description of the third procedure    Details of Procedure   Enter the ICD 10 PCS and description of the third procedure    Details of Procedure   Enter the ICD 10 PCS and description of the third procedure    Details of Procedure   Enter the ICD 10 PCS and description of the third procedure    Details of Procedure   Enter the ICD 10 PCS and description of the third procedure    Details of Procedure   Enter the ICD 10 PCS and description of the third procedure    Details of Procedure   Enter the ICD 10 PCS and description of the third procedure    Details of Procedure   Enter the ICD 10 PCS and description of the third procedure    Details of Procedure   Enter the ICD 10 PCS and description of the third procedure    Details of Procedure   Enter the ICD 10 PCS and description of the third procedure    Details of Procedure   Enter the ICD 10 PCS and description of the India procedure    Details of Procedure   Enter the ICD 10 PCS and description of the India procedure    Details of Procedure   Enter the ICD 10 PCS and description of the India procedure    Details of Procedure   Enter the ICD 10 PCS and description of the India procedure    India procedure   Enter the ICD 10 PCS and description of the India procedure    Indicat | GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled in by the Insured) |  |  |  |  |
|--|---|--|--|--|--|
| Course   Finance   Course   Enter the ICD 10 Code and description of the primary diagnosis   Standard format and open text   | DATA ELEMENT  | DESCRIPTION  | FORMAT   |  |  |
| Course   Finance   Course   Enter the ICD 10 Code and description of the primary diagnosis   Standard format and open text   | SECTION   | i<br>DN C - DETAILS OF AILMENT DIAGNOSED (PRI        | IMARY)   |  |  |
| Additional Diagnosis  Additional Diagnosis  Enter the ICD 10 Cade and description of the combridities  Enter the ICD 10 Cade and description of the combridities  Di ICD 10 PCS  Procedure 1  Enter the ICD 10 PCS and description of the first procedure  Procedure 2  Enter the ICD 10 PCS and description of the first procedure  Procedure 3  Enter the ICD 10 PCS and description of the second procedure  Procedure 3  Enter the ICD 10 PCS and description of the third procedure and procedure  Procedure 3  Enter the ICD 10 PCS and description of the third procedure and procedure  Details of Procedure 3  Enter the ICD 10 PCS and description of the third procedure and procedure  | a) ICD 10 Code  | ,  | ,  |  |  |
| deficional diagnosis Enter the ICD 10 Code and description of the comorbidities    ICD 10 PCS  | Primary Diagnosis   |  | Standard format and open text                    |  |  |
| morbidities Procedure 1 Procedure 2 Procedure 2 Procedure 2 Procedure 3 Procedure 3 Procedure 3 Procedure 3 Procedure 3 Procedure 4 Procedure 5 Procedure 5 Procedure 6 Procedure 7 Procedure 8 Procedure 8 Procedure 9 Proced | Additional Diagnosis  |  | Standard format and open text                    |  |  |
| Procedure 1 Enter the ICD 10 PCS and description of the first procedure 2 Enter the ICD 10 PCS and description of the first second procedure 3 Enter the ICD 10 PCS and description of the third second procedure 4 Procedure 3 Enter the ICD 10 PCS and description of the third procedure 5 Procedure 3 Enter the ICD 10 PCS and description of the third procedure 6 C Whether pre-outhorisation obtained 1 Indicate whether pre-outhorisation obtained 1 Indicate whether pre-outhorisation obtained 2 Indicate the Indicate whether pre-outhorisation procedure 6 If unknotization by network hospital not 2 Enter pre-authorisation number As allotted by TPA 6 Indicate whether pre-outhorisation procedure 7 Indicate the Indicate whether pre-outhorisation procedure 8 If injury due to injury 1 Indicate if hospitalisation is due to injury 1 Indicate if hospitalisation is due to injury 1 Indicate whether test conducted 1 Indicate whether test conducted 1 Indicate whether procedure 7 Indicate whether procedure 8 Indicate whether procedure 9 Indicate Whether procedure 9 Indicate Whether procedure 9 Indicate Whether procedure 9 Ind | Co-morbidities  | · ·  | Standard format and open text                    |  |  |
| Procedure 2 Enter the ICD 10 PCS and description of the second procedure Procedure 3 Enter the ICD 10 PCS and description of the third procedure Procedure 3 Enter the ICD 10 PCS and description of the third procedure Details of Procedure Enter the details of the procedure Open text    Details of Procedure   Enter the details of the procedure   Open text  | b) ICD 10 PCS   |  |  |  |  |
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| Enter reason for not obtainingpre-authorisation obtained, give reason for not obtainingpre-authorisation obtained, give reason for not obtainingpre-authorisation number  Cause Indicate in hospitalisation is due to injury Tick Yes or No  Indicate cause of injury Tick Yes or No  Indicate cause of injury Tick the right option  If injury due to substance abuse / alcohol consumption, test conducted to establish this  Medico Legal Indicate whether test conducted  Reported To police Indicate whether police report was filed Tick Yes or No  Reported To police Indicate whether police report number As issued by police authorities  If not reported to the police, give reason Enter reason for not reporting to the police Open text  Indicate whether the date when the symptom / complaint Use dd-mm-yy format  Indicate the date when the symptom / complaint Use dd-mm-yy format  Indicate whether present aliment is a complication of pre-existing diseases  Indicate whether present aliment is a complication that existed prior to policy inception  Indicate Yes or No. If 'yes' state quantity consumed Open text  Indicate Yes or No. If 'yes' state quantity consumed Open text  SECTION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST  Indicates which supporting documents are submitted.  SECTION E - DETAILS IN CASE OF NON-NETWORK HOSPITAL  Indicate STD code with telephone number of hospital Include STD code with telephone number of the doctor along with the state code  Chert the registration number of the doctor along with the foliate ovalidable at the hospital Indicate be specify  SECTION F - DECLARATION BY THE HOSPITAL  SECTION F - DECLARATION BY THE HOSPITAL   | c) Whether pre-authorisation obtained                                     | Indicate whether pre-authorisation obtained          | Tick Yes or No                                   |  |  |
| obtained, give reason [7] Hospitalization due to injury [8] Hospitalization due to injury [9] Hospitalization due to injuri [9] Hospitalization due to injuri [9] Hospitalization due to injuri [9] Hospitalization due to injuri [9] Hospitalization due to injuri [9] Hospitalization due to injuri [9] Hospitalization due to injuri [9] Hospitalizatio | d) Pre-authorisation Number   | Enter pre-authorisation number                       | As allotted by TPA                               |  |  |
| Indicate cause of injury   Tick the right option   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  |   |  | Open text  |  |  |
| If injury due to substance abuse / alcohol consumption, test conducted to establish this  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 the police, give reason Enter reason for not reporting to the police Open text  Government of Previous medical history Enter the medical history Open text  State Yes or No Durations should be in years and months  Indicate whether present ailment is a complication of pre-existing diseases Indicate Yes or No. If 'yes' state quantity consumed  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 STD code with telephone number of the doctor along with the state code  As allocated by the Income Tax department  As allocated by the Medical Council of India  Whether the Permanent Account Number As allotted by the Income Tax department  Enter the Full postal address Digits  Include STD code with telephone number of Inpatient beds Digits  Fince The Permanent Account Number As allotted by the Income Tax department  Enter the Permanent Account Number As allotted by the Income Tax department  Enter the number of Inpatient beds Digits  Include SECTION Indicate facilities available at the hospital Tick the right option. If others, please specify   | f) Hospitalization due to injury  |  | 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 the police, give reason Enter reason for not reporting to the police Open text  Government of the police of t |   | ' '  |  |  |  |
| Reported To police   |   | Indicate whether test conducted                      | Tick Yes or No                                   |  |  |
| FIR No.  Enter first information report number  As issued by police authorities  Enter reason for not reporting to the police  Open text  Open text  Description of previous medical history  i) Specific diseases  State Yes or No  Indicate whether present ailment is a complication that existed prior to policy inception  Indicate Yes or No. If 'yes' state quantity consumed  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 phone number of hospital  Include Street, City and Pin Code  Enter the registration number of the doctor along with the state code  OHOSPITAL  Enter the Permanent Account Number  As allotted by the Income Tax department  Enter the phone Inpatient beds  Enter the hospital  Indicate available at the hospital  Indicate available at the hospital  Indicate available at the hospital  Tick the right option. If others, please specify  SECTION B - DECLARATION BY THE HOSPITAL  Tick the right option. If others, please specify   | Medico Legal  | Indicate whether injury is Medico Legal              | Tick Yes or No                                   |  |  |
| If not reported to the police, give reason  Enter reason for not reporting to the police  Open text  Use dd-mm-yy format  Open text  Open text  Open text  Open text  Open text  Open text  Open text  Indicate the date when the symptom / complaint  Nomelication of pre-existing diseases  Indicate whether present ailment is a complication of pre-existing diseases  Indicate whether present ailment is a complication of pre-existing diseases  Indicate whether present ailment is a complication that existed prior to policy inception  Indicate Yes or No. If 'yes' state quantity consumed  Open text  Open text  Open text  Open text  Open text  SECTION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST  Indicate which supporting documents are submitted.  SECTION E - DETAILS IN CASE OF NON-NETWORK HOSPITAL  Open text  SECTION E - DETAILS IN CASE OF NON-NETWORK HOSPITAL  Open text  Include STD code with telephone number of hospital  Include STD code with telephone number  Open text  SECTION E - DETAILS IN CASE OF NON-NETWORK HOSPITAL  Open text  Include STD code with telephone number  Include STD code with telephone number  Open text  SECTION F - DETAILS IN CASE OF NON-NETWORK HOSPITAL  Include STD code with telephone number  As allocated by the Medical Council of India with the state code  Include STD code with telephone number  Open text  SECTION F - DETAILS IN CASE OF NON-NETWORK HOSPITAL  Include STD code with telephone number  As allocated by the Medical Council of India with the state code  Include STD code with telephone number  Open text  SECTION F - DECLARATION BY THE HOSPITAL  Include STD code with telephone number  Include STD code with telephone number  Open text  Open text  | Reported To police  | Indicate whether police report was filed             | Tick Yes or No                                   |  |  |
| Indicate the date when the symptom / complaint   Use dd-mm-yy format   | FIR No.   | Enter first information report number                | As issued by police authorities                  |  |  |
| Enter the medical history  i) Specific diseases  State Yes or No  Duration should be in years and months  Complication of pre-existing diseases  Indicate whether present ailment is a complication that existed prior to policy inception  Indicate Yes or No. If 'yes' state quantity consumed  Open text  Open text  Open text  Open text  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  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  d) Hospital PAN  Enter the Permanent Account Number  As allocated by the Medical Council of India with the state code  f) Facilities available at the hospital  Indicate facilities available at the hospital  Include STD code with telephone number  As allotted by the Income Tax department  Enter the Permanent Account Number  As allotted by the Income Tax department  Include STD code with telephone number  As allotted by the Income Tax department  Enter the number of inpatient beds  Include STD code with telephone number  As allotted by the Income Tax department  Enter the number of inpatient beds  Include STD code with telephone number  As allotted by the Income Tax department  Include STD code with telephone number  As allotted by the Income Tax department  Include STD code with telephone number  Include STD code with telephone number  Include STD code with telephone number  Include STD code with telephone number  Include STD code with telephone number  Include STD code with telephone number  Include STD code with telephone number  Include STD code with telephone number  Include STD code with telephone number  Include STD code with telephone number  Include STD code with telephone number  Include STD code with telephone number  Include STD code with telephone numbe | If not reported to the police, give reason                                | Enter reason for not reporting to the police         | Open text  |  |  |
| SECTION E - DETAILS IN CASE OF NON-NETWORK HOSPITAL  SECTION E - DETAILS IN CASE OF NON-NETWORK HOSPITAL  Segistration No. with State Code  Check Registration No. with State Code  (d) Hospital PAN  Enter the Permanent Account Number  Enter the Permanent Account Number  Enter the Permanent Account Number  Enter the number of Inpatient beds  Enter the number of Inpatient beds  Enter the number of inpatient beds  Enter the number of inpatient beds  Facilities available at the hospital  Indicate facilities available at the hospital  Indicate facilities available at the hospital  Indicate specific diseases  Indicate whether present ailment is a complex to policy inception  Open text  Open text  Open text  Open text  Open text  Open text  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  Include Street, City and Pin Code  Include STD code with telephone number  As allocated by the Medical Council of India  with the state code  Digits  Tick the right option. If others, please specify  | g) Complaints / Symptoms  | Indicate the date when the symptom / complaint       | Use dd-mm-yy format                              |  |  |
| Indicate whether present ailment is a complication of pre-existing diseases  Indicate whether present ailment is a complication that existed prior to policy inception  Indicate Yes or No. If 'yes' state quantity consumed  Open text  Open text  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  d) Hospital PAN  Enter the Permanent Account Number  As allocated by the Income Tax department  Enter the number of inpatient beds  Enter the number of inpatient beds  Indicate facilities available at the hospital  Tick the right option. If others, please specify  SECTION F - DECLARATION BY THE HOSPITAL   | h) Previous medical history   | Enter the medical history                            | Open text  |  |  |
| complication that existed prior to policy inception  k) Alcoholism  Indicate Yes or No. If 'yes' state quantity consumed  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  Enter the phone number of hospital  Include STD code with telephone number  c) Registration No. with State Code  Hospital PAN  Enter the Permanent Account Number  As allotted by the Income Tax department  e Number of Inpatient beds  Facilities available at the hospital  Indicate facilities available at the hospital  Tick the right option. If others, please specify  SECTION F - DECLARATION BY THE HOSPITAL  | i ) Specific diseases   | State Yes or No                                      | Duration should be in years and months           |  |  |
| Smoking of tobacco   | j) Complication of pre-existing diseases                                  |  | Open text  |  |  |
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