CIN U66010RJ2006PLC029979

IRDAI Registration Number – 137

SHRIRAM GENERAL INSURANCE COMPANY LIMITED
E-8, EPIP, RIICO Industrial Area, Sitapura, Jaipur, Rajasthan – 302022, INDIA
Email: chd@shriramgi.com, Website: www.shriramgi.com

REIMBURSEMENT CLAIM FORM FOR HEALTH INSURANCE POLICIES PART- A
(TO BE FILLED IN BLOCK LETTERS)

A. DETAILS OF PRIMARY INSURED:

a) Policy Number:

b) Claim Number :

c) Insured Name:

d) Insured's Address:

City: State:

Pin Code: Phone No.:

Email ID:

B. DETAILS OF INSURANCE HISTORY:

a) Currently covered by any other Mediclaim/ Health Insurance: Yes ☐ No ☐

i. If yes, Company Name

ii. Give details of the policy number

b) Date of commencement of first insurance without break: D D M M Y Y Y Y

c) Have you been hospitalized in the last 3 to 4 years since inception of the contract? Yes ☐ No ☐

i. If Yes, Please specify the Diagnosis / Ailment :

d) Previously covered by any other Mediclaim/ Health insurance: Yes ☐ No ☐

i. If yes, Company Name

C. DETAILS OF THE INSURED PERSON HOSPITALIZED :

a) Insured Name:

b) Gender: Male ☐ Female ☐ Third Gender ☐

c) Age: d) Date of Birth: D D M M Y Y Y Y

e) Relationship with primary insured: Self ☐ Spouse ☐ Child ☐ Father ☐ Mother ☐ Others ☐ (Please specify)

f) Occupation: Service ☐ Business ☐ Homemaker ☐ Student ☐ Retired ☐ Others ☐ (Please specify)

g) Insured Address *(If Different from above):*

City: State:

Pin code: Phone No:

Email ID:

D. DETAILS OF HOSPITALIZATION :

a) Name of Hospital where admitted:

b) Address of the Hospital where admitted?

City: | State: | ROHINI ID :

Pin code: | Phone No: | Registration No.

c) Hospitalization due to:

Injury	Illness	Maternity	Critical Ailment	Infectious Disease	Others
☐	☐	☐	☐	☐	☐

If others (please specify)

d) Room Category (tick the room opted)

Single AC Room ☐ Double Sharing AC ☐ Multi-Bedded AC ☐ Deluxe Room ☐

Single Non-AC Room ☐ Double Sharing Non AC ☐ Multi-Bedded Non AC ☐ ICU/HDU ☐

e) Date of Admission: f) Time of admission

g) Date of Discharge: h) Time of discharge

i) System of Medicine Surgical ☐ Non-Surgical ☐

j) Name of Surgery (If surgery done)

k) If Injury give cause:

Self-inflicted	Road traffic Accident	Substance Abuse/ Alcohol Consumption
☐	☐	☐

l) In case of RTA :

i. Reported to Police: Yes ☐ No ☐

ii. FIR Done : Yes ☐ No ☐ (if yes attach the report)

iii. MLC done : Yes ☐ No ☐ (if yes attach the report)

E. DETAILS OF THE CLAIM :

a) Details of the treatment expenses claimed :

i. Pre-hospitalization Expenses: | ii. Hospitalization Expenses

iii. Post-hospitalization Expenses: | iv. Health-Check-up Cost

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

b) **Total Amount claimed under reimbursement**

vii. Pre-hospitalization period: | viii. Post-hospitalization period:

c) Claim for Domiciliary Hospitalization: Yes ☐ No ☐ (If yes, Provide details in annexure)

d) Details of Lump sum/ cash benefit claimed:

i. Hospital Daily Cash: | ii. Surgical Cash:

iii. Critical Illness Benefit: | iv. Convalescence:

v. Pre/post hospitalization Lump sum benefit: | vi. Others:

CLAIM DOCUMENTS SUBMITTED-CHECK LIST:

☐ Claim Form Duly signed	☐ Copy of the claim intimation, If any	☐ Hospital Final Bill Break-up
☐ Hospital Bill payment Receipt	☐ Hospital Discharge Summary	☐ Doctor's Prescriptions for admission
☐ Operation Theatre Notes	☐ Pharmacy & Lab Bills	☐ Doctor's request for investigation
☐ MLC report & Police FIR	☐ Copy of photo ID card of patient	☐ Original death summary (if death)
☐ Investigation Reports (Including CT/ MRI/ USG/ HPE)	☐ KYC form (if more than 1 lakh)	☐ Others (please specify)

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F. DETAILS OF BILLS ENCLOSED :

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

G. PAYEE DETAILS (*All fields are mandatory/ Please enclose cancelled cheque copy)

Bank Name		Bank Branch	
Bank Account No.		IFSC Code	
MICR No.		PAN No.	

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, 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:		Signature of the insured	
Place:			

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) Claim Number	Enter the claim number	As allotted by the insurance company
c) Name	Enter the full name of the policyholder	Surname, First name, Middle name
d) Address	Enter the full postal address	Include Street, City and Pin Code
SECTION B – DETAILS OF INSURANCE HISTORY		
a) Currently covered by any other Mediclaim / Health Insurance?	Indicate whether currently covered by another Mediclaim /Health Insurance	Tick Yes or No
b) Date of Commencement of first Insurance without break	Enter the date of commencement of first insurance	Use dd-mm-yy format
c) Have you been hospitalized in the last 3-4 years since inception of the contract?	Indicate whether hospitalized in the last four years	Tick Yes or No
If YES, mention Diagnosis	Enter the diagnosis details	Open Text
d) Previously Covered by any other Mediclaim /Health Insurance?	Indicate whether previously covered by another Mediclaim / Health Insurance	Tick Yes or No
SECTION C – DETAILS OF INSURED PERSON HOSPITALIZED		
a) Name	Enter the full name of the patient	Surname, First name, Middle name
b) Gender	Indicate Gender of the patient	Tick Male or Female
c) Age	Enter age of the patient	Number of years and months
d) Date of Birth	Enter Date of Birth of patient	Use dd-mm-yy format
e) Relationship to primary Insured	Indicate relationship of patient with policyholder	Tick the right option. If others, please specify.
f) Occupation	Indicate occupation of patient	Tick the right option. If others, please specify.
g) Insured Address	Enter the full postal address	Include Street, City and Pin Code

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SECTION D. DETAILS OF HOSPITALIZATION		
a) Name of Hospital where admitted	Enter the name of hospital	Name of hospital in full
b) Address of the hospital	Enter full address	Include Street, City and Pin Code
c) Hospitalization due to	Indicate reason of hospitalization	Tick the right option
d) Room category occupied	Indicate the room category occupied	Tick the right option
e) Date of admission	Enter date of admission	Use dd-mm-yy format
f) Time of admission	Enter time of admission	Use hh:mm format
g) Date of discharge	Enter date of discharge	Use dd-mm-yy format
h) Time of discharge	Enter time of discharge	Use hh:mm format
i) System of Medicine	Enter the system of medicine followed in treating the patient	Open Text
j) Name of surgery	As per treatment papers mentioned the surgery name	Open Text
k) If injury give details	Indicate the type of injury	Tick the right option
l) In case of RTA		
Reported to Police	Indicate whether police report was filed	Tick Yes or No
FIR done	Indicate whether FIR done and attached	Tick Yes or No
MLC Report	Indicate whether MLC done and attached	Tick Yes or No
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) Total Amount Claimed	Enter the total hospitalisation expenses	In rupees (Do not enter paise values)
c) Claim for Domiciliary Hospitalization	Indicate whether claim is for domiciliary hospitalization	Tick Yes or No
d) Details of Lump sum/ cash benefit claimed	Enter the amount claimed as lump sum/ cash benefit	In rupees (Do not enter paise values)
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 in rupees (kindly mention – Bill Number & Bill Date)		
SECTION G. PAYEE DETAILS		
a) Bank Name	Enter the bank name	As allotted by the bank
b) Branch Name	Enter the branch name	As allotted by the bank
c) Account Number	Enter the bank account number	As allotted by the bank
d) IFSC Code	Enter the IFSC code of the bank branch	IFSC code of the bank branch in full
e) MICR number	Enter the MICR number of the bank	As allotted by the bank
f) PAN	Enter the permanent account number	As allotted by the Income Tax department
SECTION H. DECLARATION BY THE INSURED		
Read declaration carefully and mention date (in dd: mm: yyyy format), place (open text) and sign.		

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REIMBURSEMENT CLAIM FORM - TO BE FILLED IN BY THE HOSPITAL : PART B

A. DETAILS OF HOSPITAL

a. Name of hospital

b. Hospital ID ROHINI Code

c. Type of hospital Network ☐ Non Network ☐ *(If non network fill section E)*

d. Treating Doctor

e. Qualification f. Doctor Registration No.

f. Hospital Address

City State Pin code

B. DETAILS OF THE PATIENT ADMITTED

a. Name of the Patient

b. IP Registration No:

c. Gender Male ☐ Female ☐ Third gender ☐

d. Age of the Patient e. Date of Birth D D M M Y Y Y Y

f. Date of admission g. Time of admission

h. Date of discharge i. Time of discharge

j. Type of Admission Emergency ☐ Planned ☐ Day Care ☐ Maternity ☐

k. If Maternity i.) Date of Delivery: ii) Gravida Status:

l. Status at the time of discharge:

Discharge to Home	Discharge to another hospital	Insured Deceased	Discharged against Medical Advice
☐	☐	☐	☐

C. DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a.		ICD 10 Code	Description	b.		ICD 10 PCS code	Description
i)	Primary Diagnosis:			i)	Procedure 1:		
ii)	Additional Diagnosis:			ii)	Procedure 2:		
iii)	Co-morbidities:			iii)	Procedure 3:		
iv)	Co-morbidities:			iv)	Procedure 4:		

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

g. If yes, Please give cause;

Self-Inflected	Road Traffic Accident	Substance abuse/ alcohol consumption
☐	☐	☐

h. For RTA case i) Reported to police: Yes ☐ No ☐ ii) FIR / MLC done : Yes ☐ No ☐ *(If yes, attach report)*

If not reported to police give reason

D. CLAIM DOCUMENTS SUBMITTED – CHECK LIST

☐ Claim Form Duly signed	☐ Copy of the claim intimation, If any	☐ Hospital Final Bill Break-up
☐ Hospital Bill payment Receipt	☐ Hospital Discharge Summary	☐ Doctor's Prescriptions for admission
☐ Operation Theatre Notes	☐ Pharmacy & Lab Bills	☐ Doctor's request for investigation
☐ MLC report & Police FIR	☐ Copy of photo ID card of patient	☐ Original death summary (if death)
☐ Investigation Reports (Including CT/ MRI/ USG/ HPE)	☐ KYC form (if more than 1 lakh)	☐ Others (please specify)

E. 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. Registration No. with State Code: | c. Hospital PAN:

d. Phone Number | e. Email id :

f. Number of Inpatient beds:

g. Facilities available in the hospital — OT facility ☐ Yes ☐ No — ICU facility ☐ Yes ☐ No

Others:

F. DECLARATION BY THE HOSPITAL (PLEASE READY VERY CAREFULLY)

We hereby declare that the information furnished in this Claim Farm is true & correct ta 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 of the Hospital

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) Hospital address	Enter the Hospital Address	Include Street, City and Pin Code
SECTION B DET AILS OF THE PATIENT ADMITTED		
a) Name of Patient	Enter the name of hospital	Name of hospital in full
b) IP Registration Number	Enter insurance provider registration number	As allotted by the insurance provider
c) Gender	Indicate Gender of the patient	Tick Male or Female
d) Age	Enter age of the patient	Number of years and months
e) Date of Birth	Enter date of admission	Use dd-mm-yy format
f) Date of Admission	Enter date of admission	Use dd-mm-yy format
g) Time of admission	Enter time of admission	Use hh:mm format

h) Date of Discharge	Enter date of discharge	Use dd-mm-yy format
I) Time of discharge	Enter time of discharge	Use hh:mm format
j) Type of Admission	Indicate type of admission of patient	Tick the right option
k) If Maternity		
Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format
Gravida Status	Enter Gravida status if maternity	Use standard format
I) Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
SECTION C DETAILS OF AILMENT DIAGNOSED (PRIMARY)		
DATA ELEMENT	**DESCRIPTION**	**FORMAT**
a) ICD 10 Code		
Primary Diagnosis	Enter the ICD l O Code and description of the primary diagnosis	Standard Format and Open text
Additional Diagnosis	Enter the ICD l O Code and description of the additional diagnosis	Standard Format and Open text
Co-morbidities	Enter the ICD l O Code and description of the co-morbidities	Standard Format and Open text
DATA ELEMENT	**DESCRIPTION**	**FORMAT**
b) ICD 10 PCS		
Procedure 1	Enter the ICD 10 PCS and description of the first procedure	Standard Format and Open text
Procedure 2	Enter the ICD l 0 PCS and description of the second procedure	Standard Format and Open text
Procedure 3	Enter the ICD l 0 PCS and description of the third procedure	Standard Format and Open text
Description	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
g) if yes, select the reason	Indicate cause of injury	Tick the right option
h) For RTA cases		
Reported To Police	Indicate whether police report was filed	Tick Yes or No
FIR No. / MLC No.	Enter first information report number	As issued by police authorities
If not reported to police, give reason	Enter reason for not reporting to police	Open Text
SECTION D CLAIM DOCUMENTS SUBMITTED-CHECK LIST		
Indicate which supporting documents are submitted		

SECTION E DETAILS IN CASE OF NON NETWORK HOSPITAL		
a) Address	Enter the full postal address	Include Street, City and Pin Code
b) 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
c) Hospital PAN	Enter the permanent account number	As allotted by the Income Tax department
d) Phone Number	Enter the phone number of hospital	Include STD code with telephone number
e) Email ID	Enter the Registered Email ID of hospital	As per website
f) Number of Inpatient beds	Enter the number of inpatient beds	Digits
g) Facilities available in the hospital	Indicate facilities available in the hospital	Tick the right option. If others, please specify
SECTION F CLAIM DOCUMENTS SUBMITTED-CHECK LIST		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign and stamp		