ICICI Lombard Health Care Claim Form - Hospitalization

(Issuance of this form is not to be taken as an admission of liability)

Overview Health Claim Form - Hospitalization			
	Part A	**To be filled**	**Requirement**
A1	Type of Claim- To be filled by Insured	By insured/ insured relatives	To track the policy and other details of the insured
A2	Details of the insured person-To be filled by Insured		
A3	Available in Policy Copy/ Employee details		
A4	Available in Policy Copy		
A5	Available in Discharge Summary		
A6	Other policy coverages		
A7	Currently covered by any other mediclaim		
A8	Available in Hospital Bills/ Self Declaration		
A9	Available in Hospital Bills		
A10	Checklist		
A11	Reason of delay-To be filled by Insured		
Page end	Self Declaration		
	Part B		
B1	Hospital Details	To be filled by Hospital/ Treating doctor	To track the hospital details and the treatment details related to the patient admission
B2	Doctor Details		
B3	Patient details		
B4	Treatment / Procedure Details		
B5	Required only for Retail/ Individual customers		
Page end	Hospital declaration		
	Part C		
C1	EFT Details	Copy of cancelled cheque/Copy of passbook	bank statement with Payee/account holders name and IFSC code
C-KYC No.	**Part D (Only for Retail/ Individual customers if claiming > ₹ 1 lakh)**		
Yes	Please provide, if Central KYC (C-KYC) no. available:	To be filled by Insured	As per IRDA, C-KYC is mandate for claims greater than ₹ 1 lakh
	{C_KYC_ID}		
No	Please fill the C-KYC form		

Documents Submitted				
S.No.	**Document**	**Yes**	**No**	**Type of document**
1.	**Claim form duly filled**	{DOC_CLAIM_FORM_DU	{DOC_CLAIM_FORM_DU	Original
2.	**Discharge Summary/ Daycare Summary**	{DOC_DISCHARGE_SUM	{DOC_DISCHARGE_SUM	Original
3.	**ICICI Lombard Health card**	Y	N	Original
4.	**Final Hospital Bill**	{DOC_FINAL_HOSPITAL	{DOC_FINAL_HOSPITAL	Original

5.	**Payment Receipts**	{DOC_PAYMENT_RECE	{DOC_PAYMENT_RECE	Original
6.	**Investigation Reports**	{DOC_INVESTIGATION_	{DOC_INVESTIGATION_	Original
7.	**Pharmacy Bills**	{DOC_PHARMACY_BILL	{DOC_PHARMACY_BILL	Original
8.	**Implant Sticker/ Invoice**	{DOC_IMPLANT_STICKI	{DOC_IMPLANT_STICKI	Photocopy
9.	**EFT (Copy of cancelled cheque/Copy of passbook or bank statement with Payee/account holders name and IFSC code)**	{DOC_EFT_YES}	{DOC_EFT_NO}	Photocopy
10.	Consultation Paper	{DOC_CONSULTATION_	{DOC_CONSULTATION_	Photocopy
11.	Age Proof	{DOC_AGE_PROOF_YE	{DOC_AGE_PROOF_NO	Photocopy
12.	Indoor Case Paper	{DOC_INDOOR_CASE_F	{DOC_INDOOR_CASE_F	Photocopy
13.	Doctor Prescriptions	{DOC_DOCTOR_PRESC	{DOC_DOCTOR_PRESC	Original
14.	Part D - C-KYC Form (Only for Retail/ Individual customers if claiming >` 1 lakh)	{DOC_PART_D_C_KYC}	{DOC_PART_D_C_KYC}	Original
15.	**PAN Card Copy of the Proposer/ Employee (Mandatory)**	{DOC_PAN_CARD_YES}		**Photocopy**

^ Kindly **do not** furnish **Aadhaar card** and send any other document for ID proof.

ICICI Lombard General Insurance Company limited

Mailing Address: ICICI Lombard Healthcare, ICICI Bank Tower, Plot No. 12, Financial District, Nanakram Guda, Gachibowli, Hyderabad, Telangana-500032
Registered Office Address: ICICI Lombard House, 414, Veer Savarkar Marg, Near Siddhi Vinayak Temple, Prabhadevi, Mumbai 400 025.
Visit us at: www.icicilombard.com • **E-Mail us at:** ihealthcare @icicilombard.com • **Toll Free Number:** 1800 2666. • **Toll Free Fax Number:** 1800 209 8880
IRDA Registration No. 115

ICICI Lombard Health Care Claim Form - Hospitalization

(Issuance of this form is not to be taken as an admission of liability)

Do You Know

★ **Non-submission of original bills and receipts is the main reason for delay in claim settlements. Please provide the originals & mandatory documents**

★ **To receive update on your claim status, provide your mobile no. & E-mail ID**

★ **You can track your claim status at: www.icicilombard.com → Claims → Health Claims → Services → Track your claims**

Part - A (To be filled by Insured)

TO BE FILLED IN CAPITAL LETTERS ONLY

A1. Type of Claim :

- ☑ Main Hospitalisation Expenses
- ☐ Pre & Post Hospitalisation Expenses

Cashless Obtained : ☐ Yes ☐ No

A2. Details of the Insured person in respect of whom claim is made: (patient details)

Name of the Patient: AHIRRAO NILESH SURESH

Card No./ UHID of the Patient: IL23712462200

Gender : Date of Birth :

☑ Male ☐ Female

☐ Transgender DD/MM/Y

Occupation : ☐ Service ☐ Self Employed ☐ Homemaker ☐ Student ☐ Retired ☐ Other ☐ (Please specify) _____

Are you previously covered by any other Mediclaim/ Health Insurance: ☐ Yes ☐ No ☐ If yes, Company name: _____

Current residential address :

City : NAVI MUMBAI State : Maharashtra 400-101

Pin code :

Mobile No : 9833954333 Landline No :

E-mail : NSA@LNTECC.COM

ABHA Number :

ABHA is a 14 digit number that will uniquely identify you as a participant in India's digital healthcare ecosystem.

A3. For **Group/ Corporate** Policy

Member ID No./ Employee ID (Client ID):

Group/ Company name:

For **Individual/ Retail Policy** (*Mandatory)

*Claim Intimation Service Request no.:

Is this a renewal policy: ☐ Yes ☐ No

If Yes, kindly mention your previous policy no.:

A4. Name of the Proposer*/Employee: AHIRRAO NILESH SURESH

Relationship with Proposer*:

(*Policy Holder. For Retail policy, Proposer name required. For Corporate policy, provide Employee name)

Current Policy No.: IL23712462200

4016/71639601/12/000

Card No./ UHID:

A5. Diagnosis as per discharge summary:

Name of hospital where admitted: DR. AJAYANS MULTI SPECIALITY HOSPITAL

Room category occupied : ☐ Day care ☐ Single occupancy ☐ Twin sharing ☐ 3 or more beds per room ☐ Others _____

Date of Admission: 18-Oct-2024 Time: HH/MM

Date of Discharge: 21-Oct-2024 Time: HH/MM

Date of injury sustained or disease/ Illness first detected: DD/MM/YYYY

If Injury, give cause: ☐ Self inflicted ☐ Road traffic accident ☐ Substance abuse/ Alcohol consumption ☐ Others _____

If Medico legal : ☐ Yes ☐ No Reported to police : ☐ Yes ☐ No

MLC Report & Police FIR attached: ☐ Yes ☐ No

(If yes, attach report)

System of Medicine: ☐ Allopathy ☐ AYUSH

Is there any another claim in any of our policies towards the above incident? ☐ Yes ☐ No If yes, provide AL/Claim No. _____

A6.Are you covered under any Topup/Additional policy :: ☐ Yes ☐ No If yes, provide AL/Claim No. _____

A7. Currently covered by any other Mediclaim/ Health Insurance :: ☐ Yes ☐ No

Date of commencement of first Insurance without break: DD/MM/YYYY

Have you been hospitalized in the last 4 years since inception of contract: ☐ Yes ☐ No Date : DD/MM/YYYY

Dignosis : _____

Have you lodged any claim against this particular admission date/ attached bills with any other Insurance company: If yes, attach settlement letter,

Company name: _____ Sum Insured : ₹ _____

Policy No: _____

A8. Details of 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: ₹ _____

Total: ₹ _____

vii. Pre-hospitalization period: _____ Days

viii. Post-hospitalization period: _____ Days

b) Claim for

i. Domiciliary Hospitalization: ☐ Yes ☐ No

ii. Day care: ☐ Yes ☐ No

iii. Extended care/ Inpatient rehabilitation: ☐ Yes ☐ No

c) Details of lump sum/ cash benefit claimed:

i. Hospital daily cash: ₹ _____

ii. Maternity: ₹ _____

iii. Critical illness/PA/Donor Expenses: ₹ _____

iv. Convalescence: ₹ _____

v. Pre/ Post hospitalization lump sum benefit: ₹ _____

vi. Others: ₹ _____

A9. Details of the amount claimed

Bill heads (as applicable)	**Bill number**	**Bill date**	**Bills attached**	**Amount**
Room rent		DD/ MM/	☐ Yes ☐ No	₹
Doctors consultation/ Visit charges		DD/ MM/	☐ Yes ☐ No	₹
Investigation charges (Includes Radiology and Pathology reports)		DD/ MM/	☐ Yes ☐ No	₹
Surgeon and Asst. surgeon charges		DD/ MM/	☐ Yes ☐ No	₹
Anesthetist charges & Operation theatre charges		DD/ MM/	☐ Yes ☐ No	₹
Equipment charges/ Procedure charges		DD/ MM/	☐ Yes ☐ No	₹
Cost of implant (If any)		DD/ MM/	☐ Yes ☐ No	₹

Medicine charges & Pharmacy charges		DD/ MM/	☐ Yes ☐ No	₹
Taxes/Surcharges/Service		DD/ MM/	☐ Yes ☐ No	₹
Discount provided by Hospital/Miscellaneous charges		DD/ MM/	☐ Yes ☐ No	₹
Other TPA/Insurance settled amount		DD/ MM/	☐ Yes ☐ No	₹
Pre hospitalization bills & Post hospitalization bills (If any)		DD/ MM/	☐ Yes ☐ No	₹

Total claimed amount (In ₹)(Total claimed amount should be equal to the amount in attached bill documents) ₹ 22405.00

MANDATORY: ALL CLAIM SETTLEMENTS SHOULD BE MADE THROUGH NEFT(AS PER REGULATORY NORMS) PLEASE PROVIDE YOUR BANK ACCOUNT DETAILS ALONG WITH COPY OF CANCELLED CHEQUE/COPY OF PASSBOOK OR BANK STATEMENT WITH PAYEE/ACCOUNT HOLDERS NAME AND IFSC CODE.)

A10. In support of the above claim, I enclose following documents in original (Please indicate by ticking in the **Yes/ No**column below)

Type of Document(s) - *Mandatory	Yes	No	Type of Document(s) - As Applicable	Yes	No
1.Claim form duly filled and signed*	☐	☐	9. ICICI Lombard GIC Authorisation Letter	☐	☐
2.Cancelled cheque (for bank account details)*	☐	☐	10. Implant name and invoice (if any) with implant sticker	☐	☐
3.Discharge summary*	☐	☐	11. Indoor Case Papers	☐	☐
4. Hospital bills, Final/ Main hospital bill and other bills (if any)*	☐	☐	12. Prescription papers/ Consultation papers	☐	☐
5. Hospital payment receipt & other receipts supporting bills*	☐	☐	13. C-KYC FORM (Only for Retail/Individual customers, claiming > ` 1Lakh)	☐	☐
6. Investigation reports* (Including ECG/ CT/ MRI/ USG/ HPE)	☐	☐	14. Others (details)	☐	☐
7. Medicine/ Pharmacy bills with doctors prescription*	☐	☐			
8. Age proof (Driving License/ PAN card/ Passport)^*	☐	☐			

Please attach all the documents as per above serial number Films like x-ray film, CT Scan film, MRI Scan film, etc. are not required. Provide reports only

A11.Please provide the reason for delay in submitting the documents (Post 30 days from Date of Discharge) Provide Details (If Applicable)

Declaration by the Insured:

I hereby declare that the information furnished in this claim form is true and 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 and 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 and that I will not be making any supplementary claim except the pre/ post-hospitalization claim, if any
I hereby give my consent to the Company to verify my identity through Central KYC Registry or UIDAI or through any other modes for the purpose of undertaking KYC.

Date: 09-Jan-2025 Place: Insured's Signature:

^ Kindly **do not** furnish **Aadhaar card** and send any other document for ID proof.

Part - B (To be filled by Treating Doctor/ Hospital only

B1. Details of the Hospital/ Nursing home in which treatment was taken

Name of the Hospital/ Nursing home: DR. AJAYANS MULTI SPECIALITY HOSPITAL

Address:

City: NAVI MUMBAI

Maharashtra

State:

Pincode:

Telephone no.:

Mobile no.:

ROHINI ID*:

If Non Network, provide below details

Type of Hospital:: ☐ Network ☐ Non Network

Registration No. with State Code:

Number of Inpatient beds:

PAN:

Facilities available in the hospital: ☐ OT: ☐ ICU:

B2. Details of the attending Medical Practitioner/ Doctor/ Treating Physician or Surgeon

Name:

Qualification:

Registration no:

Telephone no.:

Mobile no.:

B3. Details of the patient admitted

Name of the patient: AHIRRAO NILESH SURESH

IP Registration no.:

☑ Male ☐ Female ☐ Transgender

Gender :

Date of Birth : DD/MM/YYYY

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

Type of Treatment: ☐ Surgical Procedure ☐ Multiple Surgical Procedure ☐ Medical Treatment

If Maternity, Date of Delivery: ☐ G ☐ P ☐ A ☐ L

DD/ MM/ YYYY

Gravida Status :

Premature Baby : ☐ Yes ☐ No

Status at time of discharge: ☐ Discharge to home ☐ Discharge to another hospital ☐ Deceased

Total claimed amount: ₹ 22405.00

B4. Details of the procedure

Pre-authorization obtained : ☐ Yes ☐ No If yes, Pre-authorization No.:

If authorization by network hospital not obtained, give reason :

Date of injury sustained or disease/ illness first detected: DD/ MM/ YYYY

If Injury, give cause: ☐ Self inflicted ☐ Road traffic accident ☐ Substance abuse/Alcohol consumption

Others

If Medico legal: ☐ Yes ☐ Yes

Reported to police: ☐ Yes ☐ Yes

MLC Report & Police FIR attached: ☐ Yes ☐ Yes

(If yes, attach report)

FIR no. _____

If not reported to Police, give reason:

_____

FIR no. _____ If not reported to Police, give reason: _____

If injury due to substance abuse/alcohol consumption, test conducted to establish this:

☐ Yes ☐ Yes (If yes, attach report)

B5. This section is mandatory only if your health policy is not provided by your employer

A) Diagnosis (ICD 10 Code primary & additional dignosis)	
i) Primary diagnosis (with ICD 10 code)	
ii) Additional diagnosis (with ICD 10 code)	
ciii) Procedure diagnosis (with ICD 10 PCS code)	
B) Nature of surgery/ treatment given for present ailment	
C) Date of first consultation (Prior to hospitalization)	
D) Presenting complaints of the patient during admission	
E) Past medical history of the patient along with duration of illness (If yes, attach first & all past consultation paper)	
F) Was the patient under influence of alcohol during admission	
G) Whether the present treatment ailment is a complication of pre-existing disease ?	
i) If yes, please specify the disease (or) complication of any previous surgery done ?)	
ii) If yes, please specify the details	
H) Whether the disease/ disorder is congenital in nature ?	
I) Number of in-patient beds in the hospital (including ICU)	

Declaration by the hospital:

We hereby declare that the information furnished in this Claim Form is true & correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited.

Registration No. of Hospital (Rubber stamp of the hospital) Date: 09-Jan-2025 Doctor's Seal and Signature _____

As per the policy Terms and Conditions, the Company reserves its right to have the Insured examined by a doctor appointed by it for verification of diagnosis.

Part - C - NEFT Form

(For Direct Electronic Fund Transfer)

MANDATORY: ALL CLAIM SETTLEMENTS SHOULD BE MADE THROUGH NEFT(AS PER REGULATORY NORMS) PLEASE PROVIDE YOUR BANK ACCOUNT DETAILS ALONG WITH COPY OF CANCELLED CHEQUE / BANK PASSBOOK / BANK STATEMENT.)

C1.Patient's Name: AHIRRAO NILESH SURESH

(in respect of whom claim is made):

C2.Policy Number: 4016/71639601/12/000

C3.Card No./ UHID No: IL23712462200

C4.Group/Company Name (for Group/Corporate policy holders):

C5.Claim Number (if allotted): MRN09012025000188848

C6.Claim Number (if allotted): MRN0901202[illegible]

C5.EMAIL: NSA@LNTECC.COM

C8. As per IRDA Circular No.: IRDA/F&A/CIR/GLD/056/02/2014, Proposer's/ policy holder's bank account details are mandatory to process the claim through EFT.

Please provide ANY ONE of the below documents of proposer/ policy holder-

- [ ] Please provide a self-attested copy of a valid Identity proof of the Proposer/Policy holder (provide any of the mentioned documents as stated in mandatory*)
- [ ] Cancelled cheque copy
- [ ] Bank attested copy of Passbook with IFSC code

C9. Please provide the below details (all fields are compulsory)

- Proposer/ policy holder name*(as per bank records): AHIRRAO NILESH SURESH
- Proposer/ policy holder Bank account no.: 000401701608
- Name of the bank: ICICI Bank
- Branch name: Nariman Point
- Address of the bank:
- IFSC code no. of the bank: ICIC0000004 (should be same as per the provided cheque leaflet)
- PAN No. of the Proposer: AJPPA7306P

***Proposer/ policy holder is the person who has paid premium for the policy.**

For Retail policy, Name & Account details of Proposer required. For Corporate policy, Employee Name & Account details required

- [x] I understand and agree that a verification may be carried out for this claim

Terms and Conditions for Payments through RTGS/ NEFT

1. The details provided by the Proposers/ policy holder in the Mandate Form shall be considered as final and ICICI Lombard General Insurance Company Ltd. shall not be responsible for cross verification of any of the details provided therein.
2. The RTGS/ NEFT facility shall be effective for the respective Proposer(s)/ policy holder within 15 days of the receipt of the Mandate Form by ICICI Lombard General Insurance Company Ltd. and/ or within such period as may be reasonably required by ICICI Lombard General Insurance Company Ltd. to activate the RTGS/ NEFT facility
3. The Proposer/ policy holder agrees that under the RTGS/ NEFT facility, there may be a risk of non-payment in the Proposer/ policy holder Accounts No. on the day of the credit of payments due to change in the applicable regulations pertaining to RTGS/ NEFT facility or due to any other reasons without any fault/ inaction/ failure on part of ICICI Lombard General Insurance Company or any factor beyond the control of ICICI Lombard General Insurance Company Limited.
4. The Proposer/ policy holder agrees to indemnify, without delay or demur, ICICI Lombard General Insurance Company Ltd. and its agents and keep ICICI Lombard General Insurance Company Ltd. and its agent indemnified harmless at all times from and against any and all claims, damages, losses, costs, and expenses (including attorney's fees) which ICICI Lombard General Insurance Company Ltd. may suffer or incur, directly or indirectly, arising from or in connection with, amongst other things, either of the aforesaid reasons stated in above clauses.
5. ICICI Lombard General Insurance Company Ltd. May sub-contract and employ agents to carry out any of its obligations under the RTGS/ NEFT facility. The Proposer/ policy holder may discontinue or terminate the use of RTGS/ NEFT facility by giving a minimum of 15 days prior written notice to ICICI Lombard General Insurance Company Ltd. The notice of, such termination should be given to ICICI Lombard only at its corporate address and be addressed at ICICI Lombard GIC Ltd., ICICI Lombard House (Old Tata Press Building), 414, Veer Savarkar Marg, Near Siddhi Vinayak Temple, Prabhadevi, Mumbai - 400025.
6. A confirmation of the receipt of termination notice given by the Proposer/ policy holder will be acknowledged through a confirmation letter by ICICI Lombard General Insurance Company Ltd. In no case can the Proposer/ policy holder construe his termination notice as effective unless a confirmation has been provided by ICICI Lombard to the Proposer/ policy holder stating the date of receipt of such communication by the Proposer/ policy holder.
7. The Proposer/ policy holder agrees that transaction(s) through RTGS/ NEFT facility may attract inward RTGS/ NEFT charges, which if levied by the Proposer's/ policy holder's bank, shall be borne by the Proposer/ policy holder only.
8. ICICI Lombard has the absolute discretion to amend or supplement any Terms and Condition stated herein at any time and will endeavor to give prior notice of ten days for such changes wherever feasible for the Terms and Conditions to be applicable. By using the new services, or at the completion of such period, whichever is earlier, the Proposer/ policy holder shall be deemed to have accepted the changed Terms and Conditions.
9. Submission of documents or bank details or any other information does not in any way, shape or form, imply or express or suggest admission of liability by the company
10. Notices under these Terms and Conditions may be given in writing by delivering them by hand or e-mail or on ICICI Lombard General Insurance Company Ltd. website www.icicilombard.com or by sending them by post to the last address of the Proposer/ policy holder.
11. These Terms and Conditions will be governed by the laws of India and any legal action or proceedings arising out of these Terms and Conditions shall be initiated in the courts or tribunals at Mumbai in India.
12. I/We further undertake to refund any excess amount whether demanded by ICICI Lombard General Insurance Company Ltd. or not, which has been credited in excess to my account at any time due to any reason within 7 days of such receipt of such communication from ICICI Lombard of such excess credit or such information of excess credit coming to the knowledge of the Proposer/ policy holder through any other source.
13. I/We agree that my/ our claim payment will be credited from the date ICICI Lombard General Insurance Company Ltd. gets confirmation from

its bankers, This facility will continue unless it is revoked by any party and any issuance of relevant credit instruction from ICICI Lombard General Insurance Company Ltd. to its bankers will be valid till such instruction is complete irrespective of the fact that the notice period has expired provided such a credit request has been made by ICICI Lombard General Insurance Company Ltd. before the expiry of the notice period of the Proposer/ policy holder.

Ahirrao Nilesh Suresh

ICICI Lombard General Insurance Company limited

Mailing Address: ICICI Lombard Healthcare, ICICI Bank Tower, Plot No. 12, Financial District, Nanakram Guda, Gachibowli, Hyderabad, Telangana-500032
Registered Office Address: ICICI Lombard House, 414, Veer Savarkar Marg, Near Siddhi Vinayak Temple, Prabhadevi, Mumbai 400 025.
Visit us at: www.icicilombard.com • **E-Mail us at:** ihealthcare @icicilombard.com • **Toll Free Number:** 1800 2666. • **Toll Free Fax Number:** 1800 209 8880
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