Claim with Bajaj Allianz

Bajaj Allianz General Insurance Co. Ltd.
Bajaj Allianz House, Airport Road, Yerwada, Pune – 411006. Reg.: 113 | CIN: U66010PN2000PLC015329
For more details, log on to : www.bajajallianz.com

Email Id:-bagichelp@bajajallianz.co.in
Toll free no:1800-209-5858
020-30305858

BAJAJ Allianz
Caringly yours

(To be filled in block letters)

CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT – PART A

TO BE FILLED IN BY THE INSURED
The issue of this form is not to be taken as an admission of liability

DETAILS OF PRIMARY INSURED

a) Policy No: OG-25-1919-8403-00000208 b) Sl. No/Certificate No:
c) Company TPA ID No: d) Customer ID:
e) Company Name: DELOITTE CONSULTING INDIA PRIVATE LIMITED f) Employee No: 703063
g) Name: PRAJJWAL TAWRI
h) Address: H-211, PATANJALI SHOP GANJPARA SATTICH
OURA NEAR HANUMAN MANDIR
City: DURG State: CHATTISGAR Pin Code: 491001
Phone No: 8349082028 Email ID: PTAWRI@DELOITTE.COM

SECTION A

DETAILS OF INSURANCE HISTORY

a) Currently covered by any other Mediclaim / Health Insurance ☐ Yes ☑ No
b) date of commencement of first insurance without break
c) If yes, company name: Policy No:
Sum Insured (Rs.):
d) Have you been hospitalized in the last four years since inception of the contract? ☐ Yes ☐ No Date: DD MM YYYY
Diagnosis
e) Previously covered by any other Mediclaim / Health Insurance: ☐ Yes ☐ No
f) If yes, Company Name

SECTION B

DETAILS OF INSURED PERSON HOSPITALIZED

a) Name of the Patient: PRAJJWAL TAWRI
b) Health ID card no of the Patient: DCI-25-50666977
c) Gender: Male ☑ Female ☐ d) Age: years 24 months 05 e) Date of Birth DD MM 2000
f) Relationship of Primary insured: Self ☑ Spouse ☐ Child ☐ Father ☐ Mother ☐ Other ☐ (Please Specify)
g) Occupation: Service ☑ Self Employed ☐ Homemaker ☐ Student ☐ Retired ☐ Other ☐ (Please Specify)
h) Address (if different from above)
City: State: Pin Code:
I)Phone No: 8349082028 J) Email ID: PTAWRI@DELOITTE.COM

SECTION C

DETAILS OF HOSPITALIZATION

a) Name of Hospital where Admitted: VAYAM HOSPITAL(VAYAM HEALTH CARE)
b) Room Category occupied: Day Care ☐ Single occupancy ☐ Twin sharing ☐ 3 or more beds per room ☐
c) Hospitalisation due to: Injury ☑ Illness ☐ Maternity ☐
d) Date of Injury/Date Disease first detected/Date of Delivery: DD MM 2024
e) Date of admission DD MM 2024 f) Time: HH MM g)Date of Discharge DD MM 2024 h)Time: HH MM
I) Name of treating doctor Dr. Hitesh Tawari Diagnosis Fracture of front tooth
j) If injury give cause: Self ☐ inflicted ☑ Road Traffic Accident ☐ Substance Abuse /Alcohol Consumption ☐
i) If Medico legal: Yes ☐ No ☑ ii) Reported to police: Yes ☐ No ☑
iii) MLC report and Police FIR attached: Yes ☐ No ☑ j) System of Medicine

SECTION D

Claim with Bajaj Allianz

DETAILS OF CLAIM

a) Details of the treatment expenses claimed

i. Pre-Hospitalisation Expenses: Rs.		ii. Hospitalisation Expenses Rs.	16900
iii. Post-Hospitalisation Expenses: Rs.		iv. Health checkup cost Rs.	
v. Ambulance Charges: Rs.		vi. Others (code) Rs.	
		Total Rs.	16900
vii. Pre-Hospitalisation period: days		viii. Post Hospitalisation period: days	

b) Claim for Domiciliary Hospitalisation: Yes ☐ No ☐ (If yes, provide details in annexure)

c) Details of Lump sum / cash benefit claimed:

i. Hospital Daily Cash Rs.		ii. Surgical Cash Rs.	
iii. Critical illness Benefit Rs.		iv. Convalescence Rs.	
v. Pre/Post hospitalisation lump sum benefit Rs.		vi. Others Rs.	
		Total Rs.	

Claim Documents Submitted – Check List

- ☑ Claim Form Duly Signed
- ☐ Copy of claim intimation if any
- ☑ Original Hospital Main Bill
- ☐ Original Hospital Breakup Bill
- ☐ Original Hospital Bill Payment Receipt
- ☑ Original Hospital Discharge SummaryPharmacy Bill
- ☐ Operation Theater Notes
- ☐ ECG
- ☐ Original Doctor's Prescriptions
- ☐ Original Doctors request for investigation reports (including CT/MRI/USG/HPE)
- ☐ Others
- ☐ Cancelled blank cheque leaf with payee name printed. If name of the payee is not printed on the cheque leaf please attach copy of the first page of the bank passbook.

DETAILS OF BILLS ENCLOSED

Sr.No	Bill No	Date	Issued by	Towards	Amount (Rs)
1	FB24000189	0D 5D 1M 2M 2Y 4Y	Hospital	Hospitalisation Main Bill	16900
2		D D M M Y Y		Pre-Hospitalisation Bills:__Nos	
3		D D M M Y Y		Post-Hospitalisation Bills:__Nos	
4		D D M M Y Y		Pharmacy Bills	
5		D D M M Y Y			
6		D D M M Y Y			
7		D D M M Y Y			
8		D D M M Y Y			
9		D D M M Y Y			
10		D D M M Y Y			

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

a) Name of the Account Holder (As per Bank Account): PRAJJWAL TAWRI

b) Account no (As appearing in the cheque book): 59180100000657

c) Bank Name : BANK OF BARODA

d) Branch Name & Address: BANK OF BARODA, GANJPARA BRANCH PULGAUN ROAD, GANJPARA CHOWK, DURG(C.G.)

e) Account Type : Saving ☑ Current ☐ Cash Credit ☐

f) MICR No. 491012005 | g)IFSC Code: BARB0GANJPA

h) PAN: BNEPT7552A | i) Cheque / DD Payable Details:

j) CKYC No.

k) I/We authorize Insurance Company/TPA to contact me/us through SMS/Email/WhatsApp for any update on this claim.

DECLARATION

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 Bajaj Allianz General Insurance Company Limited, to seek necessary medical information / documents from any hospital / Medical Practitioner who ha s 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.

SECTION E SECTION F SECTION G SECTION H

Claim With Bajaj Allianz

Bajaj Allianz General Insurance Co. Ltd.

Allianz

Caringly yours

DECLARATIONS – CLAIM FORM

1. **For retail policies/individual customers:**

   Consent/Declaration to be added in proposal and claim for CKYC no.:

   I/we hereby give my/our consent to the Company to verify and obtain my/our identity/address proof through Central KYC Registry or National Securities Depository Limited Portal for the purpose of undertaking KYC verification.

2. **For Juridical person/non-individual customer:**

   Consent/Declaration to be added in proposal and claim for CKYC no.:

   I/we hereby give my/our consent to the Company to verify and obtain my/our identity/address proof through Central KYC Registry or Goods and Service Tax Portal or Ministry Of Corporate Affairs Portal or National Securities Depository Limited portal for the purpose of undertaking KYC.

3. **For Group Policies:**

   Consent/Declaration to be added in claim form CKYC no.:

   I/we hereby give my/our consent to the Company to verify and obtain my/our identity/address proof through Central KYC Registry for the purpose of undertaking KYC

4. **For Juridical person/non-individual customer and Group Policies:**

   Consent/Declaration to be added in claim form CKYC no.:

   I/we hereby give my/our consent to the Company to verify and obtain my/our identity/address proof through Central KYC Registry or UIDAI or through any other modes for the purpose of undertaking KYC

Date: 08/11/2025 Place: DURG

Signature of the Insured

Claim with Bajaj Allianz

Bajaj Allianz General Insurance Co. Ltd.
Bajaj Allianz House, Airport Road, Yerwada, Pune - 411006. Reg. 113 | CIN: U66010PN2000PLC015329
For more details, log on to : www.bajajallianz.com
Email id: customercare@bajajallianz.co.in, Toll free no. 1800-209-5858, 020-30305858

Caringly yours
BAJAJ | Allianz

CLAIM FORM- PART B

TO BE FILLED IN BY THE HOSPITAL
The issue of this form is not to be taken as admission of liability
Please include the original preauthorization request form in lieu of PART-A (to be filled in block letters)

SECTION A

DETAILS OF HOSPITAL

a) Name of the hospital: VAYAM HEALTH CARE
b) Hospital ID: DURG0375/NH c) Type of hospital : Network ☐ Non-Network ☐ (If non-network fill section E)
d) Name of treating doctor: DR. HITESH TAWARI
e) Qualification: _____ f) Registration No with State Code _____ g) Phone No: 7880082991
h) Rohini Code _____ i) NABH CODE _____ j) State Level Certificate _____
k) Higher Level Certificate _____ l) National Quality Assurance Standards _____ m) National Health System Resource Center _____

SECTION B

DETAILS OF THE PATIENT ADMITTED

a) Name of the patient: MR. PRAJJWAL TAWRI
b) IP registration Number: IP2024000439 c) Gender: Male ☑ Female ☐ d) Age : Years 24 Months: ___ e) Date of birth: 08/07/2000
f) Date of admission: 10/12/24 g) Time : 21:30 h) Date of discharge : 17/12/24 i) Time: 19:45
j) Type of Admission : Emergency ☐ Planned ☐ Day Care ☐ Maternity ☐ k) If Maternity i) Date of delivery D D M M Y Y ii)Gravida Status: ___
l) Status at time of discharge: Discharge to home ☐ Discharge to another hospital ☐ Deceased: ☐ m) Total claimed Amount: ___

SECTION C

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a)	ICD 10 Codes	Description	b)	ICD 10 PCS	Description
i) Primary Diagnosis:		Fracture of upper tooth	i) Procedure 1:		
ii) Additional Diagnosis:			ii) Procedure 2:		
iii) Co-morbidities :			iii) Procedure 3:		
iv) Co-morbidities :			iv) Details of Procedure:		

d) Pre-Authorization Obtained: Yes ☐ No ☐ e) Pre-Authorization Number: ___
f) If authorization by network hospital no obtained, give reason: ___
g) Hospitalization due to injury: Yes ☐ No ☐ i)If Yes give cause: Self-inflicted: ☐ Road Traffic Accident: ☐ Substance abuse/ alcohol consumption: ☐
ii) If injury due to Substance abuse/alcohol consumption, Test conducted to establish this: Yes ☐ No ☐ (If Yes attach reports) iii)Medico Legal: Yes ☐ No ☐
iv)Reported to Police: Yes ☐ No ☐ v) FIR no: _____ vi) if not reported to police give reason: ___

SECTION D

CLAIM DOCUMENTS -CHECK LIST

- ☑ Claim form duly signed
- ☐ Original Pre-Authorization request
- ☐ Copy of Pre-Authorization letter
- ☐ Copy of photo ID card of patient verified by hospital
- ☐ Hospital discharge summary
- ☐ Operation theatre notes
- ☑ Hospital main bill
- ☐ Hospital break up bill
- ☐ Ingestion reports
- ☐ CT/MR/USG/HPE investigation report
- ☐ Doctor's reference slip for investigation
- ☐ ECG
- ☐ Pharmacy bills
- ☐ MLC report & Police FIR
- ☐ Original death summary from hospital where applicable
- ☐ Any other, please specify

SECTION E

ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON NETWORK HOSPITAL)

a) Address of hospital 4/1 Priyadarshini Parisar, opposite Supela Thana, G.E. Road
City: Bhilai State: C.G. Pin Code: 490023 Phone No: 0788-4018080 c) Registration no with State Code: ___
d) Hospital PAN: ___ e) Number of Inpatient beds: ___ Facilities available in hospital: i) OT: Yes ☐ No ☐ ii) ICU: Yes ☐ No ☐
iii) Others: ___

SECTION F

DECLARATION BY THE HOSPITAL: (PLEASE READ VERY CAREFULLY)

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

Date: 08/01/25
Place: Bhilai

VAYAM HEALTH CARE Regd. No. DURG0375/NH SUPELA BHILAI

Signature and Seal of Authority