

# Claimed with Bajaj Allianz General Insurance Co Ltd.



Allianz

Caringly yours

(To be filled in block letters)

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

## 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: **O G - 2 4 - 1 9 1 9 - 8 4 0 3 - 0 0 0 0 0 1 8 5** 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: **P R A J J W A L T A W R I**  
h) Address: **H - 2 1 1 , P A T A N J A L I S H O P G A N J P A R A S A T T I C H  
O U R A N E A R H A N U M A N M A N D I R**  
City: **D U R G** State: **C H A T T I S G A R** Pin Code: **4 9 1 0 0 1**  
Phone No: **8 3 4 9 0 8 2 0 2 8** Email ID: **PTAWRI@DELOITTE.COM**

### 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 YY YY YY**  
Diagnosis   
e) Previously covered by any other Mediclaim / Health Insurance:  Yes  No  
f) If yes, Company Name: \_\_\_\_\_

### DETAILS OF INSURED PERSON HOSPITALIZED

a) Name of the Patient: **PRAKASH TAWRI**  
b) Health ID card no of the Patient: **DTT-23-703063D**  
c) Gender: Male  Female  d) Age: years **5 9** months **0 7** e) Date of Birth **DD 0 5 1 9 6 4**  
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: **9 4 2 5 2 4 4 4 0 2** J) Email ID: **PRAKASH.TAWRI@GMAIL.COM**

### DETAILS OF HOSPITALIZATION

a) Name of Hospital where Admitted: **SUYASH HOSPITAL**  
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: **2 7 1 0 2 0 2 3**  
e) Date of admission **2 7 1 0 2 0 2 3** f) Time **HH MM** g) Date of Discharge **2 9 1 0 2 0 2 3** h) Time **HH MM**  
I) Name of treating doctor **Dr.Gaurav Tripathi, Dr.Manoj Lahoti** Diagnosis **ARTIAL FIBRILLATION & FAST VENTRICULAR RATE**  
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 A

SECTION B

SECTION C

SECTION D

# Claimed with Bajaj Allianz General Insurance Co Ltd

## DETAILS OF CLAIM

### a) Details of the treatment expenses claimed

i. Pre-Hospitalisation Expenses:	Rs. <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>1</td><td>2</td><td>5</td><td>9</td><td>0</td><td></td><td></td></tr></table>	1	2	5	9	0			ii. Hospitalisation Expenses	Rs. <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>4</td><td>7</td><td>3</td><td>2</td><td>4</td><td></td><td></td></tr></table>	4	7	3	2	4		
1	2	5	9	0													
4	7	3	2	4													
iii. Post-Hospitalisation Expenses:	Rs. <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>								iv. Health checkup cost	Rs. <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							
v. Ambulance Charges:	Rs. <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>								vi. Others (code)	Rs. <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							
vii. Pre-Hospitalisation period:	days <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>4</td><td>.</td><td>0</td></tr></table>	4	.	0	Total	Rs. <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>5</td><td>9</td><td>9</td><td>1</td><td>4</td><td></td><td></td></tr></table>	5	9	9	1	4						
4	.	0															
5	9	9	1	4													
viii. Post Hospitalisation period:	days <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>																

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. <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>								ii. Surgical Cash	Rs. <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							
iii. Critical illness Benefit	Rs. <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>								iv. Convalescence	Rs. <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							
v. Pre/Post hospitalisation lump sum benefit	Rs. <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>								vi. Others	Rs. <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>							
		Total	Rs. <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>														

### Claim Documents Submitted – Check List

- |   |  |   |
|---|--|---|
| <input checked="" type="checkbox"/> Claim Form Duly Signed  | <input type="checkbox"/> Copy of claim intimation if any                   | <input checked="" type="checkbox"/> Original Hospital Main Bill                       |
| <input checked="" type="checkbox"/> Original Hospital Breakup Bill  | <input checked="" type="checkbox"/> Original Hospital Bill Payment Receipt | <input checked="" type="checkbox"/> Original Hospital Discharge Summary/Pharmacy Bill |
| <input type="checkbox"/> Operation Theater Notes  | <input checked="" type="checkbox"/> ECG                                    | <input type="checkbox"/> Original Doctor's Prescriptions                              |
| <input type="checkbox"/> Original Doctors request for investigation reports (including CT/MRI/USG/HPE)  |  | <input type="checkbox"/> Others   |
| <input type="checkbox"/> 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)				
					4	7	3	2	1
1		2 9 1 0 2 3		Hospitalisation Main Bill					
2	2 7 1 0 2 3			Pre-Hospitalisation Bills: 5 Nos	1	2	5	9	0
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): 

5	9	1	8	0	1	0	0	0	0	6	5	7		
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c) Bank Name : **BANK OF BARODA**

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

e) Account Type : Saving  Current  Cash Credit

f) MICR No. 

4	9	1	0	1	2	0	0	5				
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g) IFSC Code: **B A R B O G A N J P A**

h) PAN: 

B	N	E	P	T	7	5	5	2	A			
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i) Cheque / DD Payable Details: 

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j) CKYC No. 

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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 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.

SECTION E

SECTION F

SECTION G

SECTION H

## 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:

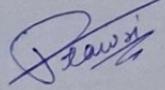
Consent/Declaration to be added in claim form CKYC no.:

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: [06] [11] [2023]

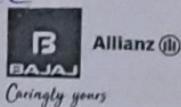
Place: [Raipur]

Signature of the Insured



# Claimed with Bajaj Allianz General Insurance Co. Ltd.

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](http://www.bajajallianz.com)  
 Email id: [customercare@bajajallianz.co.in](mailto:customercare@bajajallianz.co.in), Toll free no. 1800-209-5858, 020-30305858



## 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)

#### DETAILS OF HOSPITAL

- a) Name of the hospital: Suyash Hospital
- b) Hospital ID: \_\_\_\_\_ c) Type of hospital: Network  Non-Network  (If non-network fill section E)
- d) Name of treating doctor: Dr. Manoj Lahoti g) M.O. No. 9926386660
- e) Qualification: \_\_\_\_\_ f) Registration No with State Code: \_\_\_\_\_ h) NABH CODE H-2021-D656 i) State Level Certificate: D.M. (Gastroenterology)
- j) Rohini Code 8900080031562 k) Higher Level Certificate: \_\_\_\_\_ l) National Quality Assurance Standards: \_\_\_\_\_ m) National Health System Resource Center: \_\_\_\_\_

#### DETAILS OF THE PATIENT ADMITTED

- a) Name of the patient: Mrs. Prakash Tawari
- b) IP registration Number: 1 POD 5606-23 c) Gender: Male  Female  d) Age: Years    Months:    e) Date of birth: DDMMYY
- f) Date of admission: 27/10/23 g) Time: 08:24 AM h) Date of discharge: 29/10/23 i) Time: 05:00 PM
- j) Type of Admission: Emergency  Planned  Day Care  Maternity  k) If Maternity: \_\_\_\_\_ l) Date of delivery: DDMMYY ii) Gravida Status:
- l) Status at time of discharge: Discharge to home  Discharge to another hospital  Deceased:  m) Total claimed Amount:

#### DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a)	ICD 10 Codes	Description	b)	ICD 10 PCS	Description
i) Primary Diagnosis:		<u>CAD-1 CMP &amp; RHEM</u> <u>EF-25% At rest</u>	i) Procedure 1:		
ii) Additional Diagnosis:		<u>Fibrillation &amp;</u> <u>fast ventricular rate</u>	ii) Procedure 2:		
iii) Co-morbidities:		<u>Old CVA</u>	iii) Procedure 3:		
iv) Co-morbidities:			iv) Details of Procedure:		<u>Conservative treatment</u>

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: \_\_\_\_\_

#### CLAIM DOCUMENTS -CHECK LIST

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

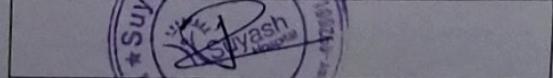
#### ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON NETWORK HOSPITAL)

- a) Address of hospital Suyash Hospital, Kota Gudbiyari Road Raipur C.C.  
 City: Raipur State: C.C. Pin Code: 492001 Phone No: 9926386660 c) Registration no with State Code: TRAI P6521
- d) Hospital PAN: AAC1CS5760K e) Number of Inpatient beds: 250 Facilities available in hospital: i) OT: Yes  No  ii) ICU: Yes  No   
 iii) Others: \_\_\_\_\_

#### 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. If we have made any false and untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited.

Date: 29/10/23  
 Place: Raipur



Signature and Seal of the Hospital Authority