



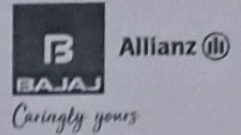






Claimed with Bajaj Allianz General Insurance Co Ltd.

Bajaj Allianz General Insurance Co. Ltd.



### 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



**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  
e) Qualification: \_\_\_\_\_ f) Registration No with State Code: 9926386660  
g) MD (Medicine)  
h) Rohini Code: 8900080031562 i) NABH CODE: H-2021-0656 j) State Level Certificate: D.M. (Gastroenterology)  
k) Higher Level Certificate: \_\_\_\_\_ l) National Quality Assurance Standards: Reg. No. 12395  
m) National Health System Resource Center: \_\_\_\_\_

**DETAILS OF THE PATIENT ADMITTED**

a) Name of the patient: Mr. Bhakash Tawari  
b) IP registration Number: 1P005606-23 c) Gender: Male ☒ Female ☐ d) Age: Years: \_\_\_\_\_ Months: \_\_\_\_\_ e) Date of birth: DDMMYY  
f) Date of admission: 27/10/23 g) Time: 03:24 PM h) Date of discharge: 29/10/23 i) Time: 05:00 PM  
j) Type of Admission: Emergency ☒ Planned ☐ Day Care ☐ Maternity ☐ k) If Maternity: i) 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>    </u>	<u>CAD-1 CMP 2 R HLM</u>	i) Procedure 1:	<u>    </u>	
	<u>    </u>	<u>EF-25% Atrial</u>			
ii) Additional Diagnosis:	<u>    </u>	<u>Fibrillation 2</u>	ii) Procedure 2:	<u>    </u>	
	<u>    </u>	<u>fast Ventricular rate</u>			
iii) Co-morbidities:	<u>    </u>	<u>Old CVA</u>	iii) Procedure 3:	<u>    </u>	
	<u>    </u>				
iv) Co-morbidities:	<u>    </u>		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

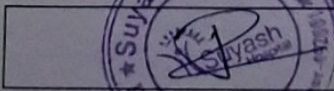
**ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON NETWORK HOSPITAL)**

a) Address of hospital: Suyash Hospital, Kota Gudhiguri Road Raipur C.G.  
City: Raipur State: C.G. Pin Code: 492001 Phone No: 9926386660 c) Registration no with State Code: TRAIP6521  
d) Hospital PAN: AALCS5760K 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