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
Email id:-customercare@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

SECTION A

DETAILS OF PRIMARY INSURED

a) Policy No: OG-24-1919-8403-00000185 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 B

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 C

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 59 months 07 e) Date of Birth DD 05 1964
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: 9425244402 J) Email ID: PRAKASH.TAWRI@GMAIL.COM

SECTION D

DETAILS OF HOSPITALIZATION

a) Name of Hospital where Admitted: Platina Heart Hospital
b) Room Category occupied: Day Care ☐ Single occupancy ☑ Twin sharing ☐ 3 or more beds per room ☐ + ICCU.
c) Hospitalisation due to: Injury ☐ Illness ☑ Maternity ☐
d) Date of Injury/Date Disease first detected/Date of Delivery: 27/10/2023
e) Date of admission 30/10/2023 f) Time 03 pm g) Date of Discharge 04/11/2023 h) Time 03 18 pm
I) Name of treating doctor Dr. P. Mundra Diagnosis SHT, DM, CVE, IDC, CCF LVEF 20%
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 ☐ k) System of Medicine

Claimed with Bajaj Allianz General Insurance Co Ltd

DETAILS OF CLAIM

SECTION E

a) Details of the treatment expenses claimed

I. Pre-Hospitalisation Expenses:	Rs.	ii. Hospitalisation Expenses	Rs. 1 83,370/-
iii. Post-Hospitalisation Expenses:	Rs. 9 1 3 9/-	iv. Health checkup cost	Rs.
v. Ambulance Charges:	Rs.	vi. Others (code)	Rs.
		Total	Rs. 1 9 2 5 0 9/-
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

SECTION F

Sr.No	Bill No	Date						Issued by	Towards	Amount (Rs)
1	1746	0	4	M	[illegible]	2	3	Hospital	Hospitalisation Main Bill	1 8 3 3 7 0 /-
2		D	D	M	M	Y	Y		Pre-Hospitalisation Bills:__Nos	
3	12266	0	7	[illegible]	[illegible]	2	3	Hospital	Post-Hospitalisation Bills:__Nos	9 1 3 9 /-
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

SECTION G

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 0 6 5 7

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

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

i) Cheque / DD Payable Details:

j) CKYC No.

SECTION H

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.

Claimed with 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: 11 12 2023 Place: DURG

Signature of the Insured

Claimed with Bajaj Allianz General Insurance Co Ltd.

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

BAJAJ Allianz — Caringly yours

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: Platina Heart Hospital
b) Hospital ID: 890 c) Type of hospital: Network ☐ Non-Network ☒ (If non-network fill section E)
d) Name of treating doctor: Dr. Pramod Mundra
e) Qualification: MD, DM Cardiology f) Registration No with State Code: 60885 g) Phone No: 0712-2566555
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. Prakash Chand Tawri
b) IP registration Number: 15335 c) Gender: Male ☒ Female ☐ d) Age: Years ☐☐ Months: ☐☐ e) Date of birth: D D M M Y Y
f) Date of admission: 30/10/23 g) Time: 10 pm h) Date of discharge: 04/11/23 i) Time: 08:18 pm
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:		S/S HTN (Oct 22) DM (Oct 22)	i) Procedure 1:		CAG+DC Cardiologers' Done ~~+PTCA with~~
ii) Additional Diagnosis:		CVE (25/10/22)	ii) Procedure 2:		
iii) Co-morbidities:		IDC! CCF, LVEF, SVD (30/10/23)	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	☐ Ingestion reports
☐ Original Pre-Authorization request	☐ CT/MR/USG/HPE investigation report
☐ Copy of Pre-Authorization letter	☐ Doctor's reference slip for investigation
☐ Copy of photo ID card of patient verified by hospital	☐ ECG
☐ Hospital discharge summary	☐ Pharmacy bills
☐ Operation theatre notes	☐ MLC report & Police FIR
☐ Hospital main bill	☐ Original death summary from hospital where applicable
☐ Hospital break up bill	☐ 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: Dhanshree Complex Sitabuldi
City: Nagpur State: MH Pin Code: 440012 Phone No: 07122566555 Registration no with State Code: 890
d) Hospital PAN: AAFCM5873D e) Number of Inpatient beds: 50 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. 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: 06/11/23
Place: NAGPUR

Signature and Seal of the Hospital Authority

PLATINA HEART ... NAGPUR