IFFCO-TOKIO General Insurance Company Limited

IFFCO-TOKIO GENERAL INSURANCE

Muskurate Raho

CLAIM FORM - PART A

TO BE FILLED IN BY THE INSURED

The issue of this Form is not to be taken as an admission of liability
(To be filled in block letters)

DETAILS OF PRIMARY INSURED

a) Policy No.	H057141	b) Sl. No./Certificate No.	
c) Company/TPA ID No.	TRIANZ HOLDINGS PVT LTD		
d) Name	JAGANI JAGADEESH		
e) Address	SRI NILAYAM H.NO 1-57/78/A BLOCK A SRI RAM NAGAR COLONY BOTANICAL GARDENS		
City	HYDERABAD		
State	TELANANA	Pin Code	500084
Ph. No.	9642676515	Email ID	jagani.jagadeesh@trianz.com

DETAILS OF INSURANCE HISTORY

a) Currently covered by any other Mediclaim/Health Insurance			Yes	No ✓
b) If yes, Company Name				
Policy No.		Sum Insured (₹)		
c) Date of commencement of first Insurance without break	__/__/____	(Copies of Policies to be attached)		
d) Have you been hospitalized in the last 4 years? (since inception of the contract)	Yes	No	Date	__/__/____
	Diagnosis			
e) Have you been covered by any other Mediclaim/Health Insurance in last 4 years			Yes	No
f) If yes, Company Name				

DETAILS OF INSURED PERSON HOSPITALIZED

a) Name	JAGANI JAGADEESH									
b) Gender	Male ✓	Female	c) Age	years 31	months 11	d) Date of Birth	06/06/1990			
e) Relationship to Primary insured	Self ✓	Spouse	Child	Father	Mother					
	Other	(Please Specify)								
f) Occupation	Service	Self Employee	Homemaker ✓	Student	Retired					
	Other	(Please Specify)								
Address (if different from above)										
City										
State						Pin Code				
Ph. No.		Email ID								

DETAILS OF HOSPITALIZATION

a) Name of Hospital where Admitted	QUEENS NRI HOSPITAL						
b) Room Category occupied	Day Care	Single occupancy	Twin sharing	3 or more beds per room			
c) Hospitalization due to	Injury	Illness	Maternity ✓				
d) Date of Injury/Date of Disease first detected/Date of Delivery				__/__/____			
e) Date of Admission	06/05/2021	f) Time	g) Date of Discharge	21/05/2021	h) Time		
i) 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 & Police FIR attached	Yes	No		
j) System of Medicine							
k) Date of Surgery	__/__/____	l) Claim Intimated	Yes	No			
i. Intimated to whom	SBU	Intermediaries	Call Centre	Health Claims Team			
ii. Intimation No. & date				__/__/____			
iii. If not Intimated, reason?							

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 (code)	₹
vii. Pre-hospitalization period	days	Total	₹
		viii. Post hospitalization period	days
b) Claim for Domiciliary Hospitalization	Yes / No	(If yes, provide details in annexure)	

c) Details of Lump sum/cash benefit claimed

i. Hospital Daily Cash	₹	ii. Surgical Cash	₹
iii. Critical Illness Benefit	₹	iv. Convalescence	₹
v. Pre/Post hospitalization Lump sum benefit	₹	vi. Others	₹
		Total	₹

Claim Documents Submitted - Check List		Operation Theatre Notes	
Claim Form Duly signed		ECG	
Copy of the claim intimation		Doctor's request for investigation	✓
Hospital Main Bill		Investigation Reports (CT/MRI/USG/HPE)	✓
Hospital Break - up Bill		Doctor's Prescriptions	✓
Hospital Bill Payment Receipt		Pre-Hosp. Bills	
Hospital Discharge Summary		Post-Hosp. Bills	
Pharmacy Bill	✓	Others	

DETAILS OF BILLS ENCLOSED

Sl. No.	Bill No.	Date	Issued by	Towards (Hospitalization/Pre-hospitalization/Post-hospitalization	Amount (₹)
1	15353	07/05/2021	NEO DIAGNOSTICS	HRCT CHEST SCAN	3000.00
2	98	07/05/2021	Satya sai clinical	Blood test	3200
3	99	20/05/2021	Satya sai clinical	Blood test	3100
4	57	9/05/2021	Amrutha Medicals	Medicines	7995
5	58	9/05/2021	Amrutha Medicals	medicines	5748
6		DD / MM / YYYY			
7		DD / MM / YYYY			
8		DD / MM / YYYY			
9		DD / MM / YYYY			
10		DD / MM / YYYY			

Do you want to opt for Automatic Reinstatement of Sum Insured in the event of a claim? If, Yes, applicable premium at short period rates would be deducted from the claim amount due to you. This reinstated sum will not be available for the same hospitalization. It will be available for treatment (other than certain chronic diseases) including the same illness or disease but separate independent case of hospitalization which are not case of relapse within 45 days of first hospitalization. Please contact the agent/our office for further details: Yes / No

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT (Please submit a cancelled cheque copy for NEFT)

a) PAN	ARBPJ6029N	b) Account Number	50100179808667
c) Bank Name and Branch	HDFC KONDAPUR		
d) Cheque/DD Payable details		e) IFSC Code	HDFC0003790

DECLARATION BY THE INSURED

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 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 & that I will not be making any supplementary claim except the pre/post-hospitalization claim, if any.

Place: Visakhapatnam

Date: 03/06/2021

J. Jayadeep

Signature of the Insured

Important:

1. Please submit copy of valid Photo ID.
2. For claimed amount above 1 lac, it is mandatory to submit the KYC (Know your customer) form.

CLAIM FORM - PART B

TO BE FILLED IN BY THE HOSPITAL

The issue of this Form is not to be taken as an admission of liability
(To be filled in block letters)

Please include the original preauthorization request form in lieu of PART A

DETAILS OF HOSPITAL

a)	Name of the Hospital	QUEENS NRI HOSPITAL				
b)	Hospital ID		c) Type of Hospital	Network	Non Network	(If non network fill section E)
d)	Name of the treating doctor	DR B V NAGABHUSHAN RAO				
e)	Qualification	Consultant Physician & Cardiologist	f) Registration No. with State Code	14886	g) Ph No.	7989743498

DETAILS OF THE PATIENT ADMITTED

a)	Name of the Patient	JAGANI JAGADEESH							
b)	IP Registration Number		c) Gender	Male	✓ Female	d) Age	Years 31	Months 11	
e)	Date of birth	06/06/1990	f) Date of Admission	06/05/2021	g) Time				
h)	Date of Discharge	21/05/2021	i) Time						
j)	Type of Admission	Emergency	Planned		Day Care		Maternity		
k)	If Maternity	i. Date of Delivery	__/__/____	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				
	i. Primary Diagnosis						
	ii. Additional Diagnosis						
	iii. Co-morbidities						
	iv. Co-morbidities						
b)		ICD 10 Codes	Description				
	i. Procedure 1						
	ii. Procedure 2						
	iii. Procedure 3						
	iv. Details of Procedure						
c)	Present ailment is a complication of PED?	Yes	No	(If Yes, specify details)			
d)	Pre-authorization obtained	Yes	No				
e)	Pre-authorization Number						
f)	If authorization by network hospital not 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. If Medico legal	Yes	No	iv. Reported to Police	Yes / No	v. FIR No.	
	vi. If not reported to police give reason						

CLAIM DOCUMENTS SUBMITTED - CHECK LIST					
Claim Form duly signed		Operation Theatre notes		Doctor's reference slip for investigation	✓
Original Pre-authorization request		Hospital main bill		ECG	
Copy of the Pre-authorization approval letter		Hospital break-up bill		Pharmacy bills	✓
Copy of photo ID card of patient verified by hospital		Investigation reports	✓	MLC report & Police FIR	
Hospital Discharge summary		CT/MR/USG/HPE investigation reports	✓	Original death summary from hospital where applicable	
Any other, please specify					

ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL (Only fill in case of non-network hospital)									
a)	Address of the Hospital								
	City			Pin Code					
	State								
b)	Phone No.		c) Registration No.						
	Date of Registration	___ / ___ / _____	Expiry date of Registration					___ / ___ / _____	
	Name of the Registering Authority								
d)	PAN		e) Number of Inpatient beds						
f)	Facilities available in the 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 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. The signature of the insured is taken on this form after Claim Form B is fully filled up by us.

Hospital have required infrastructure to fulfill the hospital definition as per IRDA guideline, which is reproduced below:

- Has at least 10 inpatient beds, in those towns having a population of less than 10,00,000 and 15 inpatient beds in all other places
- Has fully qualified nursing staff under its employment round the clock
- Has fully qualified doctor(s) in charge round the clock
- Has a fully equipped operation theatre of its own where surgical procedures are carried out.
- Maintains daily Medical records of patients and will make these accessible to the Company's authorized personnel.

Place: Visakhapatnam **Date:** 03/06/2021

J. Jagadeesh

Signature of Insured/Claimant

Signature and Seal of the Hospital Authority