

## CLAIM FORM - PART A

Muskurate Raho

### 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) SI. No./Certificate No.            |  |  |  |  |  |  |  |  |  |  |
| c) Company/TPA ID No. | TRIANTZ HOLDINGS PVT LTD  |  |  |  |  |  |  |  |  |  |                                       |  |  |  |  |  |  |  |  |  |  |
| d) Name               | JAGANI JAGADEESH  |  |  |  |  |  |  |  |  |  |                                       |  |  |  |  |  |  |  |  |  |  |
| e) Address            | SRI NILAYAM # NO 1-57/18/A BLOCK A SRI RAM NAGAR COLONY BOTANICAL GARDENS |  |  |  |  |  |  |  |  |  |                                       |  |  |  |  |  |  |  |  |  |  |
| City                  | HYDERABAD   |  |  |  |  |  |  |  |  |  |                                       |  |  |  |  |  |  |  |  |  |  |
| State                 | TELANGANA   |  |  |  |  |  |  |  |  |  | Pin Code 500084                       |  |  |  |  |  |  |  |  |  |  |
| Ph. No.               | 9642676515  |  |  |  |  |  |  |  |  |  | Email ID jagani.jagadeesh@triantz.com |  |  |  |  |  |  |  |  |  |  |

#### DETAILS OF INSURANCE HISTORY

|  |                 |    |                                     |
|--|-----------------|----|-------------------------------------|
| a) Currently covered by any other Mediciam/Health Insurance                          | Yes             | No | <input checked="" type="checkbox"/> |
| 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 Mediciam/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             | <input checked="" type="checkbox"/> | Female           |                                     | c) Age    | years | 31      | months | 11      | d) Date of Birth | 06/06/1990 |
| e) Relationship to Primary insured | Self             | <input checked="" type="checkbox"/> | Spouse           |                                     | Child     |       | Father  |        | Mother  |                  |            |
|                                    | Other            |                                     | (Please Specify) |                                     |           |       |         |        |         |                  |            |
| f) Occupation                      | Service          |                                     | Self Employee    | <input checked="" type="checkbox"/> | Homemaker |       | Student |        | Retired |                  |            |
|                                    | Other            |                                     | (Please Specify) |                                     |           |       |         |        |         |                  |            |
| Address (if different from above)  |                  |                                     |                  |                                     |           |       |         |        |         |                  |            |
| City                               |                  |                                     |                  |                                     |           |       |         |        |         |                  |            |
| State                              |                  |                                     |                  |                                     |           |       |         |        |         |                  |            |
| Ph. No.                            |                  |                                     |                  |                                     |           |       |         |        |         |                  |            |
|                                    | Email ID         |                                     |                  |                                     |           |       |         |        |         |                  |            |
|                                    | Pin Code         |                                     |                  |                                     |           |       |         |        |         |                  |            |

#### 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                               | <input checked="" type="checkbox"/> | 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 |  |
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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/<br>Post-hospitalization) | Amount (₹) |
|---------|----------|------------|-------------------|--|------------|
| 1       | 15353    | 07/05/2021 | NEO DIAGNOSTICS   | HRCT CHEST SCAN  | 3000.00    |
| 2       | 98       | 02/05/2021 | Satyasai clinical | Blood test   | 3200       |
| 3       | 99       | 20/05/2021 | Satyasai clinical | Blood test   | 3100       |
| 4       | 57       | 9/05/2021  | Anzitha medicals  | medicines  | 7995       |
| 5       | 58       | 9/05/2021  | Anzitha 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                       | A | R | B | P | J | 6 | 0 | 2 | 9 | N | b) Account Number | 5 | 0 | 1 | 0 | 0 | 1 | 7 | 9 | 8 | 0 | 8 | 6 | 6 | 7 |
| c) Bank Name and Branch      | H | D | F | C |   | K | O | N | D | A | P                 | U | R |   |   |   |   |   |   |   |   |   |   |   |   |
| d) Cheque/DD Payable details |   |   |   |   |   |   |   |   |   |   | e) IFSC Code      | H | D | F | C | 0 | 0 | 0 | 3 | 7 | 9 |   |   |   |   |

## 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 a 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. Joyale  
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                             |
| 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         | JAGAN I JAGADEESH   |
| b) | IP Registration Number      |   |
| c) | Gender                      | Male <input checked="" type="checkbox"/> 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 <input type="checkbox"/> Planned <input type="checkbox"/> Day Care <input type="checkbox"/> Maternity <input checked="" type="checkbox"/> |
| k) | If Maternity                | i. Date of Delivery <u>DD / MM / YYYY</u> ii. Gravida Status  |
| l) | Status at time of discharge | Discharge to home <input type="checkbox"/> Discharge to another hospital <input type="checkbox"/> Deceased <input type="checkbox"/>                 |
| 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 <input type="checkbox"/> No <input type="checkbox"/> | (If Yes, specify details)  |
| d)   | Pre-authorization obtained                                     | Yes <input type="checkbox"/> No <input type="checkbox"/> |  |
| e)   | Pre-authorization Number                                       |  |  |
| f)   | If authorization by network hospital not obtained, give reason |  |  |
| g)   | Hospitalization due to Injury                                  | Yes <input type="checkbox"/> No <input type="checkbox"/> | i. If Yes, give cause Self-inflicted <input type="checkbox"/> Road Traffic Accident <input type="checkbox"/>   |
|      | Substance abuse/alcohol consumption                            |  | ii. If Injury due to Substance abuse/alcohol consumption, Test Conducted to establish this Yes <input type="checkbox"/> No <input type="checkbox"/> (If Yes, attach reports) |
|      | iii. If Medico legal   | Yes <input type="checkbox"/> No <input type="checkbox"/> | iv. Reported to Police Yes <input type="checkbox"/> No <input type="checkbox"/> 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                                 |                |  |  |  |  |  |  |  |  |  |                             |                |    |         |     |    |  |  |  |  |          |  |  |  |  |  |
|    | State                                |                |  |  |  |  |  |  |  |  |  |                             |                |    |         |     |    |  |  |  |  | Pin Code |  |  |  |  |  |
| b) | Phone No.                            |                |  |  |  |  |  |  |  |  |  | c) Registration No.         |                |    |         |     |    |  |  |  |  |          |  |  |  |  |  |
|    | Date of Registration                 | DD / MM / YYYY |  |  |  |  |  |  |  |  |  | Expiry date of Registration | DD / MM / YYYY |    |         |     |    |  |  |  |  |          |  |  |  |  |  |
|    | 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: Vishakhapatnam

Date: 03/06/2021

  
Signature of  
Insured/Claimant

Signature and Seal of  
the Hospital Authority