CLAIM FORM - PART A' to 'CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT - PART A

TO BE FILLED 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:

SECTION A

a) Policy No.: 14050034220400000059 b) Sl. No/ Certificate no.:

c) Company/ TPA ID No: 122277746

d) Name: THAKUR (NAME) SUNIL (NAME) (MIDDLE NAME)

e) Address: DM-126 J7-MIh AYodhYa extention BY PASS ROAd BhoPAL MP P

City: State: MP

Pin Code: 362041 Phone No: 9753333081 Email ID: sunilthakur@gmail.com

DETAILS OF INSURANCE HISTORY:

SECTION B

a) Currently covered by any other Mediclaim / Health Insurance: ☐ Yes ☑ No b) Date of commencement of first Insurance without break: DD MM YYYY

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: MM YY

Diagnosis: e) Previously covered by any other Mediclaim /Health insurance: ☐ Yes ☐ No

f) If yes, company name:

DETAILS OF INSURED PERSON HOSPITALIZED:

SECTION C

a) Name: THAKUR (NAME) VARNIKA (NAME) (MIDDLE NAME)

b) Gender: Male ☐ Female ☑ c) Age years: 04 Months: 11 d) Date of Birth: 07 08 2018

e) Relationship to Primary insured: Self ☐ Spouse ☐ Child ☑ Father ☐ Mother ☐ Other ☐ (Please Specify)

f) Occupation: Service ☐ Self Employed ☐ Home Maker ☐ Student ☑ Retired ☐ Other ☐ (Please Specify)

g) Address (if different from above):

City: State:

Pin Code: Phone No: Email ID:

DETAILS OF HOSPITALIZATION:

SECTION D

a) Name of Hospital where Admitted: ROSHAN 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 Disease first detected /Date of Delivery: DD MM YYYY

e) Date of Admission: 24 07 23 f) Time: 09 00 g) Date of Discharge: DD MM YY h) Time: HH : MH

i) If injury give cause: Self inflicted ☐ Road Traffic Accident ☐ Substance Abuse / Alcohol Consumption ☐ i) If Medico legal ☐ Yes ☐ No

ii) Reported to Police ☐ ☐ iii. MLC Report & Police FIR attached ☐ Yes ☐ No j) System of Medicine:

DETAILS OF CLAIM:

SECTION E

a) Details of the Treatment expenses claimed

i. Pre-hospitalization expenses Rs.

ii. Hospitalization expenses Rs. 13195XX

iii. Post-hospitalization expenses Rs.

iv. Health-Check up cost Rs.

v. Ambulance Charges Rs.

vi. Others (code): Rs. 1292XXX

Total Rs. 14487XX

vii. Pre-hospitalization period: days

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 Rs.

ii. Surgical Cash: Rs.

iii. Critical Illness benefit Rs.

iv. Convalescence: Rs.

v. Pre/Post hospitalization Lump sum benefit: Rs.

vi. Others Rs.

Total Rs.

Claim Documents Submitted - Check List:

- ☐ Claim form duly signed
- ☐ Copy of the claim intimation, if any
- ☐ Hospital Main Bill
- ☐ Hospital Break-up Bill
- ☐ Hospital Bill Payment Receipt
- ☐ Hospital Discharge Summary
- ☐ Pharmacy Bill
- ☐ Operation Theater Notes
- ☐ ECG
- ☐ Doctor's request for investigation
- ☐ Investigation Reports (Including CT / MRI / USG / HPE)
- ☐ Doctor's Prescriptions
- ☐ Others

DETAILS OF BILLS ENCLOSED:

SECTION F

SL No.	Bill No.	Date	Issued by	Towards	Amount (Rs)
1.	#7631	23 07 23	Roshan hospital	Hospital main Bill	13195XX
2.	5966	24 07 23	Roshan hospital	Pre-hospitalization Bills: Nos	
3.	ADV443[illegible]	24 07 23	— 11 —	Post-hospitalization Bills: Nos	
4.	ADV243[illegible]	24 07 23	— 11 —	Pharmacy Bills	1292XXX
5.	ADV443491	24 07 23	Roshan hospital		
6.	0014956	24 07 23	Preetam Medical		
7.	5967	26 07 23	Roshan Hospital		
8.	ADV243556	16 07 23	— 11 —		
9.	0015352	26 07 23	Preetam medical		
10.	0015094	24 07 23	— 11 —		

11 0015112 25-07-23 (12) 0015273 - 25/07/23 (13) 0015302 - 26/07/23

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT:

SECTION G

a) PAN: ANGPT5328B b) Account Number: 30669576638

c) Bank Name and Branch: STATE BANK OF INDIA MATHPUR

d) Cheque / DD Payable details: ✓ 067539 e) IFSC Code: SBIN0002876

(IMPORTANT: PLEASE TURN OVER)

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
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: ROSHAN HOSPITAL

a) Hospital ID:

c) Type of Hospital: Network ☐ Non Network ☑ (if non network fill section E)

c) Name of the treating doctor: DR RAKESH SUKHADIA

e) Qualification: MD Pedia

f) Registration No. with State Code: MP 12449

g) Phone No.

SECTION B

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient: HARSHITA THAKUR

b) IP Registration Number: RMH 23/1428

c) Gender: Male ☐ Female ☑

d) Age: Years 05 Months

e) Date of birth: DD MM YY

f) Date of Admission: 24 07 23

g) Time: 03 00 Am

h) Date of Discharge: 26 07 23

i) Time: 01 00 Pm

j) Type of Admission: Emergency ☑ Planned ☐ Day Care ☐ Maternity ☐

k) If Maternity: i) Date of Delivery: DD MM YY 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
i. Primary Diagnosis		AFI c Acute Abdomen (Constipation)
ii. Additional Diagnosis		
iii. Co-morbidities		
iv. Co-morbidities		

b)

	ICD 10 PCS	Description
i. Procedure 1		
ii. Procedure 2		
iii. Procedure 3		
iv. Details of Procedure		

c) Pre-authorization obtained: ☐ Yes ☑ No

d) Pre-authorization Number:

e) If authorization by network hospital not obtained, give reason:

f) 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

SECTION D

CLAIM DOCUMENTS SUBMITTED - CHECK LIST

- ☑ Claim Form duly signed
- ☐ Original Pre-authorization request
- ☐ Copy of the Pre-authorization approval letter
- ☐ Copy of Photo ID Card of patient Verified by hospital
- ☑ Hospital Discharge summary
- ☐ Operation Theatre Notes
- ☑ Hospital main bill
- ☑ Hospital break-up bill
- ☑ Investigation reports
- ☐ CT/MR/USG/HPE investigation reports
- ☐ Doctor's reference slip for investigation
- ☐ ECG
- ☑ Pharmacy bills
- ☐ MLC reports & Police FIR
- ☐ Original death summary from hospital where applicable
- ☐ 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 the Hospital: 7A-B GOVIND GARDEN RAISEN ROAD GOVINDPURA

City: BHOPAL State: MP

Pin Code: 462023

b) Phone No. 2784148

c) Registration No. with State Code:

d) Hospital PAN: AAGFR4229B

e) Number of inpatient beds: 20

f) Facilities available in the 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 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.

Date: 03 08 23

Place: Bhopal

Signature and Seal of the Hospital Authority

ROSHAN HOSPITAL
Reg. No. NH/5407/JUL-2017
7A-B, Govind Garden,
Raisen Road, Govindpura, Bhopal (M.P.)-462023
Ph.: 0755-2784148, 4261002, 7024144851

PPN NETWORK-DECLARATION BY PATIENT/PATIENT'S ATTENDANT

Name of the Hospital: ROSHAN HOSPITAL

Address: 7 – A|B, GOVIND GARDEN, GOVINDPURA ROAD, BHOPAL-462023 Date :

PATIENT NAME (BLOCK LETTERS): VARNIKA THAKUR AGE/SEX : 5/F

IP No : UHID No : Mobile No of Patient : 9755333057

Date of Admission : 24/07/2023 Time of Admission : 09:00 AM

Date of Discharge: 26/07/2023 Time of Discharge: 1:00 pm

Address of the Patient : DM-126, Jr. MIG Ayodhya Extention, By Pass Road Bhopal (M.P)

NAME OF THE ATTENDANT : SUNIL THAKUR Relationship with the Patient: FATHER

Mobile No. of Attendant : 9755333057 Address: DM-126, Jr. MIG Ayodhya Extention By pass Road Bphal (M.P)

Declaration regarding Insurance Policy (Strike off the option which is not applicable)

(i) ***Declaration when patient has no insurance policy:***

- I declare that I do not have any insurance policy.

(ii) ***Declaration when patient has insurance policy:***

- I declare that I have following Insurance Policies

Policy No/TPA card No: 140500342204000000059

Insurance Company: THE NEW INDIA ASSURANCE CO LTD

2) Whether patient opted for Eligible Room Category under Policy: **Yes / No**

3) In case, policyholder wishes to avail better facility:

Name of the Additional Facility/ Provision/ Procedure/ Treatment

.....

Rs :..... (In words:

.....

.....

.....) only.

On my own option, I wish to avail above better facility and I hereby agree to pay on my free will, after being explained in detail by the Hospital authority in my own and understandable language about the above mentioned Additional Facility/Procedure/Treatment and associated cost of it, which is over and above the agreed PPN tariff.Further, if I opt to go for final bill reimbursement with insurance company, respective insurance company will reimburse only as peragreed PPN tariffrates and balance amount will be borne by myself or patient only.

I have also been explained that when room service of a category better than eligible room rent is availed by the patient, not only the difference in room rent but also an equal proportion of all other charges associated with the treatment shall be borne by me.

Signature : Sukumar

Name of the Patient/Patient's attendant:

Signature :

Name of the Hospital Representative &Hospital Seal :

ROSHAN HOSPITAL
Reg. No. NH/5407/JUL-2017
7A-B, Govind Garden,
Raisen Road, Govindpura, Bhopal (M.P.)-462023
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