DHFL GENERAL INSURANCE

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)**

SECTION A - DETAILS OF PRIMARY INSURED

a Policy No: XXXXXXXXXXXXXX | b Sl. No/Certificate No:

c Company/TPA ID No: DHFL 0000000

d Name: ABC EFG HIJK

e Address: 000 ABC

City: ABC | State: ABC | Pincode: 000000

Phone no: 0000000000 | Email ID: ABC@gmail.com

SECTION B - DETAILS OF INSURANCE HISTORY

a Currently covered by any other Mediclaim/Health insurance | Yes | No | Copies of policies to be attached

b Date of commencement of first insurance without break | c If Yes, Company Name

Policy No. | Sum Insured

d Have you been hospitalized in the last four years? | Yes | No | Date

Diagnosis | e Previously covered by any other Mediclaim/Health insurance | Yes | No

f If yes, Company Name

SECTION C - DETAILS OF INSURED PERSON HOSPITALISED

a Name: ABC EFG HIJK

b Gender: ✓ Male | Female | c Age: Years 00 Months 00 | d Date of Birth: 20011900

e Relationship to Primary Insured: Self | ✓ Spouse | Child | Father | Mother | Other (Please Specify)

f Occupation: Service | ✓ Self-employed | Homemaker | Student | Retired | Other (Please Specify)

g Address (if different from above): 000 ABC

City: ABC | State: ABC | Pincode: 000000

h Telephone No | i Mobile No: 0000000000

j Email ID: ABC@gmail.com

SECTION D - DETAILS OF HOSPITALISATION

a Name of the Hospital where admitted: XYZ

b Room Category occupied: Daycare | Single Occupancy | ✓ Twin Sharing | 3 or more beds per room

c Hospitallisation due to: Illness | ✓ Injury | Maternity | d Date of Injury/Date of disease first detected/Date of delivery: DD MM YYYY

e Date of admission: 20011900 | f Time: 00 | g Date of discharge: 20011900 | h Time: 00 MM

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: ABC

SECTION E - DETAILS OF CLAIM

a Details of the treatment expenses claimed

i Pre-hospitalisation Expenses	Rs	ii Hospitalisation Expenses	Rs	0	0
iii Post-hospitalisation Expenses	Rs	iv Health-Check up Cost	Rs		
v Ambulance Charges	Rs	vi Others (code)	Rs		
		Total	Rs	0	0
vii Pre-hospitalisation Period	days	viii Post - hospitalisation Period	days	0	0

b Claim for Domiciliary Hospitalization | Yes | ✓ No | (if yes, please provide details in annexure)

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c	Details of Lumpsum/cash benefit claimed:						
i	Hospital Daily Cash	Rs		ii	Surgical Cash	Rs	
iii	Critical Illness Benefit	Rs		iv	Convalescence	Rs	
v	Pre/Post hospitalisation lumpsum benefit	Rs		vi	Others	Rs	
	Claim Documents Submitted - Check List:				Total - Rs		
✓	Claim Form duly filled and signed			✓	Copy of claim intimation		
✓	Hospital Main Bill			✓	Hospital Break Up bill		
✓	Hospital Bill Payment Receipt			✓	Hospital Discharge Summary		
✓	Pharmacy Bill			-	Operation Theatre Notes		
-	ECG			✓	Doctor's Request for Investigation		
✓	Investigation Reports (Including CT, MRI/ USG/ HPE)			✓	Doctor's Prescription		
-	Others						

SECTION - F DETAILS OF BILLS ENCLOSED

S. No.	Bill No.	Date	Issued by	Towards	Amount (Rs)
		D D M M Y Y		Hospital Main Bill	0 0 0 0 0 0
				Pre Hospitalisation Bills (.....Nos)	
				Post Hospitalisation Bills (.....Nos)	
				Pharmacy Bills	0 0 0 0 0
					0 0 0 0 0 0

SECTION - G DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

a	PAN: ABC	b	Account Number: 0 0 0 0 0 0 0 0 0 0 0 0
c	Bank Name & Branch: XYZ		
d	Cheque / DD Payable details:		
e	IFSC Code: ABC0000000		*please attach a cancelled cheque pertaining to the same
f	MICR No: 000000000		*please attach a cancelled cheque pertaining to the same

SECTION H - 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, 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.

Date: 20/11/900

Place: XYZ

ABC

Signature of Insured

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GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled in by the insured)		
DATA ELEMENT	**DESCRIPTION**	**FORMAT**
SECTION A - DETAILS OF PRIMARY INSURED		
a) Policy No.	Enter the policy number	As allotted by the insurance company
b) SI. No/Certificate No.	Enter the social insurance number or the certificate number of social health insurance scheme	As allotted by the organization
c) Company TPA ID No.	Enter the TPA ID No	License number as allotted by IRDA and printed in TPA documents.
d) Name	Enter the full name of the policyholder	Surname, First name, Middle name
e) Address	Enter the full postal address	Include Street, City and Pin Code
SECTION B - DETAILS OF INSURANCE HISTORY		
a) Currently covered by any other Mediclaim/ Health Insurance?	Indicate whether currently covered by another Mediclaim/ Health Insurance	Tick Yes or No
b) Date of Commencement of first Insurance without break	Enter the date of commencement of first insurance	Use dd-mm-yy format
c) Company Name	Enter the full name of the insurance company	Name of the organization in full
Policy No.	Enter the policy number	As allotted by the insurance company
Sum Insured	Enter the total sum insured as per the policy	In rupees
d) Have you been Hospitalized in the last four years since inception of the contract	Indicate whether hospitalized in the last four years	Tick Yes or No
Date	Enter the date of hospitalization	Use mm-yy format
Diagnosis	Enter the diagnosis details	Open Text
e) Previously Covered by any other Mediclaim/ Health Insurance?	Indicate whether previously covered by another Mediclaim/ Health Insurance	Tick Yes or No
f) Company Name	Enter the full name of the insurance company	Name of the organization in full
SECTION C - DETAILS OF INSURED PERSON HOSPITALIZED		
a) Name	Enter the full name of the patient	Surname, First name, Middle name
b) Gender	Indicate Gender of the patient	Tick Male or Female
c) Age	Enter age of the patient	Number of years and months
d) Date of Birth	Enter Date of Birth of patient	Use dd-mm-yy format
e) Relationship to primary Insured	Indicate relationship of patient with policyholder	Tick the right option. If others, please specify.
f) Occupation	Indicate occupation of patient	Tick the right option. If others, please specify.
g) Address	Enter the full postal address	Include Street, City and Pin Code
h) Phone No	Enter the phone number of patient	Include STD code with telephone number
i) E-mail ID	Enter e-mail address of patient	Complete e-mail address
SECTION D - DETAILS OF HOSPITALIZATION		
a) Name of Hospital where admitted	Enter the name of hospital	Name of hospital in full
b) Room category occupied	Indicate the room category occupied	Tick the right option
c) Hospitalization due to	Indicate reason of hospitalization	Tick the right option
d) Date of Injury/Date Disease first detected/ Date of Delivery	Enter the relevant date	Use dd-mm-yy format
e) Date of admission	Enter date of admission	Use dd-mm-yy format
f) Time	Enter time of admission	Use hh:mm format
g) Date of discharge	Enter date of discharge	Use dd-mm-yy format
h) Time	Enter time of discharge	Use hh:mm format
i) If Injury give cause	Indicate cause of injury	Tick the right option
If Medico legal	Indicate whether injury is medico legal	Tick Yes or No
Reported to Police	Indicate whether police report was filed	Tick Yes or No
MLC Report & Police FIR attached	Indicate whether MLC report and Police FIR attached	Tick Yes or No
j) System of Medicine	Enter the system of medicine followed in treating the patient	Open Text
SECTION E - DETAILS OF CLAIM		
a)Details of Treatment Expenses	Enter the amount claimed as treatment expenses	In rupees (Do not enter paise values)
b)Claim for Domiciliary Hospitalization	Indicate whether claim is for domiciliary hospitalization	Tick Yes or No
c)Details of Lump sum/cash benefit claimed	Enter the amount claimed as lump sum/cash benefit	In rupees (Do not enter paise values)
d)Claim Documents Submitted-Check List	Indicate which supporting documents are submitted	Tick the right option
SECTION F - DETAILS OF BILLS ENCLOSED		
Indicate which bills are enclosed with the amounts in rupees		

DATA ELEMENT	DESCRIPTION	FORMAT
SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT		
a) PAN	Enter the permanent account number	As allotted by the Income Tax Department
b) Account Number	Enter the bank account number	As allotted by the bank
c) Bank Name and Branch	Enter the bank name along with the branch	Name of the Bank in full
d) Cheque/DD payable details	Enter the name of the beneficiary the cheque/DD should be made out to	Name of the individual/organization in full
e) IFSC Code	Enter the IFSC code of the bank branch	IFSC code of the bank branch in full
SECTION H - DECLARATION BY THE INSURED		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.		

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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	XYZ							
b	Hospital ID		c	Type of Hospital	Network	Non Network	(If non network fill form section E)		
d	Name of the treating Doctor	ABC							
e	Qualification	ABc							
f	Registration No with state Code	00000	g	Phone No:					

SECTION B - DETAILS OF PATIENT ADMITTED

a	Name of the patient	ABC											
b	IP Registration Number	000	c	Gender	Male	Female	d	Age	Years	Y Y	Months	M M	
e	Date of Birth	20011900	f	Date of Admission	20011900	g	Time of Admission	00	M M				
h	Date of Discharge	20011900	i	Time of Discharge	00	M M							
j	Type of Admission	Emergency		Planned ✓	Daycare	Maternity	k	If Maternity	i	Date of Delivery	D D M M Y Y Y Y		
ii	Gravida Status		l	Status at time of discharge	Discharged to Home	Discharged to another Hospital ✓	Deceased						

SECTION C - DETAILS OF AILMENTS DIAGNOSED (PRIMARY)

a		ICD 10 Code	Description	b		ICD 10 PCS	Description
i	Primary Diagnosis			i	Details of Procedure 1		
ii	Additional Diagnosis			ii	Details of Procedure 2		
iii	Co-morbidities			iii	Details of Procedure 3		
				iv	Details of Procedure		

c	Present ailment is complication of PED?		Yes		No	If Yes, specify details			
d	Pr authorization obtained		Yes ✓	No	e	Pre-authorization Number			
f	If authorization by network hospital not obtained, give reason								
g	Hospitalisation due to Injury		Yes ✓	No	i	If yes, give cause			
	Self inflicted?	Yes	No	Road Traffic Accident	Yes	No	Substance Abuse/Alcohol Consumption	Yes	No
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 reasons								

SECTION D - CLAIM DOCUMENTS SUBMITTED - CHECKLIST

✓ Claim form duly filled and signed	✓ Investigation reports
☐ Original pre authorization request	☐ CT/MRI/USG/HPE investigation report
☐ Copy of pre-authorization approval 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 - DETAILS IN CASE OF NON NETWORK HOSPITAL (Only fill in case of Non Network Hospital)

a	Address of the Hospital	XYZ							
	City	XYZ	State	XYZ	Pincode	000000			
b	Phone No:	0000000000	c	Registration no with State Code	0000000000				
d	Hospital PAN	ABC0000000	e	No of In-patient Beds					
f	Facilities available in Hospital	i OT ✓ Yes	No	ii ICU ✓ Yes	No				
iii	Others								

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(PLEASE READ VERY CAREFULLY)

SECTION F - 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, 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/receipt for the purpose of this claim & that I will not be making any supplementary claim expect the pre/post hospitalization claim, if any.

Date: 20/11/900

Place: ABC

ABC

Signature of the Insured

(PLEASE READ VERY CAREFULLY)

SECTION G - DECLARATION BY HOSPITAL

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.

Date: 20/11/900

Place: XYZ

Hospital stamp / ABC

Treating Doctor Signature and seal of the Hospital Authority

GUIDANCE FOR FILLING CLAIM FORM - PART B (To be filled in by the hospital)		
DATA ELEMENT	**DESCRIPTION**	**FORMAT**
SECTION A - DETAILS OF HOSPITAL		
a) Name of Hospital	Enter the name of hospital	Name of hospital in full
b) Hospital ID	Enter ID number of hospital	As allocated by the TPA
c) Type of Hospital	Indicate whether In network or non network Hospital	Tick the right option
d) Name of treating doctor	Enter the name of the treating doctor	Name of doctor in full
e) Qualification	Enter the qualifications of the treating doctor	Abbreviations of educational qualifications
f) Registration No. with State Code	Enter the registration number of the doctor along with the state code	As allocated by the Medical Council of India
g) Phone No.	Enter the phone number of doctor	Include STD code with telephone number
SECTION B - DETAILS OF THE PATIENT ADMITTED		
a) Name of Patient	Enter the name of hospital	Name of hospital in full
b) IP Registration Number	Enter insurance provider registration number	As allotted by the insurance provider
c) Gender	Indicate Gender of the patient	Tick Male or Female
d) Age	Enter age of the patient	Number of years and months
e) Date of Birth		
e) Date of Admission	Enter date of admission	Use dd-mm-yy format
f) Time	Enter time of admission	Use hh:mm format
g) Date of Discharge	Enter date of discharge	Use dd-mm-yy format
h) Time	Enter time of discharge	Use hh:mm format
i) Type of Admission	Indicate type of admission of patient	Tick the right option
j) If Maternity		
Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format
Gravida Status	Enter Gravida status if maternity	Use standard format
k) Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
l) Total claimed amount	Indicate the total claimed amount	In rupees (do not enter paise values)
SECTION C - DETAILS OF AILMENT DIAGNOSED (PRIMARY)		
a) ICD 10 Code		
Primary Diagnosis	Enter the ICD 10 Code and description of the primary diagnosis	Standard Format and Open text
Additional Diagnosis	Enter the ICD 10 Code and description of the additional diagnosis	Standard Format and Open text
Co-morbidities	Enter the ICD 10 Code and description of the co-morbidities	Standard Format and Open text
b) ICD 10 PCS		
Procedure 1	Enter the ICD 10 PCS and description of the first procedure	Standard Format and Open text
Procedure 2	Enter the ICD 10 PCS and description of the second procedure	Standard Format and Open text
Procedure 3	Enter the ICD 10 PCS and description of the third procedure	Standard Format and Open text
Details of Procedure	Enter the details of the procedure	Open text
c) Present Ailment is a Complication of PED	Indicate whether present ailment is a complication of some pre- existing disease	Tick Yes or No
d) Pre-authorization obtained	Indicate whether pre-authorization obtained	Tick Yes or No
e) Pre-authorization Number	Enter pre-authorization number	As allotted by TPA
f) If authorization by network hospital not obtained, give reason	Enter reason for not obtaining pre-authorization number	Open text
g) Hospitalization due to injury	Indicate if hospitalization is due to injury	Tick Yes or No
Cause	Indicate cause of injury	Tick the right option
If injury due to substance abuse/alcohol consumption, test conducted to establish this	Indicate whether test conducted	Tick Yes or No
Medico Legal	Indicate whether injury is medico legal	Tick Yes or No
Reported To Police	Indicate whether police report was filed	Tick Yes or No
FIR No.	Enter first information report number	As issued by police authorities
If not reported to police, give reason	Enter reason for not reporting to police	Open Text
SECTION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST		
Indicate which supporting documents are submitted		

DATA ELEMENT	DESCRIPTION	FORMAT
SECTION E - DETAILS IN CASE OF NON NETWORK HOSPITAL		
a) Address	Enter the full postal address	Include Street, City and Pin Code
b) Phone No.	Enter the phone number of hospital	Include STD code with telephone number
c) Registration No. with State Code	Enter the registration number of patient	As allocated by the Hospital
d) Hospital PAN	Enter the permanent account number	As allotted by the Income Tax department
e) Number of Inpatient Beds	Enter the number of inpatient beds	Digits
f) Facilities available in the hospital	Indicate facilities available in the hospital	Tick the right option. If others, please specify
SECTION F - DECLARATION BY THE INSURED		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.		
SECTION G - DECLARATION BY THE HOSPITAL		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign and stamp.		