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)

DETAILS OF HOSPITAL — SECTION A

a) Name of the hospital: SANKALPA MULTISPECIALITY HOSPITAL

b) Hospital ID:

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

d) Name of the treating doctor:

e) Qualification:

f) Registration No. with State Code:

g) Phone No:

DETAILS OF THE PATIENT ADMITTED — SECTION B

a) Name of the Patient: B RAJASHEKAR NAIDU.

b) IP Registration Number: 001484

c) Gender: Male ☑ Female ☐

d) Age: Years 26 Months

e) Date of birth:

f) Date of Admission: 27 09 24

g) Time: 19 05

h) Date of Discharge: 29 09 24

i) Time: 19 14.

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) — SECTION C

a)

	ICD 10 Codes	Description
i. Primary Diagnosis		Fissure in Ano
ii. Additional Diagnosis		– Grade III Haemorrhoids
iii. Co-morbidities		– External piles.
iv. Co-morbidities		

b)

	ICD 10 PCS	Description
i. Procedure 1		– EUA + Laser lateral internal Sphincterotomy
ii. Procedure 2		+ Laser Hemorrhoidopexy
iii. Procedure 3		+ Excision of External piles
iv. Details of Procedure		+ Anal dilatation, U/SA.

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:

CLAIM DOCUMENTS SUBMITTED - CHECK LIST — SECTION D

- ☐ 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

ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL) — SECTION E

a) Address of the Hospital: #47/2 OPP VISHAL MART J P NAGAR 8TH PHASE

City: BANGALORE State:

Pin Code: 560076

b) Phone No: 9606626006

c) Registration No. with State Code: BLU0037ALPHA

d) Hospital PAN: ClGPM6108Q

e) Number of inpatient beds: 025

f) Facilities available in the hospital: i. OT ☑ Yes ☐ No ii. ICU ☑ Yes ☐ No

iii. Others:

DECLARATION BY THE HOSPITAL — SECTION F

(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: 09 10 24

Place: Bangalore

Signature and Seal of the Hospital Authority

Sankalpa Multispeciality Hospital
47/2, Kothanur Dinne Main Road
Opp. To Vishal Mart, J.P. Nagar 8th Phase
BANGALORE - 560 076
Ph: 8296857141 / 080 - 23902727

Medi Assist

REIMBURSEMENT CLAIM FORM

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)

SECTION A

DETAILS OF PRIMARY INSURED:

a) Policy No:

b) TPA Ref Certificate no:

c) Company / TPA ID (MA ID) No: 4039208225

d) Name: Rajasekhar Naidu. S

e) Address:

City: Bangalore

State: Karnataka

Pin Code:

Phone No: 7095067004

Email ID: 132rajasekhar@gmail.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:

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: Rajasekhar Naidu. B

b) Gender: Male / Female

c) Age years: Months:

d) Date of Birth:

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): Same as Above

City:

State:

Pin Code:

Phone No:

Email ID:

SECTION D

DETAILS OF HOSPITALIZATION:

a) Name of Hospital where Admitted: Sankalpa Multispeciality 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:

e) Date of Admission: 27 09 24

f) Time:

g) Date of Discharge: 29 09 24

h) Time:

i) If injury give cause: Self inflicted / Road Traffic Accident / Substance Abuse / Alcohol Consumption

j) If Medico legal: Yes / No

ii) Reported to Police:

iii. MLC Report & Police FIR attached: Yes / No

j) System of Medicine:

SECTION E

DETAILS OF CLAIM:

a) Details of the Treatment expenses claimed

i. Pre -hospitalization expenses: Rs.

ii. Hospitalization expenses: Rs. 1,90,000/-

iii. Post -hospitalization expenses: Rs.

iv. Health-Check up cost: Rs.

v. Ambulance Charges: Rs.

vi. Others (code): Rs.

Total: Rs.

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. 1,90,000/-

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

SECTION F

DETAILS OF BILLS ENCLOSED:

Sl. No.	Bill No.	Date	Issued by	Towards	Amount (Rs)
1.				Hospital main Bill	1,90,000/-
2.				Pre-hospitalization Bills: Nos	
3.				Post-hospitalization Bills: Nos	
4.				Pharmacy Bills	
5.					
6.					
7.					
8.					
9.					
10.					1,90,000/-

SECTION G

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT:

a) PAN:

b) Account Number: 31760150 3212

c) Bank Name and Branch:

d) Cheque / DD Payable details:

e) IFSC Code: ICIC0003171

SECTION H

DECLARATION BY THE INSURED:

I hereby declare that the information furnished in the claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealent 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.

Date: Place: Bangalore Signature of the Insured: Rajasekhar Naidu

(IMPORTANT: PLEASE TURN OVER)