

CLAIM FORM - PART B TO BE FILLED IN BY THE HOSPITAL

The issue of theis form is not to be taken as admission of liability

(To be filled in block letters)

DETAILS OF HOSPITAL																																							
a) Name of the Hospital:						\Box				Ι	\mathbf{L}															\Box		L	T	Τ	I	\perp	\Box						
c) Hospital ID:	pital ID: c) Type of Hospital: Network Non Network													(if non network, fill Section E)																									
d) Name of the treating of	doctor:	\Box	\Box			\Box			\Box	Γ																		Γ		Τ		Ι							
e) Qualification:				_	_	_	\Box			f) l	Registra	ation N	No. with	n state	code:]		g) Pho	ne No.			Ι	Ι	\perp	\Box						
DETAILS OF PATIENT	ETAILS OF PATIENT ADMITTED																																						
a) Name of Patient:					П	\Box			\Box	$\overline{\mathbb{L}}$	\mathbb{T}															\Box		L	T	Τ	Τ	I	I	\Box		\Box	\Box	\Box	
b) IP Registration No.:			$oldsymbol{oldsymbol{oldsymbol{\square}}}$		\Box	\Box	\Box		c) G	ende	r:	Male] F	emale]	d)	Age:	years			r	nonths			e) Da	ate of	Birth:			Ι		[
f) Date of Admission:						\Box			g) Tir	ime:] :			1		h) Da	te of D	ischa	ge:]		Τ]		Τ			i)	Time:	[: [\Box	Ⅎ
j) Type of Admission:	Emergency		Plan	ned			Day	Care	,	Ma	aternity		1		k) If	Mater	rnity:	i	. Date	of De	ivery:			Ī		Τ	Ī	Г	Τ	Ī		ii.	Gravi	ida St	atus:	_[Ť	П	
I) Status at time of discha	arge:	Discha	arged to I	home	\Box		Γ	Discha	arged	to an	other ho	ospital		1	Dece	eased		1										m) T	tal cla	imed	amou	ınt 🗌	Т	П		T		П	
DETAILS OF AILMENT	DIAGNOSE	D (PRIMA	RY)		_									•				•																					
a)		IC	CD 10 Cc	odes							Desc	ription	n				b)							IC	D 10	PCS								Des	scriptio	n			
i. Primary Diagnosis :					П	\Box	.		_								i. F	Proced	dure 1	:				L						F									\Box
ii. Additional Diagnos	is:				Ш		ij		_							İ	ii.	Proced	dure 2	:								Γ		F									╡
iii. Co-morbidities :		П	\top	$\overline{}$	П	\neg	. I	_	_]]	iii.	Proce	dure 3	s:		Г	Г	Т	Г	Т	Т	Т	7	F									ᅥ
i. Ca madeiditiaa	_		_	\equiv	$\overline{}$	_ _	 		_] i		Deteil	la af D			_							_										╡
iv. Co-morbidities : iv. Details of Procedure : iv. Details of Procedure :																																							
) Pre authorization obtained: Yes No d) Pre-authorization number:																																						
e) If authorization by net		I not obtain	ned, give	reaso	n:		I	Щ							_	1					_	1											_	_					Ш
f) Hospitalization due to i	njury:	Yes	Ш	No		i.	. If yes	, give	e cause	e			Self in	flicted	\sqsubseteq	ļ	Roa	d Traff	fic Acc	ident		l				Su	bstand	ce ab	use / a	lcoho	l cons	sump	tion				-		
ii. If injurydue to Substan	If injurydue 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.		Ш		\Box	Ш	\perp	\sqcup	ĺ		٧	i. If not	report	ted to p	olice,	give rea	ason:	\Box																						
CLAIM DOCUMENTS S	UBMITTED	- CHECKL	IST			_		_																															
Claim Fo	orm duly sigr	ied															느	In	vestiga	ation re	ports																		
Original	Pre-authoriz	ation reque	est														ᆫ	CT	T/ MRI	/ USG	HPE/	Inves	tigatio	n repo	orts														
Copy of	the Pre-auth	orization ap	pproval le	etter														Do	octor's	refera	nce sli	p																	
Copy of	photo ID car	d of patien	t verified	I by ho	spital													E	CG																				
Hospital	discharge si	ummary																Ph	narma	cy bills																			
Oparatio	n Theatre No	otes																М	LC rep	ort & I	Police	FIR																	
Hospital	main bill																	10	riginal	death	summ	ary fro	m ho	spital,	where	applic	able												
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a) Address of the hospital	al:	$\Box \Box$			Ш	╝	╝		匚	\Box																				Γ	\perp	\perp	\bot	\Box	\Box	\Box	\bot	\Box	╝
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d) Hospital PAN						\Box			\sqsubseteq]	e) N	Numbe	er of in	patient	t beds					f) Fa	cilities	availa	ble in	the ho	spital	:	i. OT:		Yes		No	,		ii.	ICU:		'es		No
iii. Others:						_	_	_																															
DECLARATION BY THE	HOSPITAL							_																										(Pl	ease i	ead ve	ery ca	refully	/)
We hereby declare th forfeited.	at the inform	ation furni	shed in t	his Cla	aim Form	ı is trı	ue & c	xorrec'	t to the	e bes	t of our	knowle	edge a	nd beli	ief. If w	e hav	e made	any f	alse oi	untru	e state	ment,	supp	ress oi	conc	ealmer	it of an	nu ma	terial fa	act, o	ur righ	nt to c	laim u	ınder	this cla	aim sha	all be		
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a) Name of Hospita						_		_			Enter	r the n	iame o							_							Nam	e of I	ospital	l in fi									
EVID-04-LID									_	Enter ID number of hospital										-		ed by t																	
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d) Name of treating	doctor					_	_	_				Enter the name of the treating doctor										-		loctor i															
e) Qualification f) Registration No. v	with State (ode						_			$\overline{}$	Enter the qualifications of the treating doctor										-		ons of															
g) Phone No.	Judie C										Enter the registration number of the doctor along with the state code Enter the phone number of doctor										As al	iocat	ed by t	пе М	edical	Cour	ncil of	ındia											
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Screen Market M	b) IP Registration Number	Enter insurance provider registration number	As allotted by the insurance provider						
District Affirmation Control of Maritanian Contr	c) Gender	Indicate Gender of the patient	 						
Prime Cheek from a defension Due In the Neutral	d) Age	Enter age of the patient	Number of years and months						
Direct Direct Enter fine of admission Direct Di	e) Date of Admission	Enter date of admission	Use dd-mm-yy format						
Speed of Declarage Seed Schempsy Errord Seed Schempsy Errord	f) Time	 							
Di Yene Charlesson Selection of discharge Selection of discharge Selection of discharge Selection of Selection Selection Selection of Selection Selection Selection Selection of Selection	g) Date of Discharge	Enter date of discharge							
Organisation State of Administration of patient State Procedure State Of Delivery State of State o	h) Time	Enter time of discharge	· · · · · · · · · · · · · · · · · · ·						
Ditate of Chebry Enter Date of Delivery Enter Cravida status in maternity Uses daming formed	i) Type of Admission	· · · · · · · · · · · · · · · · · · ·	•						
Cravida Status First	j) If Maternity								
Statius at time of discharge Statius at time of discharge Tick regit option	Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format						
Address Section Number Gravida Status		· · · · · · · · · · · · · · · · · · ·							
a) ICD 10 Code Primary Diagnosis Sinder Format and Open text Additional Diagnosis Sinder Brown at and Open text Additional Diagnosis Sinder Brown at and Open text Enter the ICD 10 Code and description of the additional diagnosis Sinder Format and Open text Sinder Format and Open te	k) Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option						
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 Committed b) ICD 10 PCS Find the ICD 10 Code and description of the committed is standard Format and Open text Enter the ICD 10 PCS and description of the first procedure Procedure 1 Find the ICD 10 PCS and description of the star procedure Procedure 2 Enter the ICD 10 PCS and description of the star procedure Procedure 3 Enter the ICD 10 PCS and description of the star procedure Procedure 3 Enter the ICD 10 PCS and description of the star procedure Procedure 3 Enter the ICD 10 PCS and description of the star procedure Procedure 3 Enter the ICD 10 PCS and description of the star procedure Procedure 4 Enter the ICD 10 PCS and description of the star procedure Procedure 5 Enter the ICD 10 PCS and description of the star procedure Procedure 6 Enter the ICD 10 PCS and description of the star procedure Procedure 7 Enter the ICD 10 PCS and description of the star procedure Open text Procedure 7 Procedure 7 Enter the ICD 10 PCS and description of the star procedure Open text Tok Yes or No Cause In display you be to substance abuse/alcohol consumption, text conducted to establish this in ICD 20 PCS and description of the star procedure Indicate whether price report was filed In		SECTION C - DETAILS OF AILMENT DIAGNOSED (PRIMARY)							
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Procedure 3 Enter in Inc. Or PCS and description of the Section procedure Section Procedure Section Procedure Section Procedure Open text Open tex	Procedure 1	Enter the ICD 10 PCS and description of the first procedure	Standard Format and Open text						
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