FAMILY HEALTH PLAN (TPA) LIMITED

# 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

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:

c) 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.

## SECTION B

**DETAILS OF PATIENT ADMITTED**

a) Name of Patient:

b) IP Registration No.: c) Gender : Male Female d) Age: years months e) Date of Birth:

f) Date of Admission: g) Time: : h) Date of Discharge: i) Time: :

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: Discharged to home Discharged to another hospital Deceased m) Total claimed amount

## SECTION C

**DETAILS OF AILMENT DIAGNOSED (PRIMARY)**

| a) | ICD 10 Codes | Description | b) | ICD 10 PCS | Description |
|---|---|---|---|---|---|
| i. Primary Diagnosis : | | | i. Procedure 1 : | | |
| ii. Additional Diagnosis : | | | ii. Procedure 2 : | | |
| iii. Co-morbidities : | | | iii. Procedure 3 : | | |
| iv. Co-morbidities : | | | 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 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. vi. If not reported to police, give reason:

## SECTION D

**CLAIM DOCUMENTS SUBMITTED - CHECKLIST**

- 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
- Oparation Theatre Notes
- Hospital main bill
- Hospital break-up bill
- Investigation reports
- CT/ MRI/ USG/ HPE/ Investigation reports
- Doctor's referance slip
- ECG
- Pharmacy bills
- MLC report & Police FIR
- Original death summary from hospital, where applicable
- 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:

City: State:

Pin Code: b) Phone No: c) Registration No. with State Code:

d) Hospital PAN e) Number of inpatient beds 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, suppress or concealment of anu material fact, our right to claim under this claim shall be forfeited.

Date:

Place: Signature of the insured:

| 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 nospital | 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 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 |
| **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) Pre-authorization obtained | Indicate whether pre-authorization obtained | Tick Yes or No |
| d) Pre-authorization Number | Enter pre-authorization number | As allotted by TPA |
| e) If authorization by network hospital not obtained, give reason | Enter reason for not obtaining pre-authorization number | Open text |
| f) 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 | | |
| **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 the doctor along with the state code | As allocated by the Medical Council of India |
| 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. | | |