ICICI Lombard
Nibhaye Vaade

ICICI Lombard Health Care Claim Form - Hospitalisation

(Issuance of this form is not to be taken as an admission of liability)

ICICI Lombard Health Care

Overview Health Claim Form - Hospitalization

Part A		To be filled	Requirement
A1	Self Declaration	By insured/ insured relatives	To track the policy and other details of the insured
A2	Self Declaration		
A3	Available in Policy Copy/ Employee details		
A4	Available in Policy Copy		
A5	Available in Discharge Summary		
A6	Self Declaration		
A7	Self Declaration		
A8	Available in Hospital Bills/ Self Declaration		
A9	Available in Hospital Bills		
A10	Checklist		
A11, Page end	Self declaration		
	Part B		
B1	Hospital Details	To be filled by Hospital/ Treating doctor	To track the hospital details and the treatment details related to the patient admission
B2	Doctor Details		
B3	Patient details		
B4	Treatment / Procedure Details		
B5	Required only for Retail/ Individual customers		
Page end	Hospital declaration		
	Part C		
C1	Patient's Name	To be filled by Insured	For Electronic fund transfer to the bank account
C2	Policy Number		
C3	Card No./UHID No.		
C4	Group/ Company name		
C5	Claim number (if allotted)		
C6	Mobile/ Contact no.		
C7	Provide any 1 document of proposer		
C8	As per bank pass book		
Page end	Account holder's signature		
C-KYC No.	**Part D (Only for Retail/ Individual customers if claiming >₹ 1 lakh)**		
Yes	Please provide, if Central KYC (C-KYC) no. available:	To be filled by Insured	As per IRDA, C-KYC is mandate for claims greater than ₹ 1 lakh
	_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _		
No	Please fill the C-KYC form		

Documents Submitted

S.No.	Document	Yes	No	Type of document
1.	Claim form duly filled	Y	N	Original
2.	Discharge Summary/ Daycare Summary	Y	N	Original
3.	Final Hospital Bill	Y	N	Original
4.	Payment Receipts	Y	N	Original
5.	Investigation Reports	Y	N	Original
6.	Pharmacy Bills	Y	N	Original
7.	Implant Sticker/ Invoice	Y	N	Original
8.	Doctor Prescriptions	Y	N	Photocopy
9.	Consultation Paper	Y	N	Photocopy
10.	Age Proof	Y	N	Photocopy
11.	Indoor Case Paper	Y	N	Photocopy
12.	EFT (Copy of cancelled cheque/ self attested ID poof/ Bank attested copy of passbook with IFSC code	Y	N	Photocopy
13.	Part D - C-KYC FORM (Only for Retail/ Individual customers if claiming >₹ 1 lakh)	Y	N	Original
14.	**Aadhaar Card Copy**	Y	N	**Photocopy**
15.	**PAN Card Copy**	Y	N	**Photocopy**

ICICI Lombard
Nibhaye Vaade

Mailing Address: ICICI Lombard Healthcare, ICICI Bank Tower, Plot No. 12, Financial District, Nanakram Guda, Gachibowli, Hyderabad-500032
Registered Office Address: ICICI Lombard House, 414, Veer Savarkar Marg, Near Siddhi Vinayak Temple, Prabhadevi, Mumbai 400 025.
Visit us at: www.icicilombard.com. • **E-Mail us at:** ihealthcare@icicilombard.com.• **Toll Free Number:** 1800 2666. • **Toll Free Fax Number:** 1800-209-8880
IRDA Registration No. 115

ICICI Lombard Health Care Claim Form - Hospitalisation

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ICICI Lombard Nibhaye Vaade

ICICI Lombard Health Care

ALL CLAIM SETTLEMENTS SHOULD BE MADE THROUGH NEFT (AS PER IRDA CIRCULAR), PLEASE PROVIDE YOUR BANK ACCOUNT DETAILS. REFER TO PART C.

Do You Know

- ★ Non-submission of original bills and receipts is the main reason for delay in claim settlements. Please provide the originals & mandatory documents
- ★ To receive update on your claim status, provide your mobile no. & E-mail ID
- ★ You can track your claim status at: www.icicilombard.com→Claims→Health Claims→Services→Track your claims

Part - A (To be filled by Insured)

TO BE FILLED IN CAPITAL LETTERS ONLY

A1. Type of Claim : Main Hospitalisation Expenses ☐ Pre & Post Hospitalisation Expenses ☐ Cashless Obtained: Yes ☐ No ☐

A2. Details of the Insured person in respect of whom claim is made: (patient details)

Name of the Patient: ☐☐ FIRST ☐☐☐☐☐☐ MIDDLE ☐☐☐☐☐☐ LAST ☐☐☐☐☐

Card No./ UHID of the Patient:

Gender: Male ☐ Female ☐ Date of Birth: DD / MM / YYYY Completed age: Years ☐☐ Months ☐☐

Occupation: Service ☐ Self Employed ☐ Homemaker ☐ Student ☐ Retired ☐ Other ☐ (Please specify)_____

Are you previously covered by any other Mediclaim/ Health Insurance: Yes ☐ No ☐. If yes, Company name: _____

Current residential address:

City:

State: Pin code:

Mobile no. Landline no.

E-mail:

A3. For **Group/ Corporate** Policy	For **Individual/ Retail** Policy (*Mandatory*)
Member ID No./ Employee ID (Client ID):	*Claim Intimation Service Request no.:
Group/ Company name:	Is this a renewal policy: Yes ☐ No ☐ If Yes, kindly mention your previous policy no.:

A4. Name of the Proposer/Employee:

Aadhaar No. of the Proposer /Employee: PAN No. of the Proposer /Employee:

Relationship with Proposer*: (*Policy Holder. For Retail policy, Proposer name required. For Corporate policy, provide Employee name)

Current Policy No.: Card No./ UHID:

A5. Nature of disease/ illness contracted or injury suffered for which Insured was hospitalized (Diagnosis): _____

Name of hospital where admitted:

Room category occupied: Day care ☐ Single occupancy ☐ Twin sharing ☐ 3 or more beds per room ☐ Others _____

Date of Admission: DD / MM / YYYY Time: HH:MM Date of Discharge: DD / MM / YYYY Time: HH:MM

Date of injury sustained or disease/ Illness first detected: DD / MM / YYYY

If Injury, give cause: Self inflicted ☐ Road traffic accident ☐ Substance abuse/ Alcohol consumption ☐ Others _____

If Medico legal: Yes ☐ No ☐ Reported to police: Yes ☐ No ☐ MLC Report & Police FIR attached: Yes ☐ No ☐ (If yes, attach report)

System of Medicine: _____

Is there any another claim in any of our policies towards the above incident? Yes ☐ No ☐. If yes, provide AL/Claim No. _____

A6. Are you covered under any Topup/Additional policy : Yes ☐ No ☐ If yes, provide policy no. _____

A7. Currently covered by any other Mediclaim/ Health Insurance: YN Date of commencement of first Insurance without break: DD MM YY

Have you been hospitalized in the last 4 years since inception of contract: YN Date: DD / MM / YYYY Dignosis: _____

Have you lodged any claim against this particular admission date/ attached bills with any other Insurance company: If yes, attach settlement letter,

Company name: _____ Policy No. _____ Sum Insured: ₹ ☐☐☐☐☐☐☐

A8. Details of Claim

a) Details of the treatment expenses claimed

i.	Pre-hospitalization expenses:	₹ ☐☐☐☐☐☐☐	ii.	Hospitalization expenses:	₹ ☐☐☐☐☐☐☐
iii.	Post-hospitalization expenses:	₹ ☐☐☐☐☐☐☐	iv.	Health-check up cost:	₹ ☐☐☐☐☐☐☐
v.	Ambulance charges:	₹ ☐☐☐☐☐☐☐	vi.	Others _____:	₹ ☐☐☐☐☐☐☐
				Total:	₹ ☐☐☐☐☐☐☐
vii.	Pre-hospitalization period	☐☐☐ Days	viii.	Post-hospitalization period:	☐☐☐ Days

क्लेम फॉर्म हिन्दी के लिए कृपया हमारी वेबसाइट पर जाँच कीजिए : www.icicilombard.com

Claim documents to be dispatched to: ICICI Lombard Healthcare, ICICI Bank Tower, Plot No. 12, Financial District, Nanakram Guda, Gachibowli, Hyderabad-500032

b) Claim for

i. Domiciliary Hospitalization: Yes ☐ No ☐ (If yes, provide details in annexure)

ii. Day care: Yes ☐ No ☐

iii. Extended care/ Inpatient rehabilitation: Yes ☐ No ☐

c) Details of lump sum/ cash benefit claimed:

i. Hospital daily cash: ₹ ☐☐☐☐☐☐☐ ii. Maternity: ₹ ☐☐☐☐☐☐☐

iii. Critical illness/PA/Donor Expenses: ₹ ☐☐☐☐☐☐☐ iv. Convalescence: ₹ ☐☐☐☐☐☐☐

v. Pre/ Post hospitalization lump sum benefit: ₹ ☐☐☐☐☐☐☐ vi. Others: _____ ₹ ☐☐☐☐☐☐☐

A9. Details of the amount claimed

Bill heads (as applicable)	**Bill number**	**Bill date**	**Bills attached**	**Amount**
Room rent		D D M M Y Y	Y N	₹
Doctors consultation/ Visit charges		D D M M Y Y	Y N	₹
Investigation charges (Includes Radiology and Pathology reports)		D D M M Y Y	Y N	₹
Surgeon and Asst. surgeon charges		D D M M Y Y	Y N	₹
Anesthetist charges & Operation theatre charges		D D M M Y Y	Y N	₹
Equipment charges/ Procedure charges		D D M M Y Y	Y N	₹
Cost of implant (If any)		D D M M Y Y	Y N	₹
Medicine charges (Includes ward and OT medicines and consumables)		D D M M Y Y	Y N	₹
Pharmacy charges		D D M M Y Y	Y N	₹
Taxes/ Surcharges/ Service charge		D D M M Y Y	Y N	₹
Miscellaneous/ Other charges		D D M M Y Y	Y N	₹
Pre hospitalization bills (If any)		D D M M Y Y	Y N	₹
Post hospitalization bills (If any)		D D M M Y Y	Y N	₹
Discount provided by hospital (If any)		D D M M Y Y	Y N	₹
Total claimed amount (In ₹) (Total claimed amount should be equal to the amount in attached bill documents)				₹

MANDATORY : COPY OF AADHAAR CARD AND PAN CARD ARE REQUIRED FOR ALL CLAIMS

A10. In support of the above claim, I enclose following documents in original (Please indicate by ticking in the **Yes/ No** column below)

Type of Document(s) - *Mandatory	**Yes**	**No**	**Type of Document(s) - As Applicable**	**Yes**	**No**
1. Claim form duly filled and signed*	Y	N	9. Age proof (Driving License/ PAN card/ Passport/ Aadhar copy)*	Y	N
2. **Aadhaar Card copy***	Y	N	10. Part - C (For EFT/RTGS/ NEFT)*	Y	N
3. **PAN Card copy***	Y	N	11. ICICI Lombard GIC Authorisation Letter	Y	N
4. Discharge summary*	Y	N	12. Implant name and invoice (if any) with implant sticker	Y	N
5. Hospital bills, Final/ main hospital bill and other bills (if any)*	Y	N	13. Indoor Case Papers	Y	N
6. Hospital payment receipt & other receipts supporting bills*	Y	N	14. Prescription papers/ Consultation papers	Y	N
7. Investigation reports* (Including ECG/ CT/ MRI/ USG/ HPE)	Y	N	15. C-KYC FORM (Only for Retail/Individual customers, claiming > ₹ 1Lakh)	Y	N
8. Medicine/ Pharmacy bills with doctors prescription*	Y	N	16. Others (details) _____	Y	N

Please attach all the documents as per above serial number. Films like x-ray film, CT Scan film, MRI Scan film, etc. are not required. Provide reports only

A11.Please provide the reason for delay in submitting the documents
(Post 30 days from Date of Discharge)

Provide Details

Declaration by the Insured:

I hereby declare that the information furnished in this claim form is true and 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 with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent and 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 and that I will not be making any supplementary claim except the pre/ post-hospitalization claim, if any.

Date: D D / M M / Y Y Y Y Place: _____ Insured's Signature: _____

क्लेम फॉर्म हिन्दी के लिए कृपया हमारी वेबसाइट पर जाँच कीजिए : **www.icicilombard.com**

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Part - B (To be filled by Treating Doctor/ Hospital only)

B1. Details of the Hospital/ Nursing home in which treatment was taken

Name of the Hospital/ Nursing home:

Address:

City: State:

Pincode: Telephone no.: Mobile no.:

ROHINI ID: Type of Hospital: Network ☐ Non Network ☐. If Non Network, provide below details

Registration No. with State Code: _____ PAN: Number of Inpatient beds:

Facilities available in the hospital: OT: Y N ICU: Y N

B2. Details of the attending Medical Practitioner/ Doctor/ Treating Physician or Surgeon

Name:

Qualification: Registration no:

Telephone no.: Mobile no.:

B3. Details of the patient admitted

Name of the patient:

IP Registration no.: Gender: M F Age: Years Months Date of Birth: D D M M Y Y Y Y

Date of Admission: D D / M M / Y Y Y Y Time: H H : M M Date of Discharge: D D / M M / Y Y Y Y Time: H H : M M

Type of Admission: Emergency ☐ Planned ☐ Day Care ☐ Maternity ☐

Type of Treatment: Surgical Procedure ☐ Multiple Surgical Procedure ☐ Medical Treatment ☐

If Maternity, Date of Delivery: D D / M M / Y Y Y Y Gravida Status: G ☐ P ☐ A ☐ L ☐

Premature Baby: Yes ☐ No ☐

Status at time of discharge: Discharge to home ☐ Discharge to another hospital ☐ Deceased ☐

Total claimed amount: ₹

B4. Details of the procedure

Pre-authorization obtained: Yes ☐ No ☐ If yes, Pre-authorization No.:

If authorization by network hospital not obtained, give reason: _____

Date of injury sustained or disease/ illness first detected: D D / M M / Y Y Y Y

If Injury, give cause: Self inflicted ☐ Road traffic accident ☐ Substance abuse/Alcohol consumption ☐ Others _____

If Medico legal: Yes ☐ No ☐ Reported to police: Yes ☐ No ☐ MLC Report & Police FIR attached: Yes ☐ No ☐ (If yes, attach report)

FIR no._____ If not reported to Police, give reason: _____

If injury due to substance abuse/alcohol consumption, test conducted to establish this: Yes ☐ No ☐ (If yes, attach report)

B5. This section is mandatory only **if your health policy is not provided by your employer**

A) Diagnosis (ICD 10 Code primary & additional dignosis)	
i) Primary diagnosis (with ICD 10 code)	
ii) Additional diagnosis (with ICD 10 code)	
iii) Procedure diagnosis (with ICD 10 PCS code)	
B) Nature of surgery/ treatment given for present ailment	
C) Date of first consultation (Prior to hospitalization)	
D) Presenting complaints of the patient during admission	
E) Past medical history of the patient along with duration of illness (If yes, attach first & all past consultation paper)	
F) Was the patient under influence of alcohol during admission	
G) Whether the present treatment ailment is a complication of pre-existing disease ?	
i) If yes, please specify the disease (or) complication of any previous surgery done ?	
ii) If yes, please specify the details	
H) Whether the disease/ disorder is congenital in nature ?	
I) Number of in-patient beds in the hospital (including ICU)	

Declaration by the 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.

Registration No. of Hospital
(Rubber stamp of the hospital)

Date: D D / M M / Y Y Y Y

Doctor's Seal and Signature

As per the policy Terms and Conditions, the Company reserves its right to have the Insured examined by a doctor appointed by it for verification of diagnosis.