Claims #ÌÅÁÒÁÎÃÅ Form

Claim Details

Claim Number _____ **Pre Auth Number** _____

Vidal Health/TTK ID _____

Insurance Company Details

Insurance Company _____

Controlling Office _____ **City/Town/Village** _____ **State** _____ **Pin code** _____

Policy Details

Name of Primary Insured _____

Customer ID _____ **Policy Number** _____ **Policy Term From** _____ **Policy Term To** _____

Policy Type _____ **Product Name** _____

Agent Code _____ **Development Officer Code** _____ **Operating Office Code** _____

Operating Office _____

Sum Insured Rs. _____ **Cumulative Bonus/Buffer** Rs. _____ **Corporate Buffer** Rs. _____ **Premium Zone** _____

Payable From _____

Policy History

Sl. No.	Policy Number	Policy Type	Product Name	From	To	Sum Insured
1						
2						
3						
4						
5						

Claimant Details

Name of the Patient _____ **Age** ___ **Sex** _____ **Relation** _____

Address _____

Last 5 Claims History*

Sl. No.	Claim Number	Date of Admission	Date of Discharge	Hospital Name	Pre Auth Number	Claimed	Approved	Status
1						Rs.	Rs.	
	Ailment			Rejection Reason				
2						Rs.	Rs.	
	Ailment			Rejection Reason				
3						Rs.	Rs.	
	Ailment			Rejection Reason				
4						Rs.	Rs.	
	Ailment			Rejection Reason				
5						Rs.	Rs.	
	Ailment			Rejection Reason				

** In case details of more claims are required, the same can be provided on request.*

Hospitalization Details

Intimation Date _____ **Date of Diagnosis** _____ **Date of Admission** _____ **Date of Discharge** _____

Hospital Name _____

Hospital Code _____ **City/Town/Village** _____ **State** _____ **Pin code** _____

Diagnosis _____

Diagnosis Code Level 1 _____ **Diagnosis Code Level 2** _____ **Procedure Code Level 1** _____ **Procedure Code Level 2** _____

Diagnosis Description Level 1 _____

Diagnosis Description Level 2 _____

Procedure Description Level 1 _____

Procedure Description Level 2 _____

Claim Details

Claim Type	Claim Category	Received on	Recommended On
_____	_____	_____	_____

Requested / Claimed	Recommended	Non Admissible	Co-Pay	Voluntary Co-Pay / High Deductible	Payable	TDS	Net Payable
Rs. _____	Rs. _____	Rs. _____	Rs. _____	Rs. _____	Rs. _____	Rs. _____	Rs. _____

Deduction Reason _____

Billing Details

	Rs. ____________		Rs. ____________		Rs. ____________		Rs. ____________
	Rs. ____________		Rs. ____________		Rs. ____________		Rs. ____________
	Rs. ____________		Rs. ____________		Rs. ____________		Rs. ____________
	Rs. ____________		Rs. ____________		Rs. ____________		Rs. ____________
	Rs. ____________		Rs. ____________		Rs. ____________		Rs. ____________
	Rs. ____________		Rs. ____________		Rs. ____________		Rs. ____________
	Rs. ____________		Rs. ____________		Rs. ____________		Rs. ____________
	Rs. ____________		Rs. ____________		Rs. ____________		Rs. ____________
	Rs. ____________		Rs. ____________		Rs. ____________		Rs. ____________
	Rs. ____________		Rs. ____________		Rs. ____________		Rs. ____________
	Rs. ____________		Rs. ____________		Rs. ____________		Rs. ____________
	Rs. ____________		Rs. ____________		Rs. ____________		Rs. ____________
	Rs. ____________		Rs. ____________		Rs. ____________		Rs. ____________
	Rs. ____________		Rs. ____________		Rs. ____________		Rs. ____________
	Rs. ____________		Rs. ____________		Rs. ____________		Rs. ____________
Total	**Rs.** 0.00	**Total**	**Rs.** 0.00	**Total**	**Rs.** 0.00	**Total**	**Rs.** 0.00

Shortfall Details

Shortfall Details

____

Insured Shortfall Date	**Insured Reminder Date**	**Insured Final Reminder Date**	**Insured Reply Received Date**
Hospital Shortfall Date	**Hospital Reminder Date**	**Hospital Final Reminder Date**	**Hospital Reply Received Date**
Insurer Shortfall Date	**Insurer Reminder Date**	**Insurer Final Reminder Date**	**Insurer Reply Received Date**

Investigation Details

Investigator Name ____________________ **Investigation Date** ____________________

Recommendation ____________________

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TPA Remarks ____________________

Insurer Remarks ____________________

Approval . Need More information

Submit