Medi Assist

Z0007151396

The New India Assurance Co. Ltd.

CLAIM FORM - PART A' to 'CLAIM FORM FOR HEALTH INSURANCE POLICY

The issue of this Form is not to be taken as an admission of liability(To be filled in block letters)

DETAILS OF PRIMARY INSURED

Section A

a) Policy No.: 14200034190400000024 b) Sl. No/Certificate No.:

c) Company / TPA ID (MA ID) No.: 20102081 / 4027085871 d) Name: SANDESH AWASARKAR

e) Address: K G ROAD, VIDYANAGAR, NAWALEWADI PHATA, AKOLE

City: AKOLE DIST - AHMEDNAGAR STATE - MAHARASHTRA Pin Code: 422601

Phone No.: 9545858509 Email ID: SANDESH.AWASARKAR@VODAFONE.COM

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.: 14200034190400000024

Sum Insured (Rs): 2,00,000 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: —

DETAILS OF INSURED PERSON HOSPITALIZED:

Section C

a) Name: SANDESH AWASARKAR

b) Gender: ☑ Male ☐ Female c) Age Years: 29 Months: 8 d) Date of birth: 21/03/1991

e) Relationship to Primary insured: ☑ Self ☐ Spouse ☐ Child ☐ Father ☐ Mother ☐ Other (Please Specify): SELF

f) Occupation: ☑ Service ☐ Self Employed ☐ Home Maker ☐ Student ☐ Retired ☐ Other (Please Specify): VODAFONE INDIA

g) Address (if different from above): SAME AS ABOVE

City: AKOLE, AHMEDNAGAR State: MAHARASHTRA Pin Code: 422601

Phone No.: 9545858509 Email ID: SANDESH.AWASARKAR@VODAFONE.COM

DETAILS OF HOSPITALZIATION:

Section D

a) Name of Hospital where Admited: AROTE HOSPITAL SANGAMNER, MAHARASHTRA

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: 26-NOV-2020

e) Date of Admission: 30-NOV-2020 f) Time: 08:00 PM g) Date of Discharge: 07-DEC-2020 h) Time: 02:00 PM

i) If injury give cause: ☑ Self inflicted ☐ Road Traffic Accident ☐ Substance Abuse I Alcohol Consumption i) If Medico legal: ☐ Yes ☑ No

ii) Reported to Police: ☐ Yes ☑ No iii) MLC Report & Police FIR attached: ☐ Yes ☑ No j) System of Medicine: COVID TREATMENT

DETAILS OF CLAIM:

a) Details of the Treatment expenses claimed

i) Pre -hospitalization expenses: Rs. 3450/-

ii) Hospitalization expenses: Rs. 71420/-

iii) Post-hospitalization expenses: Rs. 0/-

iv) Health-Check up cost: Rs. 3100/-

v) Hospitalization expenses: Rs. 71420/-

vi) Others (code)0: Rs. 1597/-

Total: Rs. 79567

vii) Pre -hospitalization period: Days. 4

viii) Post -hospitalization period: days. 7

b) Claim for Domiciliary Hospitalization: (If yes, provide details in annexure) ☐ Yes ☒ No

c)Details of Lump sum / cash benefit claimed:

i) Hospital Daily cash: Rs. 5600/day

ii) Surgical Cash: Rs. -

iii) Critical Illness benefit: Rs. -

iv) Convalescence: Rs. -

v) Pre/Post hospitalization Lump sum benefit: Rs. -

vi) Others (code)0: Rs

Total: Rs. 79567

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

DETAILS OF BILLS ENCLOSED:

SL No.	Bill No.	Date	Issued By	Towards	Amount (Rs)
1	20/21RI-3216	07-Dec-2020	AROTE HOSPITAL	PATIENT (SANDESHA)	39200
2	CA/50517	30-Nov-2020	NEW PRAVARA MEDICAL	PATIENT (SANDESHA)	14160
3	200	30-Nov-2020	MEDISTREAM DIAGNOSTIC CENTER	—11—	2500
4	6028	30-Nov-2020	NIDAN DIAGNOSTICS	PATIENT (SANDESHA)	950
5	6029	01 Dec-2020	NIDAN DIAGNOSTICS	PATIENT (SANDESHA)	2150
6	6030	07-Dec-2020	NIDAN DIAGNOSTICS	PATIENT (SANDESHA)	950
7	I-22984	02-Dec-2020	HEALTH ACCURATE	PATIENT (SANDESHA)	1600
8	CR/4102	30-Nov-2020	SHIVSAI MEDICAL	PATIENT (SANDESHA)	4122
9	CR/4123	01-Dec-2020	SHIVSAI MEDICAL	PATIENT (SANDESHA)	2215
10	CR/4143	02-Dec-2020	SHIVSAI MEDICAL	PATIENT (SANDESHA)	2354
11	CR/4184	03-Dec-2020	SHIVSAI MEDICAL	PATIENT (SANDESHA)	2159
12	CR/4213	04-Dec-2020	SHIVSAI MEDICAL	PATIENT (SANDESHA)	2241
13	CR/4224	05-Dec-2020	SHIVSAI MEDICAL	PATIENT (SANDESHA)	2555
14	CR/4268	06-Dec-2020	SHIVSAI MEDICAL	PATIENT (SANDESHA)	2411

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT:

a) PAN: BEXPA0293P

b) Account No.: 34********08

c) Bank Name and Branch: STATE BANK OF INDIA, SHIV**********2601

d) Checque / DD Payable details:

e) IFSC Code: S*********6

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 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 & 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: 11-12-2020 Place: AKOLE

Signature of the insured:

GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled in by the insured)

DATA ELEMENT	DESCRIPTION	FORMAT
	SECTION A- DETAILS OF HOSPITAL	
a) Policy No.	Enter the policy number	As allotted by the Insurance Company
b) Sl. No/ Certificate No.	sEoncteiarl thheea sltohc iinasl ulnrasunrcaen scceh neummeber	As allotted by the organization
c) Company TPA ID No.	Enter the TPA ID No.	Licence number as allotted by IRDA and printed in TPA documents.
d) Name	Enter the full name of the policyholder	Surname, First name, Middle name
e) Address	Enter the full postal address	Include Street, City and Pin code
	SECTION B -DETAILS OF INSURANCE HISTORY	
a) Currently covered by any other Mediclaim / Health Insurance?	Indicate whether currently covered by another Mediclaim / Health Insurance	Tick Yes or No
b) Date of commencement of first Insurance without break	Enter the date of commencement of first Insurance	Use dd-mm-yy-formmat
c) Company Name	Enter the full name of the Insurance Company	Name of the organization in full
Policy No.	Enter the policy number	As allotted by the Insurance Company
Sum insured	Enter the total sum insured as per the policy	In rupees
d) Have you been Hospitalized in the last four years since Inception of the contract?	Indicate whether hospitalized in the last four years	Tick Yes or No
Date	Enter the date of Hospitalization	Use mm-yy format
Diagnosis	Enter the diagnosis details	Open Text
e) Previously covered by any other Mediclaim / Health Insurance?	Indicate whether previously covered by another mediclaim / Health Insurance	Tick Yes or No
f) Company Name	Enter the full name of the Insurance Company	Name of the organization in full
	SECTION C -DETAILS OF INSURED PERSON HOSPITALIZED	
a) Name	Enter the full name of the patient	Surname, First name, Middle name
b) Gender	Indicate Gender of the patient	Tick Male or Female
c) Age	Enter age of the patient	Number of years and months
d) Date of Birth	Enter Date of Birth of patient	Use dd-mm-yy format
e) Relationship to primary Insured	Indicate relationship of patient with policyholder	Tick the right option, if others, please specify
f) Occupation	indicate occupation of patient	Tick the right option. If others, please specify.
g) Address	Enter the full postal address	Include Street, City and Pin code
h) Phone No	Enter the phone number of patient	Include STD code with telephone number
i) E-mail ID	Enter e-mail address of patient	Complete e-mail address
	SECTION D - DETAILS OF HOSPITALIZATION	
a) Name of Hospital where admitted	Enter the name of hospital	Name of hospital in full
b) Room category occupied	indicate the room category occupied	Tick the right option
c) Hospitalization due to	indicate reason of hospitalization	Tick the right option
d) Date of injury/Date Disease first detected / Date of Delivery	Enter the relevant date	Use dd-mm-yy format

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) If injury give cause	indicate cause of injury	Tick the right option
If 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
MLC Report & Police FIR attached	indicate whether MLC report and Police FIR attached	Tick Yes or No
j) System of Medicene	Enter the system of medicine followed in treating the patient	Open Text

SECTION E - DETAILS OF CLAIM

a) Details of Treatment Expenses	Enter the amount claimed as treatment Expenses	In rupees (Do not enter paise values)
b) Claim for Domiciliary Hospitalization	indicate whether claim is for domiciliary hospitalization	Tick Yes or No
c) Details of Lump sum/ Cash benifit claimed	Enter the amount claimed as lump sum / cash benefit	In rupees (Do not enter paise values)
d) Claim documents Submitted-Check List	indicate which supporting documents are submitted	Tick the right option

SECTION F - DETAILS OF BILLS ENCLOSED

Indicate which bills are enclosed with the amount in rupees

SECTION G - DETAILS OF PRIMARY INSURED?s BANK ACCOUNT

a) PAN	Enter the permanent account number	As allotted by the Income Tax Department
b) Account Number	Enter the Bank account number	As allotted by the Bank
c) Bank Name and Branch	Enter the Bank name along with the branch	Name of the Bank in full
c) Cheque/ DD payable details	Enter the name of the beneficiary the cheque / DD should be made out to	Name of the individual / organization in full
c) IFSC Code	Enter the IFSC code of the Bank branch	IFSC code of the Bank branch in full

SECTION H - DECLARATION BY THE INSURED

Read declaration carefully and mention date (in dd:mm:yy format) place (open text) and sign.

Reimbursement Claim Reference Number:(102025495)
(Please quote this reference number in all future correspondence)

Medi Assist

E-card | Claims | Plan hospitalization | Hospitals

Date :12 Dec 2020

Dear Member,

Sandesh Awasarkar

Thank you for using Medi Buddy to raise your reimbursement claim online and Please note the Claim number (102025495) for future correspondence.

Based on your Insurer concurrence and on your declaration, your claims will be settled on scanned copies. Please do arrange to submit all the physical documents in original at the earliest on receipt of the settlement confirmation mail or on easing of lockdown restrictions whichever is earlier.

Beneficiary Details

Patient Name	Sandesh Awasarkar
Insurance Company	The New India Assurance Co. Ltd
Policy Holder / Primary Beneficiary	Vodafone India Services Pvt limited_SEZ / Sandesh Awasarkar
Hospital Name	Arote Hospital
Medi Assist ID	4027085871
Policy No.	14200034190400000024
Employee ID	26102081
Claimed/ Estimated amount	79567
Insurer Member ID	MEMBER5724
Insurer Claim No	TP00314200020900002742

The claim is under process as per policy terms and conditions.

You can track the status of your claim in real-time from anywhere using your **MediBuddy** online portal or mobile app. Notifications about the status of the claim will also be sent to your registered email ID and mobile number.

QUICK LINKS:

Track this claim on **MediBuddy**
Learn more about **common reasons for difference in claimed and approved amounts**
Read more about **reducing cost of care.** Plan your hospitalization with **MediBuddy.**
Get the MediBuddy app

Warm Regards,
Medi Assist Insurance TPA Pvt. Ltd
(Formerly known as Medi Assist India TPA Private Limited)
CIN: U85199KA1999PTC025676. Regd Off: Tower "D", 4th floor, IBC Knowledge Park, 4/1, Bannerghatta Road, Bangalore - 560 029.
Helpline: **1800 425 9449** | Contact: **medibuddy.in/contactus/**

Note: If you are not satisfied with our settlement, you may approach the Grievance Cell of the Insurer at their Underwriting Office or Controlling Offices. If you are not satisfied with the resolution of the Grievance Cell, you may approach the jurisdictional Insurance Ombudsman, the??address of which is available on the website of the Insurer.

App

Connect

THIS IS A COMPUTER GENERATED CORRESPONDENCE SIGNATURE IS NOT REQUIRED.