Medi Assist

REIMBURSEMENT CLAIM FORM

TO BE FILLED BY THE INSURED

The issue of this Form is not to be taken as an admission of liability

(To be Filled in block letters)

SECTION A

DETAILS OF PRIMARY INSURED:

a) Policy No: 121100342004000000031 b) SI No/ Certificate no

c) Company / TPA ID (MA ID)No: 5075824300

d) Name: MEENA SUNIL

e) Address: D-29 CHITRESH NAGAR, BORKHERA, KOTA, DIST. KOTA - 324001

City: KOTA State: RAJASTHAN

Pin Code: 324001 Phone No: 9186190073567 Email ID: SUNIL2.MEENA@RIL.COM

SECTION B

DETAILS OF INSURANCE HISTORY:

a) Currently covered by any other Mediclaim / Health Insurance: Yes ☐ No ☑ b) Date of commencement of first Insurance without break: D D M M Y Y Y Y

c) If yes, company name: Policy No.

Sum insured (Rs) d) Have you been hospitalized in the last four years since inception of the contract? Yes ☐ No ☐ Date: M M Y Y

Diagnosis: e) Previously covered by any other Mediclaim /Health insurance : Yes ☐ No ☑

f) If yes, company name:

SECTION C

DETAILS OF INSURED PERSON HOSPITALIZED:

a) Name: MEENA SUNIL

b) Gender Male ☑ Female ☐ c) Age years 21 Months 09 d) Date of Birth 10 01 2000

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

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

g) Address (if diffrent from above) :

City: State:

Pin Code: Phone No: Email ID:

SECTION D

DETAILS OF HOSPITALIZATION:

a) Name of Hospital where Admited: SHRI RAM MULTI SPECIALITY HOSPITAL

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: 19 09 2021

e) Date of Admission: 21 09 21 f) Time: 12 00 g) Date of Discharge: 25 09 21 h) Time: 12 : 00

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

ii) Reported to Police ☐ ☐ iii. MLC Report & Police FIR attached ☐ Yes ☐ No j) System of Medicine: EVRYDAY PRESCRIPTION PROVIDED BY DOC

SECTION E

DETAILS OF CLAIM:

a) Details of the Treatment expenses claimed

i. Pre -hospitalization expenses Rs. 1400

ii. Hospitalization expenses Rs. 13554

iii. Post-hospitalization expenses Rs.

iv. Health-Check up cost: Rs.

v. Ambulance Charges: Rs.

vi. Others (code): ☐☐☐ Rs.

Total Rs. 14954

vii. Pre -hospitalization period: days 02

viii. Post -hospitalization period: days 0

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

c) Details of Lump sum / cash benefit claimed

i. Hospital Daily cash: Rs.

ii. Surgical Cash. Rs.

iii. Critical Illness benefit: Rs.

iv. Convalescence: Rs.

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

vi. Others: ☐☐☐ Rs.

Total Rs.

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
- ☐ Doctors request for investigation
- ☐ Investigation Reports (Including CT / MRI / USG / HPE)
- ☑ Doctors Prescriptions
- ☐ Others

SECTION F

DETAILS OF BILLS ENCLOSED:

Sl. No.	Bill No.	Date	Issued by	Towards	Amount (Rs)
1.	4628	19/09/21	SANJIVANI HOSP	Hospital main Bill	9200
2.	4635	19/09/21	— " —	Pre-hospitalization Bills: Nos 2	1400
3.	3953	22/09/21	SHEELA DIAG. CENTRE	Post-hospitalization Bills: Nos	
4.	9082	23/09/21	SHRI RAM MEDICO	Pharmacy Bills	3554
5.	9155	22/09/21	— " —	Investigation Reports	800
6.	9261	23/09/21	— " —		
7.	9238	23/09/21	— " —		
8.	9309	24/09/21	— " —		
9.	9405	25/09/21	— " —		
10.	030	25/09/21	SHRIRAM HOSP.		

9X

SECTION G

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT:

a) PAN: GMQPM4406E b) Account Number: 37004490939

c) Bank Name and Branch: SBI POLAIKALAN

d) Cheque / DD Payable details: SUNIL MEENA e) IFSC Code: SBIN0032488

SECTION H

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 concealent of any material fact with respect to questions asked in relation to this claim, my right to claim reimbrusement 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 02 10 2021 Place: CHITRESH NAGAR, KOTA Signature of the Insured

(IMPORTANT: PLEASE TURN OVER)

CLAIM FORM - PART B

TO BE FILLED IN BY THE HOSPITAL

The issue of this Form is not to be taken as an 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: SHRI RAM MULTI SPECIALITY HOSPITAL

a) Hospital ID:

c) Type of Hospital: Network ☐ Non Network ☑ (if non network fill section E)

c) Name of the treating doctor: SUKHWANT RAMPAL

e) Qualification:

f) Registration No. with State Code: RNC 5760

g) Phone No: 09829037374

SECTION B

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient: MEENA SONI

b) IP Registration Number:

c) Gender: Male ☑ Female ☐

d) Age: Years 21 Months 09

e) Date of birth: 18 01 00

f) Date of Admission: 23 09 21

g) Time: 12 00

h) Date of Discharge: 25 09 21

i) Time: 12 00

j) Type of Admission: Emergency ☐ Planned ☑ Day Care ☐ Maternity ☐

k) If Maternity: i) Date of Delivery: D D M M Y Y

ii) Gravida Status:

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

m) Total claimed amount: 14954

SECTION C

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a)	ICD 10 Codes	Description
i. Primary Diagnosis	A90	DENGUE FEVER (CLASSICAL)
ii. Additional Diagnosis		
iii. Co-morbidities		
iv. Co-morbidities		

b)	ICD 10 PCS	Description
i. Procedure 1:		
ii. Procedure 2:		
iii. Procedure 3:		
iv. Details of Procedure:		

c) Pre-authorization obtained: ☐ Yes ☑ No d) Pre-authorization Number:

e) If authorization by network hospital not obtained, give reason: DIDN'T KNOW ABOUT THE POLICY BEFORE

f) Hospitalization due to injury: ☐ Yes ☑ No i. If Yes, give cause: Self-inflicted ☐ Road Traffic Accident ☐ Substance abuse / alcohol consumption ☐

ii) If injury due 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 - CHECK LIST

- ☑ 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
- ☐ Operation Theatre Notes
- ☑ Hospital main bill
- ☑ Hospital break-up bill
- ☑ Investigation reports
- ☐ CT/MR/USG/HPE investigation reports
- ☐ Doctor's reference slip for investigation
- ☐ ECG
- ☑ Pharmacy bills
- ☐ MLC reports & Police FIR
- ☐ Original death summary from hospital where applicable
- ☐ Any other, please specify

SECTION E

ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)

a) Address of the Hospital: 376-A SHEEL A CHOUDHARY ROAD, TALWANDI

City: KOTA State: RAJASTHAN

Pin Code: 324005 b) Phone No. 09829037378 c) Registration No. with State Code:

d) Hospital PAN: e) Number of inpatient beds: 10 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, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited.

Date: 08 10 21

Place: SRMS HOSPITAL, KOTA

Signature and Seal of the Hospital Authority:

S. RAMPAL M.D.
Professor & Head Department of Medicin
Medical College & M.B.S. Hospita
KOTA(RAJ.)