CLAIM FORM - PART A' to 'CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT - PART A TO BE FILLED BY THE INSURED

Z0017179046

DETAILS OF PRIMARY INSURED:

Policy No.:	**97000034230400000115_SEZ**	Sl. No/ Certificate no.			
Company/ TPA ID No:	**COGNIZANT TECHNOLOGY SOLUTIONS INDIA PVT. LTD**				
Name:	**ANCHAL JAISWAL**	EmpID:	**2134920**	MAID:	**5098098184**
Address:					
City:	**LUCKNOW**	State:	**UTTAR PRADESH**		
Pin Code:	**226001**	Phone No:	**9118645004**		
Email ID:	**ANCHAL.JAISWAL2@COGNIZANT.COM**				

DETAILS OF INSURANCE HISTORY:

Currently covered by any other Mediclaim / Health Insurance:	☐ Yes ☐ No	Date of commencement of first Insurance without break:	
If yes, company name:	**COGNIZANT TECHNOLOGY SOLUTIONS INDIA PVT. LTD**	Policy No.:	**97000034230400000115_SEZ**
Sum insured (Rs.):		Have you been hospitalized in the last four years since inception of the contract? ☐ Yes ☐ No	Date:
Diagnosis:	**LAPAROSCOPIC CHOLECYSTETOMY SURGERY**	Previously covered by any other Mediclaim /Health insurance:	☐ Yes ☐ No

DETAILS OF INSURED PERSON HOSPITALIZED:

Name:	**KAMLESH JAISWAL**	Gender:	☐ Male ☑ Female
Age years:	**46**	Date of Birth:	
Relationship to Primary insured:	☐ **SELF** ☐ **SPOUSE** ☐ **CHILD** ☐ **FATHER** ☑ **MOTHER** ☐ **OTHER(PLEASE SPECIFY)**		
Occupation:	☐ **SERVICE** ☐ **SELF EMPLOYED** ☐ **HOME MAKER** ☐ **STUDENT** ☐ **RETIRED** ☐ **OTHER(PLEASE SPECIFY)**		
Address(if diffrent from above):			
City:	**LUCKNOW**	State:	**UTTAR PRADESH**
Pin Code:	**226001**	Phone No:	**9118645004**
Email ID:	**ANCHAL.JAISWAL2@COGNIZANT.COM**		

DETAILS OF HOSPITALIZATION:

Name of Hospital where amited:	**AASTHA MATERNITY AND LAPAROSCOPY CENTRE,A-1654,1655,SECTOR-I, LDA COLONY,ON ROAD TO VISHAL MEGA MART,NEAR AASHIANA CHAURAHA,LUCKNOW,UTTAR PRADESH**				
Room Category occupied:	☐ **DAY CARE** ☐ **SINGLE OCCUPANCY** ☐ **TWIN SHARING** ☐ **3 OR MORE BEDS PER ROOM**				
Hospitalization due to:	☐ **INJURY** ☐ **ILLNESS** ☐ **MATERNITY**		Date of injury / Date Disease first detected /Date of Delivery:	**15-MAR-2024**	
Date of Admission:	**15-MAR-2024**	Time:	Date of Discharge:	**16-MAR-2024**	Time:
If injury give cause:	☐ **SELF INFLICTED** ☐ **ROAD TRAFFIC ACCIDENT** ☐ **SUBSTANCE ABUSE / ALCOHOL CONSUMPTION**		If Medico legal:	☐ **YES** ☐ **NO**	
Reported to Police:	☐ **YES** ☐ **NO**	MLC Report & Police FIR attached:	☐ **YES** ☐ **NO**	System of Medicine:	

DETAILS OF CLAIM:

Pre -hospitalization expenses	**INR**	Hospitalization expenses	**INR 61118**
Post-hospitalization expenses	**INR**	Health-Check up cost:	**INR**
Ambulance Charges:	**INR**	Others (code):	**INR**
Pre -hospitalization period:		Post -hospitalization period:	
Total:	**INR 61118**		
b) Claim for Domiciliary Hospitalization:	☐ **YES** ☐ **NO (IF YES, PROVIDE DETAILS IN ANNEXURE)**		
c) Details of Lump sum / cash benefit claimed:			
Hospital Daily cash:	**INR**	Surgical Cash:	**INR**
Critical Illness benefit:	**INR**	Convalescence:	**INR**
Total:	**INR 61118**		

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	Amount (Rs)	Remarks

DETAILS OF PRIMARY INSURED?S BANK ACCOUNT:

PAN:		Account Number:	**50100588841778**
Bank Name:	**HDFC BANK**	Branch:	**1170, KHAIRBAD, ALLAHABAD ROAD,**
Cheque / DD Payable details:		IFSC Code:	**HDFC0000944**

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: ..... Place: .....

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 PRIMARY INSURED		
a) Policy No.	Enter the policy number	As allotted by the Insurance Company
b) Sl. No/ Certificate No.	Enter the social insurance number or the certificate number of social health insurance scheme	As allotted by the oraganization
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-forrmat
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 Tick Yes or No 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
1) E-mail ID	Enter e-mail address of patient	Complete e-mail address
SECTION D - DETAILS OF HOSPITALIZATION		
a) Name of Hospital where admited	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) 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
i) System of Medicene	Enter the system of medicine followed in treating the patient	Open Text

SECTION E - DETAILS OF CLAIM

a) Details of Treatment Expences	Enter the amount claimed as treatment expences	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
d) 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
e) 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.

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

DETAILS OF HOSPITAL:

a) Name of the hospital: **AASTHA MATERNITY AND LAPAROSCOPY CENTRE,A-1654,1655,SECTOR-I,LDA COLONY,ON ROAD TO VISHAL MEGA MART,NEAR AASHIANA CHAURAHA, LUCKNOW,UTTAR PRADESH**

b) 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.:

DETAILS OF THE PATIENT ADMITTED:

a) Name of the Patient: **KAMLESH JAISWAL**

b) IP Registration Number:

c) Gender: ☐ Male ☐ Female

d) Date of birth:

e) Date of Admission: **15-MAR-2024** Time:

f) Date of Discharge: **16-MAR-2024** Time:

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

h) If Maternity: 1) Date of Delivery: 2) Gravida Status:

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

j) Total claimed amount:

DETAILS OF AILMENT DIAGNOSED (PRIMARY):

a)	**ICD 10 Codes**	**Description**
I. Primary Diagnosis		
ii. Additional Diagnosis:		
iii. Co-morbidities:		
iv. Co-morbidities:		
b)	**ICD 10 Codes**	**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:

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:	

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 ☐ Investigation reports ☐ Hospital main bill ☐ Hospital break-up bill
☐ 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

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

a) Address of the Hospital	**LUCKNOW ,226001**			
City:	**LUCKNOW**	State:	**UTTAR PRADESH**	
Pin Code:	**226001**	Phone No:	**9118645004**	Registration No. with State Code:
Hospital PAN:		Number of inpatient beds		
Facilities available in the hospital	i. OT	☐ **YES** ☐ **NO**	ii. ICU	☐ **YES** ☐ **NO**

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.

Date: Place:

Signature and Seal of the Hospital Authority:

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 the hospital:	Enter the name of hospital	Name of the hospital in full
b) Hospital ID	Enter ID number of hospital	As allocated by the TPA
c) Type of Hospital	Enter the name of the treating doctor	Name of doctor in full
e) Qualification	Enter the qualification 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 patient	Name of patient 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 Birth	Enter date of birth	Use dd-mm-yy format
f) Date of Admission	Enter date of admission	Use dd-mm-yy format
g) Time	Enter Time of admission	Use hh:mm format
h) Date of Discharge	Enter date of Discharge	Use dd-mm-yy format
i) Time	Enter time of Discharge	Use hh:mm format
j) Type of Admission	Indicate type of admission of patient	Tick the right option
k) If Maternity		
i) Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format
ii) Gravida Status	Enter Gravida status if maternity	Use standard format
l) Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
M) Total claimed amount	Indicate the total claimed amount	In rupees (Do not enter paise values)
SECTION C - DETAILS OF AILMENT DIAGNOSED (PRIMARY)		
a) ICD 10 Code		
b) Gender	Indicate Gender of the patient	Tick Male or Female
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 Code and description of the first procedure	Standard Format and Open text
Procedure 2	Enter the ICD 10 Code and description of the second procedure	Standard Format and Open text
Procedure 3	Enter the ICD 10 Code 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 Not

FIR No.	Enter first information report number	As issued by police authrities
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 Hospital obtained from local body like City Corporation / Municipality	As allocated by the City Corporation / Municipality
d) Hospital PAN	Enter the permanent account number	As allocated 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 HOSPITAL

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

DECLARATION:

1. Total count of documents and the content that upload have to match the documents which you courier in original to the **Chennai DLF Branch**.
2. Claim will be approved for payment processing once the original physical documents are received by MediAssist.
3. Pre/Post hospitalization claims will be settled once main hospitalization claim is settled
4. Do not club Pre/Post hospitalization Claims with the Main Hospitalization Claim. Please submit a new claim for both pre and/or post individually.
5. Main hospitalization claim is to be uploaded first followed by Pre/Post hospitalization
6. Please seal the envelope prior to dispatching with all requisite documents clearly mentioning the Employee ID and 'ForMediAssistMedicalReimbursements' on the envelope
7. Please club all relevant documents in a single file. For eg: club all pharmacy bills in a single file and upload it. If they are uploaded as separate document without clubbing them together then claim will be processed post MediAssist receiving physical document.

I hereby declare that the information furnished in this Claim Form is true & correct to the best of my knowledge & belief. If I have made any false or untrue statement, suppression or concealment of any material fact, my right to claim reimbursement shall be forfeited. I also consent & authorize TPA or insurance company to seek necessary medical information 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 Post - hospitalization claim, if any.

Date Employee Signature

Date of Submission Generated On :- 26 Mar 2024