**Checklist for Reimbursement Claims**

**(All Claim Documents to be submitted in Original)**

Copy of the Intimation Letter / Mail / Intimation Number

Duly filled, Signed & Dated Claim form of insurance company

ID Proof & Address proof of patient (Photo Copies are required)

Original Discharge Card / Discharge Summary / Day Care Summary duly signed by treating doctor and with hospital stamp

Original Hospital Bill - duly sealed & signed, with Break-up details with serial numbers

If medicine and consumable charged in the hospital then detail break up should be given (Name of the medicine / consumables with charges)

Original Pre-Numbered hospital payment receipt duly sealed & signed (with revenue stamp)

Original Prescriptions / Consultation papers with consultation receipts

Original Pharmacy Bills (please make sure patient name is mentioned on the bill)

Original Advance Paid receipt if any

Indication given by the treating doctor for lab test/surgery

Original Investigation reports along with original bills & payment receipts for the investigations done within & outside hospitals.

All Imaging Films, ECG Strips, Doppler / Angiogram CD etc. (in case of fracture/major and minor surgery)

Current year Hospital Registration Certificate with total number of beds

Any other original documents related to the claim

MLC copy /FIR in case of Accidental cases. (In case of accidental cases, fall from bike, fall at home etc.)

Detailed narration of the incidence, No alcohol certificate from treating doctor (in case of accidental cases, fall from bike, fall at home etc.)

The copy of the cancelled cheque of with IFSC code, printed name of employee

If employee has availed a cashless but if the same is not utilized, letter from the hospital mentioning the same

In case of Maternity claims, obstetric history of the patient (Gravida Para Living Abortion) Certificate from the Treating Doctor

USG Report (ultrasonography report Mandatory for Maternity cases)

For Cataract claims, IOL sticker & purchase invoice copy of the sticker is mandatory

For surgery (replacement/PTCA) invoice copy / STICKER mandatory

**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**

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

**(To be Filled in block letters)**

**DETAILS OF PRIMARY INSURED:**

a) Policy No.:

b) Sl. No/ Certificate no.

c) Company/ TPA ID No:

d) Name: **S U R N A M E F I R S T N A M E M I D D L E N A M E**

**SECTION A**

e) Address:

City: State:

Pin Code Phone No: Email ID:

**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**

**SECTION B**

Diagnosis: e) Previously covered by any other Mediclaim /Health insurance : :

Yes No

f) If yes, company name:

**DETAILS OF INSURED PERSON HOSPITALIZED: :**

a) Name: **S U R N A M E F I R S T N A M E M I D D L E N A M E**

**SECTION C**

b) Gender Male Female c) Age years

**Y Y** Months **M M**

d) Date of Birth **D D**

**M M Y Y Y Y**

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:

**DETAILS OF HOSPITALIZATION: :**

a) Name of Hospital where Admited:

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:

**D D M M Y Y Y Y**

e) Date of Admission:

**D D M M Y Y**

f) Time **H H M H**

g) Date of Discharge:

**D D M M Y Y**

h) Time: **H H**

: **M H**

**SECTION D**

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:

**DETAILS OF CLAIM:**

a) Details of the Treatment expenses claimed

I. Pre -hospitalization expenses

Rs.

ii. Hospitalization expenses Rs.

**Claim Documents Submitted - Check List:**

Claim form duly signed

iii. Post-hospitalization expenses v. Ambulance Charges:

Rs. Rs.

iv. Health-Check up cost:

vi. Others (code):

Total

Rs. Rs. Rs.

Copy of the claim intimation, if any

Hospital Main Bill

Hospital Break-up Bill

Hospital Bill Payment Receipt

**SECTION E**

vii. Pre -hospitalization period: days viii. Post -hospitalization period: days

Hospital Discharge Summary

b) Claim for Domiciliary Hospitalization:

c) Details of Lump sum / cash benefit claimed:

i. Hospital Daily cash: Rs.

Yes

No (If yes, provide details in annexure)

ii. Surgical Cash:

Rs.

Pharmacy Bill

Operation Theater Notes

ECG

iii. Critical Illness benefit:

Rs.

iv. Convalescence:

Rs.

Doctor’s request for investigation

Investigation Reports (Including CT

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

**DETAILS OF BILLS ENCLOSED:**

vi. Others: Total

Rs. Rs.

/ MRI / USG / HPE)

Doctor’s Prescriptions

**SECTION G**

Others

**Sl. No. Bill No. Date Issued by Towards Amount (Rs)**

**SECTION F**

**1.**

**2.**

**3.**

**4.**

**5.**

**6.**

**7.**

**8.**

**9.**

**10.**

**D D M M Y Y D D M M Y Y D D M M Y Y D D M M Y Y D D M M Y Y D D M M Y Y D D M M Y Y D D M M Y Y D D M M Y Y**

**D D M M Y Y**

Hospital main Bill

Pre-hospitalization Bills: Nos Post-hospitalization Bills: Nos Pharmacy Bills

**DETAILS OF PRIMARY INSURED’S BANK ACCOUNT::**

a) PAN:

c) Bank Name and Branch:

d) Cheque / DD Payable details:

b) Account Number:

e) IFSC Code:

**(IMPORTANT: PLEASE TURN OVER)**

**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

**D D M M Y Y Y Y**

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 As allotted by the oraganization social health insurance scheme

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

a) Currently covered by any other Mediclaim / Health

Enter the full postal address

**SECTION B -DETAILS OF INSURANCE HISTORY**

Indicate whether currently covered by another Mediclaim /

Include Street, City and Pin code

Insurance?

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

d) Have you been Hospitalized in the last four years since

Enter the total sum insured as per the policy

In rupees

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

1) E-mail ID

Enter the phone number of patient

Enter e-mail address of patient

**SECTION D - DETAILS OF HOSPITALIZATION**

Include STD code with telephone number

Complete e-mail address

a) Name of Hospital where admited Enter the name of hospital Name of hospital in full

b) Room category occupied c) Hospitalization due to

d) Date of injury/Date Disease first detected / Date of

Delivery

e) Date of admission f) Time

g) Date of discharge

h) Time

I) If injury give cause

If Medico legal

Reported to Police

MLC Report & Police FIR attached j) System of Medicene

a) Details of Treatment Expences

b) Claim for Domiciliary Hospitalization

c) Details of Lump sum/ Cash benifit claimed d) Claim documents Submitted-Check List

Indicate which bills are enclosed with the amount in rupees

indicate the room category occupied indicate reason of hospitalization Enter the relevant date

Enter date of admission Enter time of admission Enter date of discharge Enter time of discharge indicate cause of injury

indicate whether injury is medico legal indicate whether police report was filed

indicate whether MLC report and Police FIR attached

Enter the system of medicine followed in treating the patient

**SECTION E - DETAILS OF CLAIM**

Enter the amount claimed as treatment expences indicate whether claim is for domiciliary hospitalization Enter the amount claimed as lump sum / cash benefit

indicate which supporting documents are submitted

**SECTION F - DETAILS OF BILLS ENCLOSED**

Tick the right option

Tick the right option Use dd-mm-yy format Use dd-mm-yy format

Use hh-mm- format

Use dd-mm-yy format Use hh-mm- format Tick the right option Tick Yes or No

Tick Yes or No Tick Yes or No Open Text

In rupees (Do not enter paise values) Tick Yes or No

In rupees (Do not enter paise values) Tick the right option

a) PAN

b) Account Number

c) Bank Name and Branch

c) Cheque/ DD payable details c) IFSC Code

**SECTION G - DETAILS OF PRIMARY INSURED’s BANK ACCOUNT**

Enter the permanent account number

Enter the Bank account number

Enter the Bank name along with the branch

Enter the name of the beneficiary the cheque / DD should be made out to

Enter the IFSC code of the Bank branch

**SECTION H - DECLARATION BY THE INSURED**

As allotted by the Income Tax Department

As allotted by the Bank

Name of the Bank in full

Name of the individual / organization in full

IFSC code of the Bank branch in full

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

**SECTION H**

**DETAILS OF HOSPITAL**

**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)**

a) Name of the hospital:

a) Hospital ID:

c) Name of the treating doctor:

e) Qualification:

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

**S U R N A M E F I R S T N A M E M I D D L E N A M E**

f) Registration No. with State Code: g) Phone No.

**DETAILS OF THE PATIENT ADMITTED**

a) Name of the Patient:

**S U R N A M E F I R S T N A M E M I D D L E N A M E**

b) IP Registration Number: c) Gender: Male Female d) Age: Years **Y Y**

Months **M M**

e) Date of birth: **D D M M Y Y**

f) Date of Admission:

**D D M M Y Y**

g) Time:

**H H M M**

h) Date of Discharge: **D D M M Y Y**

**H H M M**

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: :

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

**DETAILS OF AILMENT DIAGNOSED (PRIMARY)**

m) Total claimed amount

a) ICD 10 Codes

I. Primary Diagnosis

ii. Additional Diagnosis:

iii. Co-morbidities:

iv. Co-morbidities:

Description b)

i. Procedure 1: ii. Procedure 2: iii. Procedure 3:

iv. Details of Procedure:

ICD 10 PCS Description

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.

**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

vi. If not reported to police give reason:

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

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

a) Address of the Hospital

City: State:

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

d) Hospital PAN:

iii. Others:

e) Number of inpatient beds f) Facilities available in the hospital i. OT

Yes No

ii. ICU Yes No

**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:

**D D M M Y Y**

**SECTION F**

**SECTION E**

**SECTION D**

**SECTION C**

**SECTION B**

**SECTION A**

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:

b) Hospital ID

c) Type of Hospital

c) Name of treating doctor e) Qualification

f) Registration No. with State Code g) Phone No.

a) Name of Patient

b) IP registration Number c) Gender

d) Age

e) Date of Birth

f) Date of Admission g) Time

h) Date of Discharge

i) Time

j) Type of Admission k) If Maternity

Date of Delivery

Gravida Status

l) Status at time of discharge

M) Total claimed amount

a) ICD 10 Code Primary Diagnosis Additional Diagnosis

Co-morbidities

b) ICD 10 PCS Procedure 1

Procedure 2

Procedure 3

Details of Procedure

c) Pre-authorization obtained d) Pre-authorization Number

Enter the name of hospital

Enter ID number of hospital

Indicate whether in network or non network hospital

Enter the name of the treating doctor

Enter the qualification of the treating doctor

Enter the registration number of the doctor along with the state code

Enter the phone number of doctor

**SECTION B - DETAILS OF THE PATIENT ADMITTED**

Enter the name of patient

Enter insurance provider registration number

Indicate Gender of the patient

Enter age of the patient

Enter date of birth

Enter date of admission Enter Time of admission Enter date of Discharge Enter time of Discharge

Indicate type of admission of patient

Enter Date of Delivery if maternity

Enter Gravida status if maternity

Indicate status of patient at time of discharge

Indicate the total claimed amount

**SECTION C - DETAILS OF AILMENT DIAGNOSED (PRIMARY)**

Enter the ICD 10 Code and description of the primary diagnosis

Enter the ICD 10 Code and description of the additional diagnosis

Enter the ICD 10 Code and description of the Co-morbidities

Enter the ICD 10 Code and description of the first procedure Enter the ICD 10 Code and description of the second procedure Enter the ICD 10 Code and description of the third procedure Enter the details of the procedure

Indicate whether pre-authorization obtained

Enter pre-authorization number

Name of the hospital in full

As allocated by the TPA Tick the right option

Name of doctor in full

Abbreviations of educational qualifications As allocated by the Medical Council of India Include STD code with telephone number

Name of patient in full

As allotted by the insurance provider

Tick Male or Female

Number of years and months

Use dd-mm-yy format Use dd-mm-yy format Use hh:mm format Use dd-mm-yy format Use hh:mm format Tick the right option

Use dd-mm-yy format Use standard format Tick the right option

In rupees (Do not enter paise values)

Standard Format and Open text

Standard Format and Open text

Standard Format and Open text

Standard Format and Open text Standard Format and Open text Standard Format and Open text Open text

Tick Yes or No

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

Cause

If injury due to substance abuse/alcohol consumption test conducted to establish this

Medico Legal

Reported to Police

FIR No.

If not reported to police, give reason

Indicate which supporting documents are submitted a) Address

b) Phone No.

c) Registration No. with State Code d) Hospital PAN

e) Number of Inpatient beds

f) Facilities available in the hospital

Indicate if hospitalization is due to injury

Indicate cause of injury

Indicate whether test conducted Indicate whether injury is medico legal Indicate whether police report was filed Enter first information report number Enter reason for not reporting to police

**SECTION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST**

**SECTION E - DETAILS IN CASE OF NON NETWORK HOSPITAL**

Enter the full postal address

Enter the phone number of hospital

Enter the registration number of the Hospital obtained from local body like City Corporation / Municipality

Enter the permanent account number Enter the number of inpatient beds Indicate facilities available in the hospital

**SECTION F - DECLARATION BY THE HOSPITAL**

Tick Yes or No

Tick the right option

Tick Yes or No Tick Yes or No Tick Yes or No

As issued by police authrities

Open text

Include Street, City and Pin Code

Include STD code with telephone number

As allocated by the City Corporation / Municipality

As allocated by the Income Tax Department

Digits

Tick the right option. If others, please specify

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