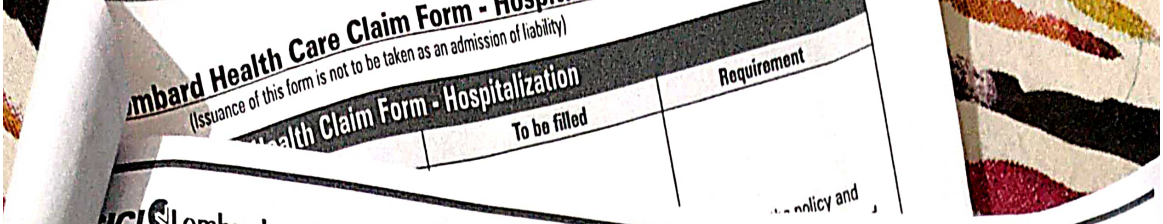

ICICI Lombard
Bhaye Vaade

ICICI Lombard Health Care Claim Form - Hospitalisation

(Issuance of this form is not to be taken as an admission of liability)

ICICI Lombard Health Care

CLAIM SETTLEMENTS SHOULD BE MADE THROUGH NEFT (AS PER IRDA CIRCULAR), PLEASE PROVIDE YOUR BANK ACCOUNT DETAILS. REFER TO PART C.

You Know

- ★ Non-submission of original bills and receipts is the main reason for delay in claim settlements. Please provide the originals & mandatory documents
- ★ To receive update on your claim status, provide your mobile no. & E-mail ID
- ★ You can track your claim status at: www.icicilombard.com→Claims→Health Claims→Services→Track your claims

TO BE FILLED IN CAPITAL LETTERS ONLY

Part - A (To be filled by Insured)

A1. Type of Claim: Main Hospitalisation Expenses ☐ Pre & Post Hospitalisation Expenses ☑ Cashless Obtained: Yes ☑ No ☐

A2. Details of the Insured person in respect of whom claim is made: (patient details)

Name of the Patient: ANITA KUMARI

Card No./ UHID of the Patient: IL2013633203

Gender: Male ☐ Female ☑ Date of Birth: 10/03/1971 Completed age: Years 52 Months

Occupation: Service ☐ Self Employed ☐ Homemaker ☑ Student ☐ Retired ☐ Other ☐ (Please specify)

Are you previously covered by any other Mediclaim/ Health Insurance: Yes ☐ No ☑. If yes, Company name:

Current residential address: B-38 MITRAM ANDAL COLONY SAKET VIHAR ANISHABAD PATNA BIHAR

City: PATNA

State: BIHAR Pin code: 800002

Mobile no. 8789091992 Landline no.

E-mail: ABHISHEKSINGH4312@GMAIL.COM

A3. For **Group/ Corporate** Policy	For **Individual/ Retail** Policy (*Mandatory)
Member ID No./ Employee ID (Client ID): 3053684	*Claim Intimation Service Request no.:
Group/ Company name: BOEING INDIA PVT LTD	Is this a renewal policy: Yes ☐ No ☐ If Yes, kindly mention your previous policy no.:

A4. Name of the Proposer*/Employee: ABHISHEK KUMAR SINGH

Aadhaar No. of the Proposer*/Employee: 7540 4793 3454 PAN No. of the Proposer*/Employee: EQXPS0830M

Relationship with Proposer*: MOTHER (*Policy Holder. For Retail policy, Proposer name required. For Corporate policy, provide Employee name)

Current Policy No.: 4016/X/198469072/02/000 Card No./UHID: IL2013633200

A5. Nature of disease/ illness contracted or injury suffered for which Insured was hospitalized (Diagnosis): RESIDUAL GB CALCULI, GENERALISED LYMPHADENOPATHY

Name of hospital where admitted: RUBAN MEMORIAL HOSPITAL PATNA

Room category occupied: Day care ☐ Single occupancy ☑ Twin sharing ☐ 3 or more beds per room ☐ Others

Date of Admission: 22/03/2023 Time: 12:10 Date of Discharge: 24/03/2023 Time: 11:39

Date of injury sustained or disease/ Illness first detected: 06/12/2022

If Injury, give cause: Self inflicted ☐ Road traffic accident ☐ Substance abuse/ Alcohol consumption ☐ Others

If Medico legal: Yes ☐ No ☐ Reported to police: Yes ☐ No ☐ MLC Report & Police FIR attached: Yes ☐ No ☐ (If yes, attach report)

System of Medicine:

Is there any another claim in any of our policies towards the above incident? Yes ☑ No ☐. If yes, provide AL/Claim No. 110201458572

If yes, provide policy no. 4016/X/221407019/01/000

A6. Are you covered under any Topup/Additional policy: Yes ☑ No ☐

A7. Currently covered by any other Mediclaim/ Health Insurance: NO Date of commencement of first Insurance without break:

Have you been hospitalized in the last 4 years since inception of contract: ☐ ☐ Date: DD/MM/YYYY Dignosis:

Have you lodged any claim against this particular admission date/ attached bills with any other Insurance company: If yes, attach settlement letter,

Company name: Policy No. Sum Insured: ₹

A8. Details of Claim

a) Details of the treatment expenses claimed

i. Pre-hospitalization expenses:	₹ 8842	ii. Hospitalization expenses:	₹
iii. Post-hospitalization expenses:	₹ 3802	iv. Health-check up cost:	₹
v. Ambulance charges:	₹	vi. Others _____:	₹
		Total:	₹

vii. Pre-hospitalization period 30 Days viii. Post-hospitalization period: 60 Days

क्लेम फॉर्म हिन्दी के लिए कृपया हमारी वेबसाइट पर जाँच कीजिए : www.icicilombard.com

Claim documents to be dispatched to: ICICI Lombard Healthcare, ICICI Bank Tower, Plot No. 12, Financial District, Nanakram Guda, Gachibowli, Hyderabad, TS-500032

i. Domiciliary Hospitalization:
ii. Day care: Yes ☐ No ☐ (If yes, provide details in annexure)
iii. Extended care/ Inpatient rehabilitation: Yes ☐ No ☐

c) Details of lump sum/ cash benefit claimed:
i. Hospital daily cash: ₹
ii. Maternity: ₹
iii. Critical illness/PA/Donor Expenses: ₹
iv. Convalescence: ₹
v. Pre/ Post hospitalization lump sum benefit: ₹ 12664
vi. Others: ₹

A9. Details of the amount claimed

Bill heads (as applicable)	Bill number	Bill date	Bills attached	Amount
Room rent				₹
Doctors consultation/ Visit charges				₹
Investigation charges (Includes Radiology and Pathology reports)				₹
Surgeon and Asst. surgeon charges				₹
Anesthetist charges & Operation theatre charges				₹
Equipment charges/ Procedure charges				₹
Cost of implant (If any)				₹
Medicine charges (Includes ward and OT medicines and consumables)				₹
Pharmacy charges				₹
Taxes/ Surcharges/ Service charge				₹
Miscellaneous/ Other charges				₹
Pre hospitalization bills (If any)				₹
Post hospitalization bills (If any)				₹
Discount provided by hospital (If any)				₹
Total claimed amount (In ₹) (Total claimed amount should be equal to the amount in attached bill documents)				₹

MANDATORY : COPY OF AADHAAR CARD AND PAN CARD ARE REQUIRED FOR ALL CLAIMS

A10. In support of the above claim, I enclose following documents in original (Please indicate by ticking in the **Yes/ No** column below)

Type of Document(s) - *Mandatory	Yes	No	**Type of Document(s) - As Applicable**	Yes	No
1. Claim form duly filled and signed*	☐	☐	9. Age proof (Driving License/ PAN card/ Passport/ Aadhaar copy)*	☐	☐
2. **Aadhaar Card copy of the Proposer/ Employee***	✓	☐	10. Part - C (For EFT/RTGS/ NEFT)*	☐	☐
3. **PAN Card copy of the Proposer/ Employee***	✓	☐	11. ICICI Lombard GIC Authorisation Letter	☐	☐
4. Discharge summary*	☐	☐	12. Implant name and invoice (if any) with implant sticker	☐	☐
5. Hospital bills, Final/ main hospital bill and other bills (if any)*	☐	☐	13. Indoor Case Papers	☐	☐
6. Hospital payment receipt & other receipts supporting bills*	☐	☐	14. Prescription papers/ Consultation papers	☐	☐
7. Investigation reports* (Including ECG/ CT/ MRI/ USG/ HPE)	☐	☐	15. C-KYC FORM (Only for Retail/Individual customers, claiming > ₹ 1Lakh)	☐	☐
8. Medicine/ Pharmacy bills with doctors prescription*	☐	☐	16. Others (details) _____	☐	☐

Please attach all the documents as per above serial number. Films like x-ray film, CT Scan film, MRI Scan film, etc. are not required. Provide reports only

A11.Please provide the reason for delay in submitting the documents
(Post 30 days from Date of Discharge)

Provide Details (If Applicable)

Declaration by the Insured:

I hereby declare that the information furnished in this claim form is true and 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 and 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 and that I will not be making any supplementary claim except the pre/ post-hospitalization claim, if any.

Date: 03/04/2023 Place: PATNA Insured's Signature: Abhishek Ojha

क्लेम फॉर्म हिन्दी के लिए कृपया हमारी वेबसाइट पर जाँच कीजिए : **www.icicilombard.com**

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