ICICI Lombard Health Insurance

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

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

Do 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 & wellness→IL Health care→Claims corner→Track your claims

Part - A (To be filled by Insured)

TO BE FILLED IN CAPITAL LETTERS ONLY

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 Patient: ANITA KUMARI

Card No./UHID of the Patient: IL22265190603

Gender : Male ☐ Female ☑ Date of Birth: 10/03/1971 Completed age: Years: 53 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 Mitramandal colony, saket vihar ,anishabad, patna-800002, Bihar

City: Patna Pin code: 800002

State: Bihar Landline no. 8789091992

Mobile no. 8789091992

E-mail: abhisheksingh4312@gmail.com

A3. For **Group/Corporate** Policy

Member ID No./Employee ID (Client ID): 3053684

Group/Company name: Boeing India Pvt Ltd

For **Individual/ Retail** Policy (*Mandatory)

*Claim Intimation Service Request no.:

Is this a renewal policy: Yes ☐ No ☐

If Yes, kindly mention your previous policy no.:

A4. Name of the Proposer*: ANITA KUMARI

Relationship with the Proposer*: SON

Current Policy No.: 4016/X/198469072/04/000 Card No./ UHID: IL22265190603

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

A5. Nature of disease/ illness contracted or injury suffered for which Insured was hospitalized (Diagnosis):

Hypercalcemia and Pedal edema, knee pain

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: 15/07/2024 Time: 12:50 PM Date of Discharge: 24/07/2024 Time: 11:23 AM

Date of injury sustained or disease/ Illness first detected: 15/06/2024

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 ☐ ☐ (If yes, attach report)

System of Medicine:

A6. Are you covered under any Topup/Additional policy : Yes ☑ No ☐ If yes, provide policy no. 4016/X/221407019/03/000

A7. Currently covered by any other Mediclaim/ Health Insurance: Yes ☐ No ☐ Date of commencement of first Insurance without break: DD/MM/YYYY

Have you been hospitalized in the last 4 years since inception of contract:Yes ☐ No ☐ Date: 22/03/2023 Dignosis: laparoscopic surgery

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:	14527	ii. Hospitalization expenses:	
iii. Post-hospitalization expenses:	17552	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, Varun Tower II, 1st, 4th, 5th & 6th Floor, Begumpet, Hyderabad, Telangana, Pincode – 500016

b) Claim for

i. Domiciliary Hospitalization: Yes ☐ No ☐ (If yes, provide details in annexure)

ii. Day care: Yes ☐ No ☐

iii. Extended care/ Inpatient rehabilitation: Yes ☐ No ☐

c) Details of lump sum/ cash benefit claimed:

i. Hospital daily cash:		ii. Surgical cash:	
iii. Critical illness:		iv. Convalescence:	
v. Pre/ Post hospitalizationlump sum benefit:	32079	vi. Others:	

A9. Details of the amount claimed

Bill heads (as applicable)	Bill number	Bill date	Bills attached	Amount
Room rent:		DD/MM/YYYY	Yes ☐ No ☐	
Doctors consultation/ Visit charges:		DD/MM/YYYY	Yes ☐ No ☐	
Investigation charges (Includes Radiology and Pathology reports):		DD/MM/YYYY	Yes ☐ No ☐	
Surgeon and Asst. surgeon charges:		DD/MM/YYYY	Yes ☐ No ☐	
Anesthetist charges & Operation theatre charges:		DD/MM/YYYY	Yes ☐ No ☐	
Equipment charges/ Procedure charges:		DD/MM/YYYY	Yes ☐ No ☐	
Cost of implant (If any):		DD/MM/YYYY	Yes ☐ No ☐	
Medicine charges (Includes ward and OT medicines and consumables):		DD/MM/YYYY	Yes ☐ No ☐	
Pharmacy charges:		DD/MM/YYYY	Yes ☐ No ☐	
Taxes/ Surcharges/ Service charge:		DD/MM/YYYY	Yes ☐ No ☐	
Miscellaneous/ Other charges:		DD/MM/YYYY	Yes ☐ No ☐	
Pre hospitalization bills (If any):		DD/MM/YYYY	Yes ☐ No ☐	
Post hospitalization bills (If any):		DD/MM/YYYY	Yes ☐ No ☐	
Discount provided by hospital (If any):		DD/MM/YYYY	Yes ☐ No ☐	
Total claimed amount (In INR) (Total claimed amount should be equal to the amount in attached bill documents)				

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

10. 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. ICICI Lombard GIC Authorisation Letter	☐	☐
2. Discharge summary*	☑	☐	10. Implant name and invoice (if any) with implant sticker	☐	☐
3. Hospital bills, Final/ main hospital bill and other bills (if any)*	☑	☐	11. Indoor Case Papers	☐	☐
4. Hospital payment receipt & other receipts supporting bills*	☑	☐	12. Prescription papers/ Consultation papers	☐	☐
5. Investigation reports* (Including ECG/ CT/ MRI/ USG/ HPE)	☑	☐	13. Others (details):	☐	☐
6. Medicine/ Pharmacy bills with doctors prescription**	☑	☐			
7. Age proof (Driving License/ PAN card/ Passport/ Aadhar copy)*	☑	☐			
8. Part - C (For EFT/RTGS/ NEFT)*	☐		14. Part - D (KYC documents required if total claimed amt. is > 1 lakh)	☐	☐

*Mandatory.

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

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: 29/07/2024 Place: PATNA Insured's Signature: Abhishek Singh

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