Family Health Plan(TPA) Limited

REIMBURSEMENT CLAIM FORM

T50 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)

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2 0 2 1 Place: Hyderabad

Signature of 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
o)	SI. No/ Certificate No.	Enter the social Insurance number or the certificate number of social health insurance scheme	As allotted by the oraganization
			Licence number as allotted by IRDA and printed
:)	Company TPA ID No.	Enter the TPA ID No.	in TPA documents.
)	Name	Enter the full name of the policyholder	Surname, First name, Middle name
)	Address	Enter the full postal address	Include Street, City and Pin code
)	Currently covered by any other Mediclaim / Health	SECTION B -DETAILS OF INSURANCE HISTORY Indicate whether currently covered by another Mediclaim /	T
,	Insurance?	Health Insurance	Tick Yes or No
)	Date of commencement of first Insurance without break	Enter the date of commencement of first Insurance	Use dd-mm-yy-forrmat
)	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
)	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
	Previously covered by any other Mediclaim / Health	Indicate whether previously covered by another mediclaim /	Tick Yes or No
	Insurance?	Health Insurance	
	Company Name	Enter the full name of the Insurance Company	Name of the organization in full
		CTION C -DETAILS OF INSURED PERSON HOSPITALIZED	
)	Name	Enter the full name of the patient	Surname, First name, Middle name
	Gender	Indicate Gender of the patient	Tick Male or Female
	Age	Enter age of the patient	Number of years and months
	Date of Birth	Enter Date of Birth of patient	Use dd-mm-yy format
	Relationship to primary Insured	Indicate relationship of patient with policyholder	Tick the right option, if others, please specify
	Occupation	indicate occupation of patient	Tick the right option. If others, please specify.
	Address	Enter the full postal address	Include Street, City and Pin code
	Phone No	Enter the phone number of patient	Include STD code with telephone number
	E-mail ID	Enter e-mail address of patient	Complete e-mail address
		SECTION D - DETAILS OF HOSPITALIZATION	
)	Name of Hospital where admited	Enter the name of hospital	Name of hospital in full
)	Room category occupied	indicate the room category occupied	Tick the right option
	Hospitalization due to	indicate reason of hospitalization	Tick the right option
)	Date of injury/Date Disease first detected / Date of Delivery	Enter the relevant date	Use dd-mm-yy format
)	Date of admission	Enter date of admission	Use dd-mm-yy format
	Time	Enter time of admission	Use hh-mm- format
)	Date of discharge	Enter date of discharge	Use dd-mm-yy format
)	Time	Enter time of discharge	Use hh-mm- format
_	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
	System of Medicene	Enter the system of medicine followed in treating the patient	Open Text
	eyetem of modioono	SECTION E - DETAILS OF CLAIM	-1 -1
)	Details of Treatment Expences	Enter the amount claimed as treatment expences	In rupees (Do not enter paise values)
<u>/</u>	Claim for Domiciliary Hospitalization	indicate whether claim is for domiciliary hospitalization	Tick Yes or No
'	Details of Lump sum/ Cash benifit claimed	Enter the amount claimed as lump sum / cash benefit	In rupees (Do not enter paise values)
)	Claim documents Submitted-Check List	indicate which supporting documents are submitted	Tick the right option
		SECTION F - DETAILS OF BILLS ENCLOSED	1 and right option
di/	ate which bills are enclosed with the amount in rupees		
ui	•	ON G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT	
	PAN	Enter the permanent account number	As allotted by the Income Tax Department
	Account Number	Enter the Bank account number	As allotted by the Bank
_	Bank Name and Branch	Enter the Bank account number Enter the Bank name along with the branch	Name of the Bank in full
)		Enter the name of the beneficiary the cheque / DD should be	
)	Cheque/ DD payable details	made out to	Name of the individual / organization in full
)	IFSC Code	Enter the IFSC code of the Bank branch	IFSC code of the Bank branch in full
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