

CLAIM FORM - PART A

TO BE FILLED IN BY THE INSURED

The issue of theis form is not to be taken as admission of liability

(To be filled in block letters)

DETAILS OF PRIMARY INSURED													
a) Policy no:		b) SI. No/ Certificate N	lo:] _					
c) Company/ TPA ID No:]											
d) Name:													
e) Address:													
City:		State:				П			Т				
Pin Code: Phone No:			Email ID:										
DETAILS OF INSURANCE HISTORY			<u>-</u>										
a) Currently covered by any other Mediclaim/ Health Insurance:	b) Date of commenc	ement of first insurance withou	ut break:										
c) If yes, company name:	Policy No:] ,			
Sum Insured (·): d) Have you been hospitalize	zed in the last four years	since inception of the contract	? Yes No	Date:									
Diagnosis:		e) F	Previously covered by any oth	er Mediclaim/	/ Health In:	surance	:		Yes	No			
f) If yes, Company Name :													
DETAILS OF INSURED PERSON HOSPITALIZED	<u> </u>												
a) Name :						Π	Т						
b) Gender : Male Female c) Age: years months	d) [Date of Birth:		Ti Ti									
e) Relatuionship to Primary Insured: Self Spouse Child Father	=		(Please specify)	_									
f) Occupation: Service Self Employed Homemaker Student	Retired	= =	(Please specify)										
g) Address (if different from above):			· · · · · · · · · · · · · · · · · · ·	TT	T	П	Т	П	Т				
g) , seesee (n universit item decree).		 	 	+	+	\forall	+	\forall	+	++			
City		State:	+ + + +	+	+	十	+	+	+	┿┿.			
City:			moil ID:										
Pin Code:													
					_		_		_				
a) Name of Hospital where Admitted:		 	<u> </u>	\dashv		ш							
b) Room category occupied: Day Care Single occupancy	Twin sharing		3 or more beds per room		_		_	_					
c) Hospitalization due to: Injury Illness Maternity	d) Dat	te of injury/ Date Disease first	detected/ Date of Delivery:	+	_	Ш	⊨	Щ	_	:			
e) Date of Admission: f) Time:		g) Date of Discharge:	╇	Щ	╡ ,	h) Time	: ∟		: L				
i) If injury, give cause: Self inflicted Road Traffic Accident	Substance abus	se / Alcohol Consumption	i. If Medic	co Legal:	Yes	N	0						
E Description Company of the Company													
ii. Reported to police: Yes No iii. MLC Report & Police FIR attached:	Yes No	j) System of medicine	e:										
ii. Reported to police: Yes No iii. MLC Report & Police FIR attached: DETAILS OF CLAIM	Yes No	j) System of medicine	e:										
	Yes No	j) System of medicine	e: [CI	laim Docu	ıments	Submitte	d- Chec	k List:				
DETAILS OF CLAIM a) Details of treatment expenses claimed	Yes No	j) System of medicine	e:	CI	_		Submitte		k List:				
a) Details of treatment expenses claimed i. Pre Hospitalization Expenses ii. Ho		j) System of medicine		CI	Claim	FormDu							
DETAILS OF CLAIM a) Details of treatment expenses claimed i. Pre Hospitalization Expenses iii. Post Hospitalization Expenses iv. H	ospitalization Expenses	j) System of medicine		CI	Claim	FormDu	uly signed						
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d) Cheque/ DD Payable details:						e) IFSC Cod	de:								\Box			工	G
DECLARATION BY THE INSURED																			_
I hereby declare that the information for																			- 1
claim, my right to claim reimbursemer made. I hereby declare that I have inc										itioner	who has at	ended on	1 the pe	rson a	gainst wh	nom this o	laim is		2
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Date:		Place:																	
						_							_	_					
	DATA ELEMENT		GUID	ANCE FOR FILLING CLAIM			the ins	ured)		_									
	DATA ELEMENT			SECTION A - DE		RIPTION								FOI	RMAT				
a) Policy No.				Enter the policy number	TAILS OF FRIE	IART INSURED				Δς	allotted b	v the in	suran		mnany				
b) SI. No/ Certificate No.				Enter the social insurance	e number or the	e certificate number	r of soc	ial healt	h	$\overline{}$	allotted b				прапу				_
b) of Nor Octanicate No.				insurance scheme						_					DDA		die TD		
c) Company TPA ID No.				Enter the TPA ID No							ense num uments.	ber as a	allotted	ı by ı	RDA an	ia printe	ain ip	'A	
d) Name				Enter the full name of the	policyholder					Sur	name, Fi	rst name	e, Mid	dle n	ame				
e) Address	idress				ess					Incl	ude Stre	et, City a	and Pi	n Co	de				
					TAILS OF INSUR														
	Currently covered by any other Mediclaim / Health Insurance?				covered by ar	nother Mediclaim / I	Health	Insurano	ce	Ticl	k Yes or I	10							
				Enter the date of commer	ncement of first	t insurance				Use	e dd-mm-	yy forma	at	=					
c) Company Name Policy No.				Enter the full name of the Enter the policy number	insurance con	npany				$\overline{}$	ne of the								_
Sum Insured										$\overline{}$	allotted b	y the ins	suranc	e co	mpany				
d) Have you been Hospitalized in the la	last 4 years since incer	otion of the contra	ct?	Enter the total sum insure Indicate whether hospital						_	upees k Yes or I	Vn.		—					
Date				Enter the date of hospital		- youro				+	mm-yy f			_					_
Diagnosis				Enter the diagnosis detail	ls					$\overline{}$	en Text								
e) Previously Covered by any other Me	ediclaim/ Health Insura	nce?		Indicate whether previous	sly covered by a	another Mediclaim	/ Healtl	h Insurai	nce	Ticl	k Yes or I	No							
f) Company Name				Enter the full name of the	insurance con	nany				Nar	me of the	organiz	ration	in full					
				SECTION C - DETAILS		· ·	ED					organiz	41.011						
a) Name				Enter the full name of the	patient					Sur	name, Fi	rst name	e, Mid	dle n	ame				
b) Gender				Indicate Gender of the pa	ntient					Ticl	k Male or	Female	3						
c) Age d) Date of Birth				Enter age of the patient						-	mber of y			ths					
e) Relationship to primary Insured				Enter Date of Birth of pati Indicate relationship of pa		ryholder				-	dd-mm- k the righ	-		ore r	nlease s	enecify			
f) Occupation				Indicate occupation of pa		synoidei				$\overline{}$	k the righ								_
g) Address				Enter the full postal addre						$\overline{}$	ude Stre								
h) Phone No				Enter the phone number	of patient					Incl	ude STD	code w	ith tel	ephor	ne numb	ber			
i) E-mail ID				Enter e-mail address of p						Cor	nplete e-	mail add	dress						
a) Name of Hospital where admitted				SECTION D - DI		PITALIZATION				N.		-14-1 1-	£.11				—		_
b) Room category occupied				Enter the name of hospital Indicate the room categorian						$\overline{}$	me of hos								_
c) Hospitalization due to				Indicate reason of hospita						$\overline{}$	k the righ								_
d) Date of Injury/Date Disease first det	tected/ Date of Delivery	у		Enter the relevant date						$\overline{}$	dd-mm-								
e) Date of admission				Enter date of admission						Use	dd-mm-	yy forma	at						
f) Time g) Date of discharge				Enter time of admission						$\overline{}$	hh:mm		_						
h) Time				Enter date of discharge						$\overline{}$	dd-mm- hh:mm		at		—	—	—		
i) If Injury give cause				Enter time of discharge Indicate cause of injury						-	k the righ								_
If Medico legal				Indicate whether injury is	medico legal					_	k Yes or I		_	_					_
Reported to Police				Indicate whether police re	eport was filed					Ticl	k Yes or I	No							
MLC Report & Police FIR attached				Indicate whether MLC rep	oort and Police	FIR attached				Ticl	k Yes or I	10							
j) System of Medicine				Enter the system of medi	cine followed in		nt			Ope	en Text								
a) Details of Treatment Expenses				Enter the amount claimed						ln r	upees (D	o not on	tor no	ico v	aluan)				
b) Claim for Domiciliary Hospitalization	1			Indicate whether claim is						$\overline{}$	Yes or I		ет ра	ise v	alues)				
c) Details of Lump sum/ cash benefit c	claimed			Enter the amount claimed						$\overline{}$	upees (D		iter pa	ise v	alues)				
d) Claim Documents Submitted-Check	List			Indicate which supporting						Ticl	k the righ	option							
Indicate which hills are analoged	the amounts in sunce			SECTION F - D	ETAILS OF BILL	S ENCLOSED													
Indicate which bills are enclosed with t	ne amounts in rupees			SECTION G - DETAILS OF	DDIMARY INC.	IDED'S DANK ACCO	אוור												
a) PAN				Enter the permanent acco		MED 3 BANK ACCC	JONI			Δο	allotted b	v the In	come	Tay	denartm	nent			
b) Account Number				Enter the bank account n						$\overline{}$	allotted b				.oparull	-OIR			
c) Bank Name and Branch				Enter the bank name alor		nch				_	ne of the								_
d) Cheque/ DD payable details				Enter the name of the ber	neficiary the ch	eque/ DD should be	e made	e out to		Nar	ne of the	individu	ual/ or	ganiz	ation in	full			
e) IFSC Code				Enter the IFSC code of th						IFS	C code o	f the ba	nk bra	ınch i	n full				
Read declaration carefully and mention	n date (in dd:mm:vv fo	rmat), place (oner	text) and sign	SECTION H - DE	CLAKATION BY	I HE INSURED						—	—		—	—	—		
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CLAIM FORM - PART B

TO BE FILLED IN BY THE HOSPITAL

The issue of theis form is not to be taken as admission of liability

Please include the original preauthorization request form in lieu of PART A

DETAILS OF HOSPITAL																																	(To	be fill	led in b	olock	letters
a) Name of the Hospital:	Т				Ī	T	T	T	T	Т	T	T	Т	T	T	T	Т	T	T	Т	Т			П	T	Т	T	Т	Т	T	T	T	T	T	〒	T	ī
c) Hospital ID:						Ť	Ī	Ť	Ī			с) Туре	of H	ospital:			1	Vetw	ork	1	Non N	etwork						(if n	on ne	twork, 1	fill Se	ction E	:)				
d) Name of the treating do	tor:						T	\equiv	Ī		T							Τ	Ī	Ī										L	L		L	I	L		
e) Qualification:								\Box		f) Regi	stration	No. v	vith sta	te cod	e: [Ι		Τ					g) Ph	one N	o. 🗀			T	工		${\mathbb T}$	T	T		
DETAILS OF PATIENT AL	MITTED																																				
a) Name of Patient:							T	$oldsymbol{oldsymbol{oldsymbol{oldsymbol{\Box}}}$	I		T	T						T											Π	${\mathbb T}$	Ι		Ι	Ι	T		
b) IP Registration No.:							Т		С) Gend	er:	Ma	e [Fema	le			d) Age	: year	s		m	onths	Τ	e) [Date of	Birth:			工]		工]		
f) Date of Admission:]					\Box	g)) Time:				: [h)	Date of	Disch	arge:]		i) Ti	ime:		工]:		
j) Type of Admission: En	nergency	,		Planne	ed			Day Ca	are	N	Matern	ity			k)	If Ma	temity:		i. Da	te of D	elivery:]		ii. G	Gravida	Status	S:			
I) Status at time of discharg	e:	D	scharg	ed to ho	me			Dis	charg	ged to a	nothe	r hospi	tal		De	ecease	ed 🗌										m) To	otal cla	imed a	amount	t 🗀		L	工	\Box		
DETAILS OF AILMENT DI	AGNOSE	D (PR	IMARY)																																	
a)			ICD	10 Code	es						D	escripti	on				b)							ICD 1	0 PCS							[Descrip	ption			
i. Primary Diagnosis :								F	_]		i. Pro	ocedure	1:																	
	_		_		_		_	F	=							╡						_			_	_	_	-	⊨	=	=		=	=	_		
ii. Additional Diagnosis	· <u>L</u>	<u> </u>			_		_	H	—							┨		ii. Pr	ocedure	2:		Ш						J	⊢	—				—	—		
iii Co morbidition :		_		Т	_	$\overline{}$	\neg	F	=							╡		::: D.	rooodure	٥.				П	$\overline{}$	_	$\overline{}$	٦	H	_	_		_	_	_		
iii. Co-morbidities :	_		_				_	F								\dashv		ııı. Pî	rocedure	υ.		ш			_			_	\vdash								
iv. Co-morbidities :					Ī			F	_							Ī		iv. D	etails of	Proce	dure :								_	_	_		_	_	_		
	_				_		_		_											_										_	_		_				
c) Pre authorization obtaine	d:								Y	es	N	0		d)	Pre-a	uthori	zation i	numb	oer:	Ι	L	$ldsymbol{oxed}$			Ι	Ι	\perp	\perp	$oxed{L}$	工]						
e) If authorization by netwo	rk hospit	al not o	btaine	d, give re	easoi	n:			_																					_	_		_	_			
f) Hospitalization due to inj	ıry:		Yes	N	0		i. I	lf yes, gi	jive ca	ause			Sel	f inflicte	d _		R	oad 1	Traffic A	cciden	t]			_	Substa	nce ab	use / a	Icohol	consu	.mptio	n]	_	_	_	_
ii. If injurydue to Substance	abuse / a	alcohol	consu	mption, 1	Test (Conducte	d to	astablis ⁱ	h this	S :				Ye		No		(if y	es, attac	h repo	orts)	iii. I	Med	co Legal	: <u>L</u>	Yes	<u> </u>	No		iv.	Repor	rted to	Police	<u> </u>	Yes		No
v. FIR No.											vi. If r	not repo	orted t	o police	e, give	reaso	n:														_						
CLAIM DOCUMENTS SUE	MITTED	- CHE	CKLIS	T					_									_																			
Claim Forn	duly sig	ned															L	╛	Investi	gation	reports																
Original Pr	e-authoriz	zation r	equest														L	╛	CT/ M	RI/ US	G/ HPE	/ Invest	igatio	n reports													
Copy of the	Pre-auth	norizati	on app	roval lett	er													╛	Doctor	's refe	rance sl	ip															
Copy of ph	oto ID ca	rd of p	atient v	erified b	y hos	spital											L	╛	ECG																		
Hospital di	charge s	umma	ry														Ļ	╛	Pharm	acy bi	lls																
Oparation	heatre N	lotes															Ļ	╛	MLC r	eport 8	& Police	FIR															
Hospital m																	L	╡	Origina	al deat	h summ	ary fro	n hos	pital, who	ere app	licable											
Hospital br	eak-up bi	II															L	+	Any ot	her, pl	ease sp	ecify									—						
DETAILS IN CASE OF NO	N NETW	ODKI	IO C DIT	AL (ON	VE	II IN CA	.c.	OE NON	NI NIE"	TWODI	/ IIOO	DITAL						L													_						
Address of the hospital:		I	l corn	AL (OIV	1	ILL IIV OF	TOL (T	Ŧ	IWOKI	T	IIIAL	T	Т	Т	Т	Т	Т	Т	Т	Т			П	Т	Т	Т	Т	Т	〒	〒	Т	〒	〒	一	Τ	Т
a) Address of the Hospital.	⊨	t	H	\dashv	╡	\pm	t	十	肀	÷	t	÷	t	÷	÷	t	+	÷	+	÷	÷	H		H	÷	+	÷	÷	÷	十	十	÷	肀	十	十	H	÷
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	l Code.	H	H	\dashv	Ħ	\pm	┽	op	-		_	a\ Nive		lanati.		<u>.</u> -	+	÷	\dagger	Δ.	- allitica		ر ما ما			i. 0		Yes		No	_		ii. ICU	늗	Yes	十	╁.
d) Hospital PAN	\vdash	<u> </u>	_		_		_	<u> </u>	+	<u> </u>		e) Num	ber o	праце	ent bed	is	_	_		1) F	acilities	avallat	ne in	he hospi	ldi.	1. U	: <u> </u>	res	_	INO	_		II. ICU	느	res	<u> </u>	No
iii. Others: DECLARATION BY THE I	LLL ATIGROI								_																								(Dlage	0 103/	d very	carofi	ully)
DECLARATION BY THE P	OSPITA								_																								rieas	ereau	very	Caren	ully)
We hereby declare that forfeited.	the inforr	nation	furnish	ed in this	Clai	m Form i	is tru	e & corr	rect to	the be	st of c	our kno	wledg	e and b	elief. I	f we h	ave ma	ide a	ny false	or unt	rue state	ement,	suppr	ess or co	ncealm	ent of a	anu ma	terial fa	act, ou	r right t	to clai	im und	er this	claim	shall b	е	
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			NIA E	LIMILIA	<u> </u>			—	—					SE	CTION	I A - [DETAI		SCRIPT OF HOS											—		FORM	AT	—	—		
a) Name of Hospital									_		Er	nter the	name													Nai	ne of h	ospita	l in full		_						
b) Hospital ID											\neg	nter ID															allocate										
c) Type of Hospital	oter.				_		_		_		$\overline{}$	dicate v						rk no	spital							$\overline{}$	k the ric				_		_				
d) Name of treating d e) Qualification	octor							_	_		_	nter the						oto -								_	ne of d			tions.	auci:e	ootier		_	_		
f) Registration No. wit	h State (Code						—	_		\neg	nter the							ong with	the st	ate code	9				\neg				itional d idical C							
g) Phone No.									_		-	nter the	phon	e numl	er of	doctor														teleph				_	_		
								_	_		_					TAIL	S OF	THE	PATIEI	NT AD	MITTE	D								_	_		_	_			
 a) Name of Patient 											le,	ntor the	nami	of hos	nital											Nai	ne of h	nsnital	l in full								

C) Gender	Enter insurance provider registration number ndicate Gender of the patient Enter date of admission Enter time of admission Enter time of admission 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	As allotted by the insurance provider Tick Male or Female Number of years and months Use dd-mm-yy format Use hh:mm format Use dh-mm-yy format Use hh:mm format Tick the right option Use dd-mm-yy format Use dd-mm-yy format
d) Age	Enter age of the patient 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	Number of years and months 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
e) Date of Admission E f) Time E g) Date of Discharge h) Time E li) Type of Admission In me Date of Discharge in f) Time E li) Type of Admission In Maternity Date of Delivery Gravida Status E li k) Status at time of discharge	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	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
f) Time E g) Date of Discharge E h) Time E i) Type of Admission In j) If Maternity Date of Delivery Gravida Status E k) Status at time of discharge In	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	Use hh:mm format Use dd-mm-yy format Use hh:mm format Tick the right option Use dd-mm-yy format
9) Date of Discharge h) Time Ei 1) Type of Admission In 1) If Maternity Date of Delivery Gravida Status k) Status at time of discharge In	Enter date of discharge Enter time of discharge Indicate type of admission of patient Enter Date of Delivery if maternity Enter Gravida slatus if maternity	Use dd-mm-yy format Use hh:mm format Tick the right option Use dd-mm-yy format
h) Time	Enter time of discharge Indicate type of admission of patient Enter Date of Delivery if maternity Enter Gravida status if maternity	Use hh:mm format Tick the right option Use dd-mm-yy format
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Date of Delivery Gravida Status E k) Status at time of discharge In	Enter Gravida status if maternity	· ·
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Gravida Status E. k.) Status at time of discharge In	Enter Gravida status if maternity	· ·
·	ndicate status of nations at time of discharge	403C Stanuaru ronnat
	nuicate status of patient at tille of discipline	Tick the right option
a) ICD 10 Code	SECTION C - DETAILS OF AILMENT DIAGNOSED (PRIMARY)	3 - 1
a) IOD TO CODE		
Primary Diagnosis	Enter the ICD 10 Code and description of the primary diagnosis	Standard Format and Open text
Additional Discourse	Enter the ICD 10 Code and description of the primary diagnosis	Standard Format and Open text
0	Enter the ICD 10 Code and description of the additional diagnosis	Standard Format and Open text
b) ICD 10 PCS	Enter the ICD TO Code and description of the co-morbidities	Standard Format and Open text
Procedure 1	Table the ICD 40 DCC and description of the first according	Standard Format and Open text
Proceedings 0	Enter the ICD 10 PCS and description of the first procedure	'
December 2	Enter the ICD 10 PCS and description of the second procedure	Standard Format and Open text
Details of Presenture	Enter the ICD 10 PCS and description of the third procedure	Standard Format and Open text
c) Pro authorization obtained	Enter the details of the procedure	Open text
d) Dro outhorization Number	ndicate whether pre-authorization obtained	Tick Yes or No
C	Enter pre-authorization number	As allotted by TPA
A Harristination during the horizontal and the hori	Enter reason for not obtaining pre-authorization number	Open text
	ndicate if hospitalization is due to injury	Tick Yes or No
	ndicate cause of injury	Tick the right option
If injury due to substance abuse/alcohol consumption, test conducted to establish this In	ndicate whether test conducted	Tick Yes or No
Medico Legal In	ndicate whether injury is medico legal	Tick Yes or No
Reported To Police	ndicate whether police report was filed	Tick Yes or No
FIR No.	Enter first information report number	As issued by police authorities
If not reported to police, give reason	Enter reason for not reporting to police	Open Text
<u> </u>	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) Dhara Na	Enter the phone number of hospital	Include STD code with telephone number
a) Paristantian Na with Otata Onda	Enter the registration number of the doctor along with the state code	As allocated by the Medical Council of India
d) Hospital PAN	Enter the permanent account number	As allotted by the Income Tax department
a) Number of Innations Dada	Enter the number of inpatient beds	Digits
C Continue and the boundary	·	Tick the right option. If others, please specify
y street	ndicate facilities available in the hospital SECTION F - DECLARATION BY THE INSURED	rick the right option. If others, please specify
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign		