Medi Assist

Medi Assist Insurance TPA Private Limited

MEDI ASSIST HYD01408073

REIMBURSEMENT CLAIM FILE : PRIVATE AND CONFIDENTIAL

DOCUMENT INDEX SHEET

MAID	SOU9429424	Claim No	
Claim Type	☑ Main ☐ Pre Hosp ☐ Post Hosp		
	☐ Domi/OPD ☐ IR/Def. Doc ☐ Priority Claim		
Policy No.		Policy Holder	Rahm
Benif Name	Mahesh	Processing Branch	Hyd
Claim Amount	14160/-	Claim Received Date	
HID Updation	☐ Required? ☐ Completed?	Dummy Claim	☐ Action Required? ☐ Completed?

Document Checklist (Mandatory) To be filled by Help desk / Front Desk

☑ Claim Form ☐ Cheque ☐ Verified with CF and Name

☑ Bills No of Pages [ ] ☐ Main Bill / Breakup avilable? **Total No of Docs** 14

☑ Dis. Summary No of Pages [ ] ☐ Reports

Remarks.....

Non Scannable Documents (To be filled by Inward/ Receiving Personnal)

		Nos	Description
CT / MRI Scan			
X-Ray			
CD			
Lens/ Implant Sticker			
Test Strips			
Others			

HELP DESK / CRM

RECEIVER/ INWARD

SCANNING SEAL

(13)

Medi Assist

REIMBURSEMENT CLAIM FORM

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)

SECTION A

DETAILS OF PRIMARY INSURED:

a) Policy No.: 6010429424 b) Sl. No/ Certificate no.

c) Company / TPA ID (MA ID)No: JIIC2300869130466 53251

d) Name: BALAMONI M MAHESH MIDDLE NAME

e)Address: H-NO-13-8/12, GAYATHRI HTCLS CALONY ROAD NO 2 BADANGPET, HYD

City: HYDERABAD State: TELANGANA

Pin Code 500058 Phone No: 9951598086 Email ID:

SECTION B

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

Diagnosis: e) Previously covered by any other Mediclaim /Health insurance : : Yes No

f) If yes, company name:

SECTION C

DETAILS OF INSURED PERSON HOSPITALIZED:

a) Name: BALAMONI MAHESH MIDDLE NAME

b) Gender Male ☑ Female c) Age years 92 Months M N d) Date of Birth 24 08 1932

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:

SECTION D

DETAILS OF HOSPITALIZATION:

a) Name of Hospital where Admited: JEEVAN HOSPITAL

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: 23 08 24 f) Time 06 53 g) Date of Discharge: 24 08 24 h) Time: 08 : 40

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:

SECTION E

DETAILS OF CLAIM:

a) Details of the Treatment expenses claimed

i. Pre -hospitalization expenses Rs.

ii. Hospitalization expenses Rs. 10000

iii. Post-hospitalization expenses Rs.

iv. Health-Check up cost: Rs.

v. Ambulance Charges Rs.

vi. Others (code): pharmacy Rs. 4160

Total Rs. 14160

vii. Pre -hospitalization period: days

viii. Post -hospitalization period: days

b) Claim for Domiciliary Hospitalization: Yes No (If yes, provide details in annexure)

Total :- 14,160

c) Details of Lump sum / cash benefit claimed:

i. Hospital Daily cash: Rs. ii. Surgical Cash: Rs.

iii. Critical Illness benefit: Rs. iv. Convalescence: Rs.

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

Total Rs.

Claim Documents Submitted - Check List:

- ☑ Claim form duly signed
- ☑ Copy of the claim intimation, if any
- ☑ Hospital Main Bill
- ☑ Hospital Break-up Bill
- ☑ Hospital Bill Payment Receipt
- ☑ Hospital Discharge Summary
- ☑ Pharmacy Bill
- ☑ OperationTheater Notes
- ☑ ECG
- ☑ Doctols request for investigation
- ☑ Investigation Reports (Including CT / MRI / USG / HPE)
- ☑ Doctols Prescriptions
- ☑ Others

SECTION F

DETAILS OF BILLS ENCLOSED:

Sl. No.	Bill No.	Date	Issued by	Towards	Amount (Rs)
1.		D D M M Y Y		Hospital main Bill	10,000/-
2.		D D M M Y Y		Pre-hospitalization Bills: Nos	
3.		D D M M Y Y		Post-hospitalization Bills: Nos	
4.		D D M M Y Y		Pharmacy Bills	05 SEP 2024,160
5.		D D M M Y Y			
6.		D D M M Y Y			
7.		D D M M Y Y			
8.		D D M M Y Y			
9.		D D M M Y Y			
10.		D D M M Y Y		Total:	14,160/-

SECTION G

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT:

a) PAN: BHRPB8218C b) Account Number: 44611249408

c) Bank Name and Branch: STANDARD CHRTERD BANK SOMOSI GUDA

d) Cheque / DD Payable details: 000020 e) IFSC Code: SCBL0036075

SECTION H

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 reimbursement 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 04 09 2024 Place: Hyderabad Signature of the Insured Bmgoud...

(IMPORTANT: PLEASE TURN OVER)

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)

SECTION A

DETAILS OF HOSPITAL

a) Name of the hospital: JEEVAN HOSPITAL

a) Hospital ID.

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

c) Name of the treating doctor: DR SUNDER VYAS FIRST NAME MIDDLE NAME

e) Qualification: MD f) Registration No. with State Code: 03998 g) Phone No.

SECTION B

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient: MAHESH MALAVIYA FIRST NAME MIDDLE NAME

b) IP Registration Number: 8230615 c) Gender: Male ☐ Female ☐ d) Age: Years 32 Months MM e) Date of birth: DD MM YY

f) Date of Admission: 13 08 24 g) Time: 06 5 PM h) Date of Discharge: 14 08 24 i) Time: 08 00

j) Type of Admission: Emergency ☐ Planned ☐ Day Care ☐ Maternity ☐ k) If Maternity l) Date of Delivery: DD MM YY ii) Gravida Status: :

l) Status at time of discharge: Discharge to home ☐ Discharge to another hospital ☐ Deceased ☐ m) Total claimed amount

SECTION C

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a)	ICD 10 Codes	Description	b)	ICD 10 PCS	Description
i. Primary Diagnosis		DENGUE FEVER	i. Procedure 1:		
ii. Additional Diagnosis:			ii. Procedure 2:		
iii. Co-morbidities:			iii. Procedure 3:		
iv. Co-morbidities:			iv. Details of Procedure:		

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. vi. If not reported to police give reason:

SECTION D

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
- ☑ 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

SECTION E

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: e) Number of inpatient beds f) Facilities available in the hospital i. OT ☐ Yes ☐ No ii. ICU ☐ Yes ☐ No

iii. Others:

SECTION F

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: 30 08 24

Place: Karmanghat

Signature and Seal of the Hospital Authority:

JEEVAN HOSPITAL Hyd -79. Karmanghat

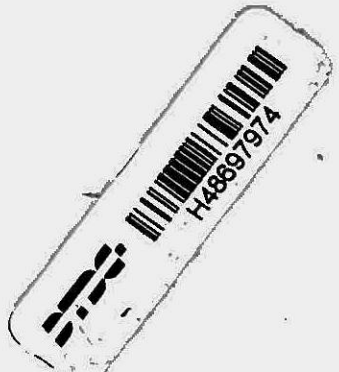
TO,

MEDI ASSIST INSURANCE TPA PVT Ltd

2nd floor, white HOUSE,
H-NO- 6-3-1192/1/1, 3rd BLOCK.....
Kundanbagh colony, Begumpet
Hyderabad, Telangana, PIN :- 500016

Internal :-

Name :- Mahesh Balamoni
Company :- Tech Mahindra
Emp ID :- 665325
Ph :- 9951598086,



From :-
Mahesh Balamoni
Ph :- 9951598086