care HEALTH INSURANCE

Health Claim Form

Part A

1. To be filled in by the Insured.
2. The issue of this Form is not to be taken as an admission of liability.
3. To be filled in block letters.

Claim Intimation No.:_____

Section A - Details of Primary Insured

a) Policy No. : 73510100

b) SL No./Certificate No.:

c) Company/TPA ID No.: A2343115

d) Name : DYNATECH SYSTEMS PVT LTD

e) Address : 18, TIMES CORPORATE PARK THALTEJ AHMEDABAD

City: AHMEDABAD

State : GUJARAT

Pin Code: 380059

Phone Number :

E-mail : hardik.shah3982@gmail.com

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 : / /

c) If yes, Company Name :

Policy Number :

Sum Insured (Rs.):

d) Have you ever been hospitalized in the last 4 years since inception of the contract? Yes No

Date: / /

Diagnosis: _____

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

f) If yes, Company Name :

Section C - Details of Insured Person Hospitalised

Title : Mr. ✓ Ms.

a) Name : ASHVINI (First) - DINESH BHAI (middle) LAKHANI (Last Name)

b) Gender : M ✓ F c) Age: 28/08 d) Date of Birth: 16/08/1995

e) Relationship with Primary Insured : Self ✓ Spouse Child Father Mother

Others (Please Specify) _____

f) Occupation : ✓ Service Self Employed Homemaker Retired Student Others (Please Specify) _____

g) Address : AS ABOVE

City:

State :

Pin Code:

Phone Number :

E-mail :

Section D - Details of Hospitalisation

a) Name of Hospital where Admitted : SHIV HOSPITAL

b) Room Category occupied : Day Care ✓ Single Occupancy Twin Sharing 3 or more beds per room

c) Hospitalisation due to : Injury ✓ Illness Maternity

d) Date of Injury/Date Disease first detected/Date of Delivery : / / (DD/MM/YYYY)

e) Date of Admission : 08/02/2024 f) Time of Admission : 12 : 00 (HH:MM)

g) Date of Discharge : 09/02/2024 h) Time of Discharge : 18 : 00 (HH:MM)

i) If Injury, give cause : Self Inflicted Road Traffic Accident Substance Abuse/Alcohol Consumption

i) If Medico Legal : Yes ✓ No ii) Reported to Police : Yes No

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.

(iii) Post-hospitalization Expenses : Rs.

(iv) Health Check-up cost : Rs.

(v) Ambulance Charges : Rs.

(vi) Others (code) : Rs.

Total : Rs.

(vii) Pre-hospitalization period : days

(viii) Post-hospitalization period : days

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

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.

d) Claim Documents Submitted - Checklist

(i) Claim Form Duly signed :

(ii) Copy of the claim intimation, if any :

(iii) Hospital Main Bill :

(iv) Hospital Break-up Bill :

(v) Hospital Bill Payment Receipt :

(vi) Hospital Discharge Summary :

(vii) Pharmacy Bill :

(viii) Operation Theatre Notes :

(ix) ECG :

(x) Doctor's request for investigation :

(xi) Investigation Reports (Including CT/MRI/USG/HPE) :

(xii) Doctor's Prescriptions :

(xiii) Others _____

Section F - Details of Bills Enclosed

S No.	Bill No.	Date	Issued by
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

In case of more details, please attach a separate sheet.

Towards	Amount (INR)
Hospital Main Bill	13,438
Pre-hospitalization Bills: ____Nos	
Post-hospitalization Bills: ___Nos	
Pharmacy bills	

Section G - Details of Primary Insured's Bank Account

a) PAN :

b) Account Number :

c) Bank Name & Branch :

d) Cheque/DD payable details :

e) IFSC Code :

Section H - Declaration by the Insured

I hereby declare that the information furnished in this claim form is true & 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 & authorize TPA/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 : 23/02/2024

Signature of the Insured :

Place : Kusindra

Part B

1. To be filled in by the hospital.
2. The issue of this Form is not to be taken as an admission of liability.
3. Please include the original pre-authorization request form in lieu of PART A.
4. To be filled in block letters.

Section A - Details of Hospital

a) Name of the Hospital : SHIV HOSPITAL
b) Hospital ID :
c) Type of Hospital : Network / Non-network (if non-network fill section E)
d) Name of the treating doctor :
e) Qualification :
f) Registration No. with State Code :
g) Contact No. :

301, Diamond Ickon, Nr. Sai Elegance, [illegible] Road, Kasindra-382210

Dr. CHIRAG PATEL
M.B.B.S.,M.D. PHYSICIAN
Reg. No. G-52669

Section B - Details of the Patient Admitted

a) Name of the Patient: MISS ASHVINIBEN LAKHANI (Middle Name)
b) IP Registration No. : I230-2024
c) Gender : M ✓F d) Age : 28 / e) Date of Birth : / /
f) Date of Admission : 08/02/2024 g) Time of Admission : 12:00 (HH:MM)
h) Date of Discharge : 09/02/2024 i) Time of Discharge : 18:00 (HH:MM)
j) Type of Admission : ✓Emergency Planned Day Care ☐ Maternity
k) If Maternity,
(i) Date of Delivery : / / (ii) Gravida Status : _____
l) Status at the time of discharge : ✓Discharge to home Discharge to another hospital ☐ Deceased
m) Total Claimed Amount :

Section C - Details of Ailment Diagnosed (Primary)

a) (i) Primary Diagnosis : ICD 10 Code : AGE Description : _____
(ii) Additional Diagnosis : ICD 10 Code : Description : _____
(iii) Co-morbidities : ICD 10 Code : Description : _____
(iv) Co-morbidities : ICD 10 Code : Description : _____
b) (i) Procedure 1 : ICD 10 PCS Description : _____
(ii) Procedure 2 : ICD 10 PCS : Description : _____
(iii) Procedure 3 : ICD 10 PCS : Description : _____
(iv) Details of Procedure : _____
c) Present ailment is a complication of PED : Yes No
If yes, specify details : _____
d) Pre-authorization obtained : Yes No
e) Pre-authorization no. :
f) If authorization by network hospital not obtained, give reason : _____

g) 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 - Checklist

(i)	Duly signed Claim Form	:	(ix)	Investigation Report	:
(ii)	Original Pre-authorization request	:	(x)	CT/ MRI/ USG /HPE investigation reports	:
(iii)	Copy of Pre-authorization approval letter	:	(xi)	Doctor's reference slip for investigation	:
(iv)	Copy of photo ID card of patient verified by hospital	:	(xii)	ECG	:
(v)	Hospital Discharge Summary	:	(xiii)	Pharmacy Bills	:
(vi)	Operation Theatre notes	:	(xiv)	MLC report & Police FIR	:
(vii)	Hospital Main Bill	:	(xv)	Original death summary from hospital where applicable:	
(viii)	Hospital Break-up Bill	:	(xvi)	Any other, please specify_____	:

Section E - Additional Details in case of Non-Network Hospital (Only fill in case of non-network hospital)

a) Address of the Hospital :

SHIV HOSPITAL
301, Diamond Ickon,
Nr. Sai Elegance,
Dholka Road, Kasindra-382210

City :

State : Pin Code :

b) Contact No. : 9 4 2 2 8 - 4 3 3 4 2

c) Registration No. with State Code :

d) Hospital PAN : G - 5 2 6 6 9

e) No. 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

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 facts, our right to claim under this claim shall be forfeited.

SHIV HOSPITAL KASINDRA

Date : 17/02/2024

Signature & Seal of the Hospital Authority : _____

Place : Kasindra

Dr. CHIRAG PATEL
M.B.B.S.,M.D. PHYSICIAN
Reg. No. G-52669
Phone:- 6357576757

Consent Letter

Date 17/02/2024

Dr. CHIRAG PATEL
M.B.B.S.,M.D. PHYSICIAN
Reg. No. G-52669

To,
The Medical Suprintendent
_____
_____
_____

Dear Sir,

Re : Authorization in favour of M/s Care Health Insurance Limited and its authorized agents.

I have undergone treatment for

illness

_____ from 08-02-2024 to 09-02-2024 in your hospital under Inpatient No I230/2024

I hereby authorise M/s Care Health Insurance Limited and/or its authorised representative to seek any medical information / records from you or from the Medical Practitioners who has attended on me in connection with the above ailment.

I have no objection in case they seek such information/records in whatsoever regards.

Thanking You,
Yours Faithfully

(Signature of the Claimant)
Address of the Insured -

Dr. CHIRAG PATEL
M.B.B.S.,M.D. PHYSICIAN
Reg. No. G-52669

SHIV HOSPITAL
301, D...
...32210