RELIGARE Values that bind | Health Insurance

Ab Health Hamesha

Claim Form - 'Group Care'

To be filled by the Insured. Please fill in CAPITAL only.

Pre-Authorization obtained : ☐ Yes ☐ No If Yes, Pre-Authorization No.: _____ If No, Claim Intimation No.: _____

Details of Primary Insured

Policy No. :

Name : (First Name) (Last Name)

Name of the Entity :

Member ID/Employee ID : Grade : Sum Insured :

Address :

City :

State : Pin Code :

Landline : - Mobile :

E-mail :

Insurance History

Currently covered by any other Mediclaim/Health Insurance : ☐ Yes ☐ No

If yes, Insurer's Name :

Policy Number : Sum Insured :

Date of commencement of the above specified insurance, without any break : / / (DD/MM/YYYY) (Attach Policy Copy)

Have you been hospitalized in the last 4 years : ☐ Yes ☐ No

- Date : / / (DD/MM/YYYY)
- Illness/Treatment : _____

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

Insurer's Name :

Details of the Insured Person Hospitalized

Title : ☐ Mr. ☐ Ms.

Name :

Member ID :

Age (in years/months) : / (YY/MM) Gender : ☐ M ☐ F

Date of Birth : / / (DD/MM/YYYY)

Relationship with Primary Insured : ☐ Self ☐ Spouse ☐ Son ☐ Daughter ☐ Father ☐ Mother ☐ Others Specify _____

Address :

City :

State : Pin Code :

Landline : - Mobile :

E-mail :

Details of Hospitalization

Hospital Name :

Room Category : ☐ Day Care ☐ Single Occupancy ☐ Twin Sharing ☐ 3 or more beds

Hospitalization due to : ☐ Injury ☐ Illness ☐ Maternity

Date of Injury/Detection of Disease/Delivery : / / (DD/MM/YYYY)

Date of Admission : / / (DD/MM/YYYY)

Time of Admission : : (HH:MM)

Date of Discharge : / / (DD/MM/YYYY)

Time of Discharge : : (HH:MM)

If Injury, specify cause : ☐ Self inflicted ☐ Road Traffic Accident ☐ Substance Abuse/Alcohol Consumption

Medico Legal Case : ☐ Yes ☐ No

Reported to Police : ☐ Yes ☐ No

MLC Report & Police FIR attached : ☐ Yes ☐ No

System of Medicine : _____

Details of Claim

a. Details of the treatment expenses claimed

- Pre-hospitalization Expenses :
- Hospitalization Expenses :
- Post-hospitalization Expenses :
- OPD :
- Others _____ :
- Others _____ :
- Others _____ :
- Others _____ :
- Others _____ :
- Additional Services :
- Total :

b. Pre-hospitalization period (Days) :

c. Post-hospitalization period (Days) :

d. Claim for domiciliary hospitalization : ☐ Yes ☐ No (If yes, provide the details in annexure)

Original Claim Documents submitted ñ checklist

- Duly signed Claim Form : ☐
- Hospital Bill : ☐
- Hospital Break-up Bill : ☐
- Hospital Bill Payment Receipt : ☐
- Hospital Discharge Summary : ☐
- Pharmacy Bill : ☐
- Operation Theater notes : ☐
- ECG : ☐
- Doctor's request for investigation : ☐
- Investigation Reports (Including CT/MRI/USG/HPE) : ☐
- Doctor's prescriptions : ☐
- Others _____ : ☐

Details of Bills Enclosed

S No.	Bill No.	Date	Issued by	Towards	Amount (INR)
1				Hospital bill	
2				Pre-hospitalization bills	
3				Post-hospitalization bills	
4				Pharmacy bills	
5					
6					
7					
8					
9					

Primary Insured's Bank Details

Bank :

Account Number :

Branch :

PAN :

Cheque/DD No. :

IFSC/Swift Code :

To be filled by the Hospital. Please fill in CAPITAL only.

Hospital Details

Hospital Name :

Hospital ID :

Type of Hospital : ☐ Network ☐ Non-network

Name of treating doctor :

Qualification :

Registration No. with State Code :

Contact No. :

Details of Patient Admitted

Patient name :

IP Registration No. :

Gender : ☐ M ☐ F

Age (in years/months) : ☐☐ / ☐☐

Date of Birth : ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)

Date of Admission : ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)

Time of Admission : ☐☐ : ☐☐ (HH:MM)

Date of Discharge : ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)

Time of Discharge : ☐☐ : ☐☐ (HH:MM)

Type of Admission : ☐ Emergency ☐ Planned ☐ Day Care ☐ Maternity

If Maternity,

- Date of Delivery : ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)
- Gravida Status : _____

Status at the time of discharge : ☐ Discharge to home ☐ Discharge to another hospital ☐ Deceased

Details of Ailment Diagnosed

Primary Diagnosis : ICD 10 Code : ☐☐☐☐ Description : _____

Additional Diagnosis : ICD 10 Code : ☐☐☐☐ Description : _____

Co-morbidities : ICD 10 Code : ☐☐☐☐ Description : _____

Co-morbidities : ICD 10 Code : ☐☐☐☐ Description : _____

Procedure 1 : ICD 10 Code : ☐☐☐☐ Description : _____

Procedure 2 : ICD 10 Code : ☐☐☐☐ Description : _____

Procedure 3 : ICD 10 Code : ☐☐☐☐ Description : _____

Details of Procedure : _____

a. Present ailment is a complication of PED : ☐ Yes ☐ No

If yes, specify details : _____

b. Pre-authorization obtained : ☐ Yes ☐ No

c. Pre-authorization no. : ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

d. If authorization by network hospital not obtained, give reason : _____

_____

e. Hospitalization due to Injury : ☐ Yes ☐ No

If yes, give reason : ☐ Self inflicted ☐ Road Traffic Accident ☐ Substance Abuse/Alcohol Consumption

If Injury due to Substance abuse/Alcohol consumption, Test conducted to establish this : ☐ Yes ☐ No
(If yes, attach reports)

Medico Legal Case : ☐ Yes ☐ No

Reported to Police : ☐ Yes ☐ No

FIR No. : ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

If not reported to Police, give reason : _____

Claim Documents Submitted - Checklist

- Duly signed Claim Form : ☐
- Original Pre-authorization request : ☐
- Copy of Pre-authorization approval letter : ☐
- Copy of photo ID card of patient verified by hospital : ☐
- Hospital Discharge Summary : ☐
- Operation Theatre notes : ☐
- Hospital Bill : ☐
- Hospital Break-up Bill : ☐
- Hospital Bill Payment Receipt : ☐
- Investigation Reports : ☐
- CT/MRI/USG/HPE investigation reports : ☐
- Doctor's request for investigation : ☐
- ECG : ☐
- Pharmacy Bills : ☐
- MLC report & Police FIR : ☐
- Original death summary from hospital, where applicable : ☐
- Others, please specify_____ : ☐

Details in case of Non-Network Hospital

Hospital Address :

City :

State : PIN Code :

Contact No. : -

Registration No. :

PAN :

No. of inpatient beds :

Facilities available in the hospital : OT : Yes No

ICU : Yes No

Others : _____

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, my right to claim reimbursement shall be forfeited. I also consent & authorize the TPA/insurance company to seek necessary medical information/documents from any hospital/medical practitioner who has attended to me. 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 pre/post hospitalization claim, if any.

Date : / / (DD/MM/YYYY) Signature of the Insured : _____

Place : _____

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 fact, our right to claim shall be forfeited. Signature of the insured is taken on this claim form after Part – B is fully filled up by us.

Date : / / (DD/MM/YYYY) Signature & Seal of the Hospital Authority : _____

Place : _____