HDFC ERGO General Insurance Company Limited

HDFC Group Health Insurance Claim Form

CLAIM For Pre-hospitalization Expenses

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CLAIM FORM – PART A
TO BE FILLED IN BY THE INSURED

The issue of this Form is not to be taken as an admission of liability

SECTION A – DETAILS OF PRIMARY INSURED

a) Policy No. 2 9 9 9 2 0 4 4 5 2 0 4 7 8 3 0 3 8 b) Sl. No/ Certificate No: c) Company/ TPA ID No

d) Name DINESH KUMAR

e)Address VPO KASWAR TEH BARSAR DISTT HAMIRPUR HP 174313

Phone No 7 0 1 8 0 9 9 6 1 7 Email ID

SECTION B- DETAILS OF INSURANCE HISTORY

a) Currently covered by any other Medi Claim Health Insurance. Yes ☐ No ☑ b) Date of commencement of first insurance without break

c) If Yes, Company Name

Policy No. Sum Insured

d) Have you been hospitalized in the last four years since inception of the contract Yes ☐ No ☐ b) Date

Diagnosis

e) Previously covered by any other Medi Claim / Health Insurance Yes ☐ No ☐

f) If yes, Company Name

SECTION C- DETAILS OF INSURED PERSON HOSPITALISED

a) Name PARV THAKUR

b) Relationship ☐ Self ☐ spouse ☑ Child ☐ Father ☐ Mother Other_____

c) Date of Birth 3 0 0 3 2 0 2 4 d) Age 0 1 0 5

e) Address (If different than above)

f) Gender ☑ Male ☐ Female Occupation: ☐ Service ☐ Self Employed ☐ Homemaker ☐ Student ☐ Retired Others_____

h) Telephone No 7 0 1 8 0 9 9 6 1 7 i) Mobile No

j) E-mail ID, if any

SECTION D- DETAILS OF HOSPITALISATION

a) Name of the Hospital where admitted

SRI KRISHANA CHILDREN HOSPITAL

b) Room Category occupied ☐ Daycare ☑ Single Occupancy ☐ Twin Sharing ☐ 3 or more beds per room

c) Hospitalization due to ☑ Illness ☐ Injury ☐ Maternity

d) Date of Injury/ Date of disease first detected/ Date of delivery 20th June e) Date of admission 23-06-25 f) Time 11:15 Am

g) Date of discharge 2 6 0 6 2 0 2 5 h) Time 0 6:0 0

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 ☑ Allopathic ☐ Other systems of medicine

SECTION E- DETAILS OF CLAIM

a) Claim under Hospitalization Cover

i) In-Patient Hospitalization YES ☐ NO ☐ ii) Pre-hospitalization Expenses YES ☑ NO ☐ iii) Post-hospitalization Expenses YES ☐ NO ☑

iv) Day Care Procedures YES ☐ NO ☐ v) Domiciliary Hospitalization YES ☐ NO ☐ vi) Road Ambulance Cover YES ☐ NO ☑

vii) Organ Donor YES ☐ NO ☑

CF/Ver - 1 FEB 2021

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b) Please tick the applicable Optional Cover claimed under Hospitalization Cover:

i) Hospital Cash YES ✓ NO ☐ <Please provide details>_____

ii) Preventive Health Check Up YES ☐ NO ☐ <Please provide details>_____

iii) Restore Benefit YES ☐ NO ☐ <Please provide details>_____

iv) Alternative Treatment YES ☐ NO ☐ <Please provide details>_____

Claim Documents Submitted Check List Hospitalization Claim		Check list of additional documents for Critical Illness claims
☐ Duly filled and signed Claim Form	☐ Copy of intimation letter if any	☐ Medical certificate confirming the diagnosis of Critical Illness
☐ Hospital Main Bill	☐ Hospital bill break up	☐ Certificate from attending Medical Practitioner confirming the duration of illness
☐ Hospital Bill Payment Receipt	☐ Hospital Discharge summary	☐ First consultation letter and subsequent prescriptions
✓ Pharmacy Bill	☐ Operation theatre notes	☐ Indoor case papers if applicable
☐ Investigation / diagnostic Reports with bills and payment receipt	☐ Doctors request for investigations	☐ FIR copy or medico legal certificate(wherever applicable)
☐ ECG	☐ Prescriptions	☐ Photo ID and Age proof
☐ Copy of the Network Provider's Registration Certificate	☐ MLC/FIR copy of applicable	☐ Death Summary with Death Certificate (In death claims only)
☐ KYC Documents	☐ implant stickers for all implants used during surgeries	☐ Invoice for Vaccination and payment receipt

SECTION – F DETAILS OF BILLS ENCLOSED

S no	Bill No	Date	Issued By	Towards	Amount (Rs)
1	SB-3917	20/06/25	Neha		Rs. 1928
				Total	Rs. 1928

SECTION – G DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

a) PAN DVRPK6011E b) Account Number 65146325168

c) Bank Name/ Branch SBI d) Payable details: ✓ Cheque ☐ DD

e) IFSC Code SBIN0005296 e) *please attach a cancelled cheque pertaining to the same

f) MICR No

Note:

It is agreed that the Policyholder/Claimant will intimate in writing to HDFC ERGO General Insurance Co. Ltd. about any change in bank account details.

In an event Insured person bears expenses for treatment please provide account details of Insured Persons in the above format along with proof of incurring such expenses.

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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 / 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 08/09/25 Place VNA Signature of Insured

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 pre-authorization request form in lieu of PART A

SECTION A – DETAILS OF HOSPITAL

a) Name of the Hospital where treate

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) Phone No:

SECTION B – DETAILS OF PATIENT ADMITTED

a) Name of the patient

b) IP Registration Number c) Gender ☐ Male ☐ Female

d) Age e) Date of Birth

f) Date of Admission h) Date of Discharge

i) Time of Discharge j) Type of Admission ☐ Emergency ☐ Planned ☐ Daycare ☐ Maternity

k) If Maternity i) Date of Delivery ii) Gravida Status

l) Status at time of discharge ☐ Discharged to Home ☐ Discharged to another Hospital ☐ Deceased Total Claimed Amount

SECTION C – DETAILS OF AILMENTS DIAGNISED (PRIMARY)

a) ICD 10 Codes	Primary Diagnosis		Additional Diagnosis		Co-morbidities	
Details of Procedure/s done						
b) ICD 10 PCS	Procedure 1		Procedure 2		Procedure 3	
i) Pre-authorization obtained	☐ YES ☐ NO		j) Pre-authorization No			
f) If authorization by network hospital not obtained, give reason						
g) Hospitalisation due to Injury	☐ YES ☐ NO		i) If yes, give cause			
Self inflicted?	☐ YES ☐ NO	Road Traffic Accident	YES ☐ NO ☐	Substance Abuse /Alcohol Consumption	YES ☐ NO ☐	

ii) If Injury due to Substance abuse / alcohol consumption, Test Conducted to establish this:		☐ YES ☐ NO (If yes, attach reports		iii) Medico Legal	☐ YES ☐ NO
iv) Reported to Police	☐ YES ☐ NO			v) FIR No	
vi) If not reported to Police give reasons					

SECTION D – CLAIM DOCUMENTS SUBMITTED – CHECKLIST

Claim form duly filled and signed	Investigation reports
Pre authorization Request	CT/MRI/USG/HPE investigation Report
Copy of Pre-authorization approval Letter	Doctor's reference slip for Investigation
Copy of photo ID card of patient verified by Hospital	ECG
Hospital Discharge Summary	Pharmacy Bills
Operation Theatre Notes	MLC Report & Police FIR
Hospital Main Bill	Death summary from hospital where applicable
Hospital break up Bill	Any other, Pl specify

SECTION E – DETAILS IN CASE OF NON NETWORK HOSPITAL

Address of the Hospital

b) Phone NO: c) Registration no with State Cod

d) Hospital PAN e) No of In-patient Beds

f) Facilities available in Hospital OT ☐ YES ☐ NO ICU ☐ YES ☐ NO Others

SECTION F – DECLARATION BY 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, suppre or concealment of any material fact, our right to claim under this claim shall be forfeited.

Signature and seal of the Hospital Auth

Date:

Place:

LIST OF ENCLOSURES FOR SUBMISSION OF CLAIM

Note:

1. When bills, receipts, prescriptions, reports and other documents are submitted to the other insurer or to the reimbursement provider, verified photocopies attested by other organization/provider have to be submitted.
2. If bills, receipts, prescriptions, reports and other documents are submitted to Usand Insured Person requires same for claiming from other organization/provider, the request from the Insured Person We will provide attested copies of the bills and other documents submitted by the Insured Person.
3. If below mentioned documents are not provided in full or are insufficient for Us to consider the claim, then Wemay request additional information or documentation.

List of Documents for Reimbursement Claims:

- ☐ Completely filled claim form, duly signed (by claimant/proposer) and stamped (by hospital).
- ☐ Photo ID & Age Proof
- ☐ Copy of claim intimation letter / reference of Claim Intimation Number in the absence of main claim documents
- ☐ Copy of the Hospital's Registration Certificate/Hospital Registration number in case of hospitalization in any non network hospital of HDFC ERGO GIC or certificate hospital authorities providing facilities available including number of beds.
- ☐ Discharge Card / Day Care Summary / Transfer Summary

- ☐ Final hospital bill with all deposit and final payment receipt and refund receipt(s), if advance amount refunded
- ☐ Invoice with payment receipt and implant stickers for all implants used during surgeries e.g. lens sticker and invoice in cataract Surgery, stent invoice and sticker in Angioplasty Surgery.
- ☐ All previous consultation papers indicating history and treatment details for current Illness and advice for current hospitalization.
- ☐ All diagnostic reports (including imaging and laboratory) along with prescription by Medical Practitioner and invoice / bill with receipt from diagnostic centre
- ☐ All medicine / pharmacy bills along with prescription by Medical Practitioner
- ☐ MLC / FIR Copy – in Accidental cases only
- ☐ History of alcohol consumption or any intoxication certified by first treating doctor in case of accidental cases.
- ☐ Copy of Death Summary and copy of Death Certificate (in death claims only)
- ☐ Pre and Post-Operative Imaging reports
- ☐ Copy of indoor case papers with nursing sheet detailing medical history of the patient, treatment details, and patient's progress (to be submitted wherever required by the insurer).
- ☐ Invoice for Vaccination and payment receipt
- ☐ KYC documents (in all claims above Rs 1 lakh) - (Ration Card/ Driving License/ Aadhar Card/ Passport /any other Government authorized identity proof of the Proposer carrying name, photograph & address) and duly filled KYC form with 1 signed across passport size coloured photograph of the Proposer. ***
- ☐ Duly filled NEFT form with cancelled blank cheque (with IFSC code, A/C number, and name mentioned on cheque leaf)
- ☐ Settlement letter(s), copy(-ies) of payment receipts, and entire certified copy of paid claims in case of partial claim settlement from other insurer.

*** In case of death of proposer, the same document requirement would be for nominee/legal heir of proposer (NOC in favour of 1 or more than 1 undisputedly selected legal heir(s) by remaining legal heir(s).

In-patient Treatment /Day Care Procedures

- ☐ Duly filled and signed Claim Form.
- ☐ Photocopy of ID card / Photocopy of current year policy.
- ☐ Detailed Discharge Summary with date of admission & discharge, clinical history, past history / procedure details/ Day care summary from the hospital.
- ☐ Consolidated hospital bill with break up of each Item, duly signed by the insured.
- ☐ Payment Receipt of the hospital bill.
- ☐ First Consultation letter and subsequent Prescriptions.
- ☐ Bills, payment receipts and Reports for investigation.
- ☐ Medicine bills and receipts with corresponding Prescriptions.
- ☐ Invoice/Sticker of implants/bills for Implants (viz. Stent /PHS Mesh/ IOL etc.) with payment receipts.

Road Traffic Accident

In addition to the In-patient Treatment documents:

- ☐ Copy of the First Information Report from Police Department / Copy of the Medico-Legal Certificate.

In Non Medico legal cases

- ☐ Treating Doctor's Certificate giving details of injuries (How, when and where injury sustained)

In Accidental Death cases

- ☐ Copy of Post Mortem Report & Death Certificate (If conducted)

Pre and Post-hospitalization

- ☐ Duly filled and signed Claim Form.
- ☐ Photocopy of ID card / Photocopy of current year policy.
- ☐ Medicine bills, payment receipt with prescriptions.
- ☐ Investigations bills, payment receipt with prescriptions and report.
- ☐ Consultation documents and bills, payment receipt with prescription.
- ☐ Copy of the Discharge Summary of the main claim.(except for out patient dental claim)

Organ Donation/Transplantation

In addition to the documents of general hospitalization

- ☐ Organ Function test / blood test proving organ failure.
- ☐ Treatment Certificate issued by the Transplant Surgeon of the hospital concerned.

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Ambulance Benefit

- ☐ Duly filled and signed Claim Form.
- ☐ Photocopy of ID card / Photocopy of current year policy.
- ☐ Bill with Payment Receipt.
- ☐ Treating Doctor's consultation prescription indicating Emergency Hospitalization.

Hospital Cash Benefit

- ☐ Duly filled and signed Claim Form.
- ☐ Discharge card / day care summary / transfer summary
- ☐ Final Hospital Bill
- ☐ Previous consultation papers indicating history and treatment details for current ailment.
- ☐ Diagnostic test reports (including imaging and laboratory) along with the Medical prescription & copy of invoice / bill and receipt from the diagnostic centre.
- ☐ MLC / FIR copy – in Accidental cases only
- ☐ Death summary & death certificate (in death claims only)

Preventive Health Check up

- ☐ Duly filled and signed Claim Form.
- ☐ Health check up test reports
- ☐ Bill and receipt from the diagnostic centre.

For Death Cases

In addition to the In-patient Treatment documents:

- ☐ Death Summary from the hospital.
- ☐ Copy of the Death certificate from treating doctor or the hospital authority.
- ☐ Copy of the Legal heir certificate, if the claim is for the death of the principle insured.
- ☐ Bank Account Details of nominee/legal heir with a copy of cancelled cheque

Customer Identification Procedure (as per KYC norms of IRDAI)	
Please submit the following documents in case of claim amount exceeds Rs. 100,000	
Legal name and any other names used (Any one of the mentioned documents)	Passport/ PAN Card/ Voter's Identity Card/ Driving License/ Letter from a recognized public authority or public servant verifying the identity and residence of the customer
Proof of Residence (Any one of the mentioned documents)	Telephone bill/ Bank account statement/ Letter from any recognized public authority/ Electricity bill/ Ration card