Medi Assist

Medi Assist Insurance TPA Private Limited

MEDI ASSIST HYD01237168

REIMBURSEMENT CLAIM FILE : PRIVATE AND CONFIDENTIAL

DOCUMENT INDEX SHEET

MAID		Claim No	
Claim Type	☑ Main ☐ Domi/OPD	☐ Pre Hosp ☐ IR/Def. Doc	☐ Post Hosp ☐ Priority Claim
Policy No.		Policy Holder	
Benif Name	M Seenit	Processing Branch	
Claim Amount		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** 40

☑ Dis. Summary No of Pages [ ] ☐ Reports

Remarks... Cheque Not Given

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

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 SECTION B SECTION C SECTION D SECTION E SECTION F SECTION G SECTION H

DETAILS OF PRIMARY INSURED:

a) Policy No.: MD1500387901780 b) Sl. No/ Certificate no.

c) Company / TPA ID (MA ID)No: ALPLA INDIA

d) Name: MANHAS SUMIT

e) Address: VPO TIKKER TEH PALAMPUR DISTT KANGRA

City: PALAMPUR State: HIMACHAL PRADESH

Pin Code 176087 Phone No: 8219746912 Email ID: Sumitmanhas38@gmail.com

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:

DETAILS OF INSURED PERSON HOSPITALIZED:

a) Name: MANHAS SUMIT

b) Gender Male ☑ Female ☐ c) Age years 25 Months M M d) Date of Birth 11 02 1998

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) :

SAME AS ABOVE

City: State:

Pin Code Phone No: Email ID:

DETAILS OF HOSPITALIZATION:

a) Name of Hospital where Admited: ACE MEDICENTRE BADDI

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: 12 01 23 f) Time 09 00 g) Date of Discharge: 13 01 23 h) Time: 10 00

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:

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.

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
- ☐ Doctor's request for investigation
- ☐ Investigation Reports (Including CT / MRI / USG / HPE)
- ☐ Doctor's Prescriptions
- ☐ Others

DETAILS OF BILLS ENCLOSED:

Sl. No.	Bill No.	Date	Issued by	Towards	Amount (Rs)
1.	8439	17/12/22	HOPE DIAGNOSTICS	Hospital main Bill	3000
2.	195	13/01/23	Hospital	Pre-hospitalization Bills: Nos	2630
3.	195	13/01/23	Hospital	Post-hospitalization Bills: Nos	370
4.				Pharmacy Bills	
5.					
6.					
7.					
8.					
9.					
10.					3000

RECEIVED 20 FEB 2023 MEDI ASSIST INSURANCE TPA (P) LTD HYDERABAD

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT:

a) PAN: FJPPM6131P b) Account Number: 919010050769894

c) Bank Name and Branch: AXIS BANK NALAGARH

d) Cheque / DD Payable details: e) IFSC Code: UTIB0003610

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 reimbrusement 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 15 02 1998 Place: BADDI Signature of the Insured

(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)

DETAILS OF HOSPITAL

a) Name of the hospital: ACE MEDICENTRE BADDI

a) Hospital ID: 5436 HPMC c) Type of Hospital: Network : ☐ Non Network ☑ (if non network fill section E)

c) Name of the treating doctor: GUPTA SHISHIR

e) Qualification: f) Registration No. with State Code: 5436 HPMC g) Phone No. 9023285999

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient: MANAS SUMIT NAME

b) IP Registration Number: c) Gender: Male ☑ Female ☐ d) Age: Years 25 Months MM e) Date of birth: 10 02 98

f) Date of Admission: 12 01 23 g) Time: 09 00 h) Date of Discharge: 13 01 23 i) Time: 10 00

j) Type of Admission: Emergency ☐ Planned ☑ Day Care ☐ Maternity ☐ k) If Maternity i) 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 30000/-

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a)	ICD 10 Codes	Description	b)	ICD 10 PCS	Description
i. Primary Diagnosis		Right DNS	i. Procedure 1:		Septoplasty
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. NA vi. If not reported to police give reason:

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

ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)

a) Address of the Hospital PLOT NO 89 HOUSING BOARD PHASE III

City: BADDI State: HP

Pin Code: 173205 b) Phone No. 9023285999 c) Registration No. with State Code: 5436 HPMC

d) Hospital PAN: e) Number of inpatient beds 06 f) Facilities available in the hospital i. OT ☑ Yes ☐ No ii. ICU ☐ Yes ☑ No

iii. Others:

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: 15 02 23

Place: Baddi

Signature and Seal of the Hospital Authority:

Dr. SHISHIR GUPTA
M.B.B.S ; M.S. (E.N.T)
ACE MEDICENTRE
No. 89, Phase-III, Housing Board- Baddi (HP)
Reg. No. 5436 (HPMC)

SECTION A | SECTION B | SECTION C | SECTION D | SECTION E | SECTION F

The New India Assurance Company Limited

M/S.ALPLA INDIA PRIVATE LIMITED

Emp Name : Sumit Manhas

MDID No : MDI5-0038790178

Emp No : 1232

Name : Sumit Manhas

Date of Birth : 11/02/1998 Age : 24

MDIndia Health Insurance (TPA) Pvt. Ltd.

S NO. - 46/1, E-Space, A Wing, 3rd floor,Pune Nagar Road, Vadgaonsheri, Pune - 411014 Website : www.mdindiaonline.com

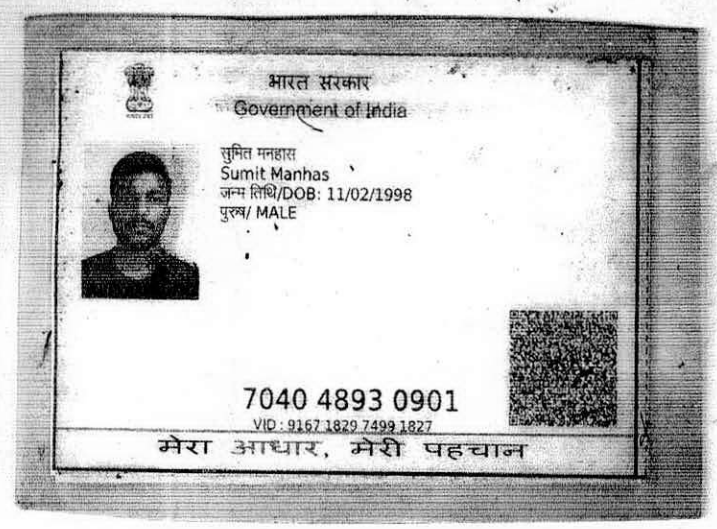
HEALTH INSURANCE CARD

This card is for identification purpose only.

General & Claim Enquiry Helpline		Cashless Enquiry Helpline	
Toll Free	: 1800-209-7777	Toll Free	: 1800-209-7800
Uan No	: 1860-233-4446	Uan No	: 1860-233-4448
Fax No	: 1860-233-4447	Fax no	: 1860-233-4449
Email :	customercare@mdindia.com	Email :	authorisation@mdindia.com

TERMS AND CONDITIONS

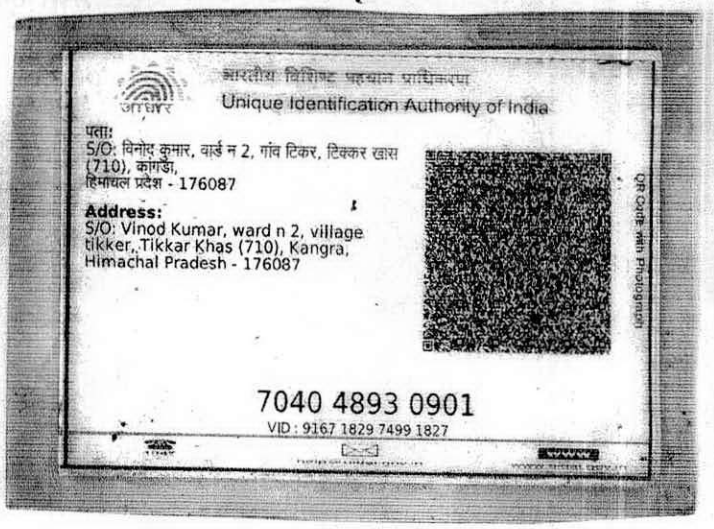
1. Pre-authorisation is compulsory from tpa prior to a planned admission and within 24 hours for emergencies.
2. Admission for investigation/evaluation not covered.
3. All terms and conditions of the policy would be applicable.
4. Cashless hospitalisation in network hospitals can be obtained in conjunction with this card, an authorisation letter issued by the tpa and photo identification such as voters id, driver license, passport etc.


भारत सरकार
Government of India

सुमित मनहास
Sumit Manhas
जन्म तिथि/DOB: 11/02/1998
पुरुष/ MALE

7040 4893 0901
VID : 9167 1829 7499 1827

मेरा आधार, मेरी पहचान


भारतीय विशिष्ट पहचान प्राधिकरण
Unique Identification Authority of India

पता:
S/O: विनोद कुमार, वार्ड न 2, गांव टिकर, टिक्कर खास (710), कांगड़ा, हिमाचल प्रदेश - 176087

Address:
S/O: Vinod Kumar, ward n 2, village tikker,,Tikkar Khas (710), Kangra, Himachal Pradesh - 176087

7040 4893 0901
VID : 9167 1829 7499 1827

QR Code with Photograph

Sumit

ALPLA

To

DTDC dtdc lite T17138020

Medi Assist Insurance TPA Pvt. Ltd.
White House, 2nd floor, Block-3,
Kundan Bagh, Begumpet, Hydrabad.
PIN- 500016

RECEIVED
20 Feb 2023
MEDI ASSIST INSURANCE TPA (P) LTD
HYDERABAD

MEDI ASSIST PTN1236932B

Alpla India Pvt. Ltd.
Plot No. 100, EPIP Phase - II, Vill. Thana,
Baddi, District Solan
Himachal Pradesh, India, Pin- 173 205
Ph.: 92185 68904