

# 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)

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	DATA ELEMENT	DESCRIPTION  SECTION A DETAILS OF REMARK INSURED	FORMAT
		SECTION A - DETAILS OF PRIMARY INSURED	1
a)	Policy No.	Enter the policy number	As allotted by the Insurance Company
b)	SI. No/ Certificate No.	Enter the social Insurance number or the certificate number of social health insurance scheme	As allotted by the organization  Licence number as allotted by IRDA and printed
c)	Company TPA ID No.	Enter the TPA ID No.	in TPA documents.
d)	Name	Enter the full name of the policyholder	Surname, First name, Middle name
e)	Address	Enter the full postal address	Include Street, City and Pin code
		SECTION B -DETAILS OF INSURANCE HISTORY	ı
a)	Currently covered by any other Mediclaim / Health Insurance?	Indicate whether currently covered by another Mediclaim / Health Insurance	Tick Yes or No
o)	Date of commencement of first Insurance without break	Enter the date of commencement of first Insurance	Use dd-mm-yy-forrmat
c)	Company Name	Enter the full name of the Insurance Company	Name of the organization in full
	Policy No.	Enter the policy number	As allotted by the Insurance Company
	Sum insured	Enter the total sum insured as per the policy	In rupees
d)	Have you been Hospitalized in the last four years since Inception of the contract?	Indicate whether hospitalized in the last four years	Tick Yes or No
	Date	Enter the date of Hospitalization	Use mm-yy format
	Diagnosis	Enter the diagnosis details	Open Text
e)	Previously covered by any other Mediclaim / Health Insurance?	Indicate whether previously covered by another mediclaim / Health Insurance	Tick Yes or No
)	Company Name	Enter the full name of the Insurance Company	Name of the organization in full
	SECT	TION C -DETAILS OF INSURED PERSON HOSPITALIZED	
a)	Name	Enter the full name of the patient	Surname, First name, Middle name
o)	Gender	Indicate Gender of the patient	Tick Male or Female
c)	Age	Enter age of the patient	Number of years and months
d)	Date of Birth	Enter Date of Birth of patient	Use dd-mm-yy format
e)	Relationship to primary Insured	Indicate relationship of patient with policyholder	Tick the right option, if others, please specify
)	Occupation	indicate occupation of patient	Tick the right option. If others, please specify.
g)	Address	Enter the full postal address	Include Street, City and Pin code
h)	Phone No	Enter the phone number of patient	Include STD code with telephone number
1)	E-mail ID	Enter e-mail address of patient	Complete e-mail address
		SECTION D - DETAILS OF HOSPITALIZATION	·
a)	Name of Hospital where admitted	Enter the name of hospital	Name of hospital in full
b)	Room category occupied	indicate the room category occupied	Tick the right option
c)	Hospitalization due to	indicate reason of hospitalization	Tick the right option
d)	Date of injury/Date Disease first detected / Date of Delivery	Enter the relevant date	Use dd-mm-yy format
e)	Date of admission	Enter date of admission	Use dd-mm-yy format
<u> </u>	Time	Enter time of admission	Use hh-mm- format
<u>′</u> g)	Date of discharge	Enter date of discharge	Use dd-mm-yy format
) 1)	Time	Enter time of discharge	Use hh-mm- format
)	If injury give cause	indicate cause of injury	Tick the right option
,	If Medico legal	indicate whether injury is medico legal	Tick Yes or No
	Reported to Police	indicate whether police report was filed	Tick Yes or No
	MLC Report & Police FIR attached	indicate whether MLC report and Police FIR attached	Tick Yes or No
)	System of Medicene	Enter the system of medicine followed in treating the patient	Open Text
		SECTION E - DETAILS OF CLAIM	
a)	Details of Treatment Expenses	Enter the amount claimed as treatment Expenses	In rupees (Do not enter paise values)
b)	Claim for Domiciliary Hospitalization	indicate whether claim is for domiciliary hospitalization	Tick Yes or No
c)	Details of Lump sum/ Cash benifit claimed	Enter the amount claimed as lump sum / cash benefit	In rupees (Do not enter paise values)
d)	Claim documents Submitted-Check List	indicate which supporting documents are submitted	Tick the right option
-/		SECTION F - DETAILS OF BILLS ENCLOSED	Tion are right option
nd	icate which bills are enclosed with the amount in rupees	OLOTION 1 - DETAILS OF BILLS ENGLOSED	
	SECTIO	N G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT	
a)	PAN	Enter the permanent account number	As allotted by the Income Tax Department
b)	Account Number	Enter the Bank account number	As allotted by the Bank
c)	Bank Name and Branch	Enter the Bank name along with the branch	Name of the Bank in full
c)	Cheque/ DD payable details	Enter the name of the beneficiary the cheque / DD should be made out to	Name of the individual / organization in full
c)	IFSC Code	Enter the IFSC code of the Bank branch	IFSC code of the Bank branch in full
		I	I
		SECTION H - DECLARATION BY THE 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 preauthorization request form in lieu of PART A

(To be Filled in block letters)

DETAILS OF HOSPITAL								
a) Name of the hospital:  a) Hospital ID:  c) Type of Hospital:	Network: Non Network: (if non network fill section E)							
c) Name of the treating doctor: SURNAME FIRE	STNAME MIDDLE NAME 5							
e) Qualification: f) Registration No. with State Code:	g) Prione No.							
DETAILS OF THE PATIENT ADMITTED								
a) Name of the Patient: SURNAME STATE STAT								
b) IP Registration Number: c) Gender: Male Female f) Date of Admission: D D M M Y Y A g) Time: H H M M	d) Age: Years Y Y Months M M e) Date of birth: D D M M Y Y Y h) Date of Discharge: D D M M Y Y ) i) Time: H H M M M							
f) Date of Admission:  D D M M Y Y g) Time: H H M M  j) Type of Admission: Emergency Planned Day Care Maternity k) If Mater	The state of Polivery D. D. M. M. V. V. ii) Crouids Status:							
Notatus at time of discharge: Discharge to home Discharge to another hospital Deceased								
DETAILS OF AILMENT DIAGNOSED (PRIMARY)								
a) ICD 10 Codes Description	b) ICD 10 PCS Description							
I. Primary Diagnosis	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 N	lumber:							
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:	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:								
CLAIM DOCUMENTS CURMITTED, CUECK 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  City:  Pin Code:  b) Phone No.  e) Number of inpatient beds	State: c) Registration No. with State Code: 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 our right to claim under this claim shall be forfeited.	. If we have made any false or untrue statement, suppression or concealment of any material fact,							
	, and the second							
Date: D D M M Y Y								
Place: Signature and Seal of the Ho	-   -   -   -   -   -   -   -   -   -							

	GUIDANCE FOR FI	LLING CLAIM FORM - PART B (To be filled in by the hos	pital)
	DATA ELEMENT	DESCRIPTION	FORMAT
		SECTION A - DETAILS OF HOSPITAL	
a)	Name of the hospital:	Enter the name of hospital	Name of the hospital in full
b)	Hospital ID	Enter ID number of hospital	As allocated by the TPA
c)	Type of Hospital	Indicate whether in network or non network hospital	Tick the right option
c)	Name of treating doctor	Enter the name of the treating doctor	Name of doctor in full
e)	Qualification	Enter the qualification of the treating doctor	Abbreviations of educational qualifications
f)	Registration No. with State Code	Enter the registration number of the doctor along with the state code	As allocated by the Medical Council of India
g)	Phone No.	Enter the phone number of doctor	Include STD code with telephone number
	SEC	TION B - DETAILS OF THE PATIENT ADMITTED	
a)	Name of Patient	Enter the name of patient	Name of patient in full
b)	IP registration Number	Enter insurance provider registration number	As allotted by the insurance provider
c)	Gender	Indicate Gender of the patient	Tick Male or Female
d)	Age	Enter age of the patient	Number of years and months
e)	Date of Birth	Enter date of birth	Use dd-mm-yy format
f)	Date of Admission	Enter date of admission	Use dd-mm-yy format
g)	Time	Enter Time of admission	Use hh:mm format
h)	Date of Discharge	Enter date of Discharge	Use dd-mm-yy format
i)	Time	Enter time of Discharge	Use hh:mm format
j)	Type of Admission	Indicate type of admission of patient	Tick the right option
k)	If Maternity		
i.	Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format
ii.	. Gravida Status	Enter Gravida status if maternity	Use standard format
l)	Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
M)	Total claimed amount	Indicate the total claimed amount	In rupees (Do not enter paise values)
,		I C - DETAILS OF AILMENT DIAGNOSED (PRIMARY)	
a)	ICD 10 Code	,	
	Primary Diagnosis	Enter the ICD 10 Code and description of the primary diagnosis	Standard Format and Open text
	Additional Diagnosis	Enter the ICD 10 Code and description of the additional diagnosis	·
	Co-morbidities	<u> </u>	Standard Format and Open text
		Enter the ICD 10 Code and description of the Co-morbidities	Standard Format and Open text
b)	ICD 10 PCS		
	Procedure 1	Enter the ICD 10 Code and description of the first procedure	Standard Format and Open text
	Procedure 2	Enter the ICD 10 Code and description of the second procedure	Standard Format and Open text
	Procedure 3	Enter the ICD 10 Code and description of the third procedure	Standard Format and Open text
	Details of Procedure	Enter the details of the procedure	Open text
c)	Pre-authorization obtained	Indicate whether pre-authorization obtained	Tick Yes or No
d)	Pre-authorization Number	Enter pre-authorization number	As allotted by TPA
e)	If authorization by network hospital not obtained, give reason	Enter reason for not obtaining pre-authorization number	Open text
f)	Hospitalization due to injury	Indicate if hospitalization is due to injury	Tick Yes or No
	Cause	Indicate cause of injury	Tick the right option
	If injury due to substance abuse/alcohol consumption test	Indicate whether test conducted	Tick Yes or No
	conducted to establish this	Indicate whether injury is medico legal	Tick Yes or No
	Medico Legal Reported to Police	Indicate whether injury is medico legal  Indicate whether police report was filed	Tick Yes or No
	FIR No.	Enter first information report number	As issued by police authorities
	If not reported to police, give reason	Enter reason for not reporting to police	Open text
		TION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST	· · · · · · · · · · · · · · · · · · ·
Indica	ate which supporting documents are submitted	110K D - CLAIM DOCUMENTS SUBMITTED-CRECK LIST	
ıııulG		ION E - DETAILS IN CASE OF NON NETWORK HOSPITA	ı
2)	Address	Enter the full postal address	Include Street, City and Pin Code
a) b)	Phone No.	Enter the phone number of hospital	Include STD code with telephone number
-		Enter the phone number of nospital  Enter the registration number of the Hospital obtained from local body	
c)	Registration No. with State Code	like City Corporation / Municipality	As allocated by the City Corporation / Municipality
d)	Hospital PAN	Enter the permanent account number	As allocated by the Income Tax Department
e)	Number of Inpatient beds	Enter the number of inpatient beds	Digits
f)	Facilities available in the hospital	Indicate facilities available in the hospital	Tick the right option. If others, please specify
		SECTION F - DECLARATION BY THE HOSPITAL	
Rea	d declaration carefully and mention date (in dd:mm:yy format),	place (open text) and sign. and stamp	

### REIMBURSEMENT CLAIM FORM

TO BE FILLED BY THE INSURED
The issue of this Form is not to be taken as an admission of liability

(To be Filled in block letters)

RY INSURED:  b) SI No/ Certificatie no  FRUCTURE PRIVATE LATD  INE CONBUILDING MARON  State: MAHARASHTRA  CE HISTORY: ment of first Insurance without break:  e) Previously covered by any other Mediclaim /Health insurance:  ves Insurance without break:  e) Previously covered by any other Mediclaim /Health insurance:  ves Insurance without break:  Consumer of first Insurance without break:  Previously covered by any other Mediclaim /Health insurance:  ves Insurance without break:  Previously covered by any other Mediclaim /Health insurance:  ves Insurance without break:  College of Birth  Previously covered by any other Mediclaim /Health insurance:  ves Insurance without break:  Previously covered by any other Mediclaim /Health insurance:  ves Insurance without break:  Insurance without break:  Previously covered by any other Mediclaim /Health insurance:  Ves Insurance without break:  Insura
State: Mahar RASHTRA at the Color of the contract? Yes No Date  e) Proviously covered by any other Mediclaim Atealth insurance: Yes In Date of Birth 2 1 0 8 196 5  Other Other (Please Specify)  eitred Other (Please Specify)  eitred Other (Please Specify)  g) Date of Discharge: Color of Date of Delivery: Of 0 8 2 0 1 9  g) Date of Discharge: Of 0 8 196 5 0 1 196  i) System of Medicine:  LAIM: Claim Documents Submitted - Check List;
State: Mahar RASHTRA at the Color of the contract? Yes No Date  e) Proviously covered by any other Mediclaim Atealth insurance: Yes In Date of Birth 2 1 0 8 196 5  Other Other (Please Specify)  eitred Other (Please Specify)  eitred Other (Please Specify)  g) Date of Discharge: Color of Date of Delivery: Of 0 8 2 0 1 9  g) Date of Discharge: Of 0 8 196 5 0 1 196  i) System of Medicine:  LAIM: Claim Documents Submitted - Check List;
State: Mahar RASHTRA at the Color of the contract? Yes No Date  e) Proviously covered by any other Mediclaim Atealth insurance: Yes In Date of Birth 2 1 0 8 196 5  Other Other (Please Specify)  eitred Other (Please Specify)  eitred Other (Please Specify)  g) Date of Discharge: Color of Date of Delivery: Of 0 8 2 0 1 9  g) Date of Discharge: Of 0 8 196 5 0 1 196  i) System of Medicine:  LAIM: Claim Documents Submitted - Check List;
State: MAHARASHTRA  2
State: MAHARASHTRA  2 JI Semail ID: Nitron Abbrok @ atctower. In  CE HISTORY: ment of first inaurance without break:  e) Previously covered by any other Mediclaim Atealth insurance: Yes in  ON HOSPITALIZED:  Other (Please Specify)  ehired Other (Please Specify)  ehired Other (Please Specify)  ALIZATION:  First inaurance without break:  State: Email ID:  ALIZATION:  First inaurance without break:  In Other (Please Specify)  ALIZATION:  First in Other (Please Specify)  If Medico legal 1 9 Yes No 6 3 0  If Medico legal 1 9 Yes No 6 3 0  Claim Documents Submitted - Check List:  LAIM:  Claim Documents Submitted - Check List:
CE HISTORY: ment of first Insurance without break:  ince inception of the contract? Yes No Date  e) Proviously covered by any other Medicialm Atealth insurance :: Yes Indiana    ON HOSPITALIZED:  U) Date of Birth
ment of first insurance without break:    Previously covered by any other Mediclaim /Health insurance   Yes
e) Previously covered by any other Mediclaim Health insurance:  Yes In MosPITALIZED:  J Date of Birth
e) Previously covered by any other Mediclaim Health insurance:  Yes In MosPITALIZED:  J Date of Birth
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rring 3 or more beda per room  ry / Date Disease first detected #Date of Delivery: 0 6 0 8 2 0 1 9  g) Date of Discharge: 1 0 0 6 1 9 h) Time: 0 1 1 9  use / Alcohol Consumption 13 1) If Medics legal 1 9 Yes No 6 3 0  j) System of Medicine:  LAIM:  Claim Documents Submitted - Check List;
ry / Date Disease first delected #Date of Delivery: 0 6 0 8 2 0 1 9 g) Date of Discharge: 1 0 0 6 1 9 h) Time: 0 1 1 9 use / Alcohol Consumption 1 3 1) If Medics legal 1 9 Yes No 1 6 2 3 0 j) System of Medicine:  LAIM:  Claim Documents Submitted - Check List:
g) Date of Discharge: 1 3 1) If Medico legal 1 97 Yes No 1 5 3 0  i) System of Medicine:  LAIM:  Claim Documents Submitted - Check List:
use / Alcohol Consumption 3   ) If Medico legal 1 9 Yes No 1 6 : 3 0  j) System of Medicine:  LAIM:  Claim Documents Submitted - Check List:
j) System of Medicine:  LAIM:  Claim Documents Submitted - Check List;
Claim Documents Submitted - Check List:
xpenses Rs. 1 1 19 7 10 0 Claim form duly signed
p cost: Rs. Copy of the claim intimation, if any
Rs. Hospital Main Bill Hospital Break-up Bill
Rs. 3 9 2 3 8 1 60 Hospital Bill Payment Receipt
ration period: days 0 4 2 Hospital Discharge Summary
Pharmacy Bill
OperationTheater Notes
Rs. Doctors request for investigation
Investigation Reports (Including CT   MRI / USG / HPE)
Rs. Doctols Prescriptions .
NCLOSED:
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TOTAL 39238.00
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00401501206
DO 401501206 ROAD BRANCH 0) IFSC Code: 1 C1 C0001728
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# CHECK LIST FORM

## For Hospitalization / Daycare Reimbursement claim.

- A) Original Detailed Discharge Summary of Hospital/Nursing Home.
- B) Original Detailed Final Bill of Hospital/Nursing Home.
- C) Detailed Break-Up of Final Bill.
- D) Receipt of Payment of Final bill (Advance & Balance Amount).
- E) All Doctor Prescriptions for Medicines & Lab Investigations.
- F) All Lab Investigation Reports and films of X-ray / CT / MRI Done.
- G) All Medicines/Pharmacy/Medical Store Bills.
- H) All stickers and invoice of implants / lens used
- I) Hospital registration certificate with details No. of Beds, ICU facility, 24 Hrs. Nursing Staff facility, Emergency services in Hospital.
- J) Complete filled and signed claim form Part A, Claim Form Part B to be filled in by the hospital.
- K) Copy of Mediassist card and ID proof of the patient
- L) Hospital should be minimum of 15 beds
- M) Attested copy of Indoor case papers which includes admission notes, presenting complaints, course in the hospital, complete treatment details, with vital monitoring chart, duly Doctor/Nursing notes with surgical notes etc.

# Hospital definition

#### In Case of Fracture.

Original X-Ray Film & Reports.

#### In Case of Road Traffic Accident.

Non-Alcohol Influence Certificate by the Treating Doctor. Medico Legal Certificate (MLC Copy) / Copy of FIR

# In case Of Maternity.

GPLA History (Gravida Para Living Abortion) Certified by the Treating Doctor.

### For Pre / Post Hospitalization Reimbursement Claim.

- A) Receipt of Payments.
- B) All Doctor Prescriptions for Medicines & Lab Investigations.
- C) All Lab Investigation Reports.
- D) All Medicines/Pharmacy/Medical Store Bills.
- 1. Cancelled cheque or Passbook Copy with Account Number, IFSC code (Name of primary beneficiary should be written on cancelled cheque)
- 2. Pan card copy & Govt ID proof of employee.
- 3. Govt id proof of patient.

SIGN (	CONSENT	FORM	ATTACHED	IS THE	E FORMAT

Employee Signature-	. Da	te

Please Bind/ Staples /Clip all the Documents of Reimbursement Claim