

CLAIM FORM - PART A

TO BE FILLED IN BY THE INSURED

The issue of theis form is not to be taken as admission of liability

(To be filled in block letters)

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d) Cheque/ DD Payable details:		e) IFSC Code:											G
DECLARATION BY THE INSURED													
I hereby declare that the information furnished in this claim form is true & correct to the best of m													
claim, my right to claim reimbursement shall be forfeited. I also consent & authorize TPA / insura made. I hereby declare that I have included all the bills / receipts for the purpose of this claim & t					ner who has	atten	ded on t	ne persor	n against	whom t	his claim	is	ď
													<u> </u>
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			Г									\neg	
Date: Place:		Signature of the	insured:										
GUIL DATA ELEMENT	DANCE FOR FILLING CLAIM FORM - PART A		sured)										
DATA ELEMENT	SECTION A - DETAILS OF PRIM.	ARY INSURED						F	ORMA'	<u> </u>			
a) Policy No.	Enter the policy number	AKT INSUKED			As allotted	l by t	he insi	rance o	ompar	v			
b) SI. No/ Certificate No.	Enter the social insurance number or the	certificate number of so	ocial healt	h	As allotted					,			
b) 6. No. Continuate No.	insurance scheme											TDA	
c) Company TPA ID No.	Enter the TPA ID No				License nu documents		r as all	ottea by	/ IRDA	and pr	intea in	IPA	
d) Name	Enter the full name of the policyholder			9	Surname,	First	name,	Middle	name				
e) Address	Enter the full postal address			l	nclude St	reet,	City ar	d Pin C	ode				
	SECTION B - DETAILS OF INSUR	ANCE HISTORY											
a) Currently covered by any other Mediclaim / Health Insurance?	Indicate whether currently covered by an	other Mediclaim / Health	n Insuranc	e 1	Tick Yes o	or No							
b) Date of Commencement of first Insurance without break	Enter the date of commencement of first	insurance		ı	Jse dd-mr	m-yy	format						
c) Company Name Policy No.	Enter the full name of the insurance com	pany			Name of th								
Sum Insured	Enter the policy number Enter the total sum insured as per the po	dicy		$\overline{}$	As allotted n rupees	by t	ne insu	rance o	ompar	у			
d) Have you been Hospitalized in the last 4 years since inception of the contract?	Indicate whether hospitalized in the last				Tick Yes o	or No							
Date	Enter the date of hospitalization	,		U	Jse mm-y	y forr	nat						_
Diagnosis	Enter the diagnosis details				Open Text	t							
e) Previously Covered by any other Mediclaim/ Health Insurance?	Indicate whether previously covered by a	nother Mediclaim / Heal	lth Insurar	nce 7	Tick Yes o	or No							
f) Company Name	Enter the full name of the insurance com	pany			Name of the	he or	ganizat	ion in f	ull				
	SECTION C - DETAILS OF INSURED PE	•					<i>J</i>						
a) Name	Enter the full name of the patient			9	Surname,	First	name,	Middle	name				
b) Gender c) Age	Indicate Gender of the patient				Tick Male								
d) Date of Birth	Enter age of the patient Enter Date of Birth of patient				Number of Use dd-mr			months					
e) Relationship to primary Insured	Indicate relationship of patient with police	vholder			Tick the rig			fothers	. pleas	e spec	ifv.		
f) Occupation	Indicate occupation of patient	,		-	Tick the rig								
g) Address	Enter the full postal address				nclude St	reet,	City ar	d Pin C	ode				
h) Phone No i) E-mail ID	Enter the phone number of patient			-	nclude ST				one nu	mber			
I) C-III II U	Enter e-mail address of patient SECTION D - DETAILS OF HOSE	DITALIZATION		C	Complete	e-ma	il addr	ess					
a) Name of Hospital where admitted	Enter the name of hospital	FITALIZATION			Name of h	nenit	al in fu						
b) Room category occupied	Indicate the room category occupied			$\overline{}$	Tick the rig	_							
c) Hospitalization due to	Indicate reason of hospitalization				Tick the rig	ght o	otion						
d) Date of Injury/Date Disease first detected/ Date of Delivery	Enter the relevant date			U	Jse dd-mr	m-yy	format						
e) Date of admission f) Time	Enter date of admission			-	Jse dd-mr								
g) Date of discharge	Enter time of admission			$\overline{}$	Jse hh:mr								
h) Time	Enter date of discharge Enter time of discharge				Jse dd-mr Jse hh:mr								
i) If Injury give cause	Indicate cause of injury				Tick the rig								
If Medico legal	Indicate whether injury is medico legal			1	Tick Yes o	or No							
Reported to Police	Indicate whether police report was filed				Tick Yes o	or No							
MLC Report & Police FIR attached j) System of Medicine	Indicate whether MLC report and Police				Tick Yes o								
g cyacin or wedicine	Enter the system of medicine followed in SECTION E - DETAILS OF				Open Text	t							
a) Details of Treatment Expenses	Enter the amount claimed as treatment e				n rupees ((Do n	ot ente	r paise	values)			
b) Claim for Domiciliary Hospitalization	Indicate whether claim is for domiciliary				Tick Yes o			ранов					
c) Details of Lump sum/ cash benefit claimed	Enter the amount claimed as lump sum/	cash benefit			n rupees ((Do n	ot ente	r paise	values)			
d) Claim Documents Submitted-Check List	Indicate which supporting documents are			1	Tick the rig	ght o	otion						
Indicate which bills are enclosed with the amounts in rupees	SECTION F - DETAILS OF BILL	5 ENCLUSED											
	SECTION G - DETAILS OF PRIMARY INSU	RED'S BANK ACCOUNT											
a) PAN	Enter the permanent account number				As allotted	by t	he Inco	me Tax	k depar	tment			
a) FAIN					As allotted								
b) Account Number	Enter the bank account number				to unotiou			Λ					
b) Account Number c) Bank Name and Branch	Enter the bank name along with the bran			1	Name of the	he Ba	nk in f	ull					
b) Account Number c) Bank Name and Branch d) Cheque/ DD payable details	Enter the bank name along with the bran Enter the name of the beneficiary the che		de out to	1	Name of the	he Ba	nk in f dividua	ull I/ organ		in full			
b) Account Number c) Bank Name and Branch	Enter the bank name along with the bran	eque/ DD should be mad	de out to	1	Name of the	he Ba	nk in f dividua	ull I/ organ		in full			



CLAIM FORM - PART B

TO BE FILLED IN BY THE HOSPITAL

The issue of theis form is not to be taken as admission of liability Please include the original preauthorization request form in lieu of PART A

a) Name of the Hospital:		П	T	T	П	П		Т	T						Т	П	T	Т	T			T	T	T	T	ī				Ī	T	T
c) Hospital ID:	H		\pm	+		$\dagger \dagger$	〓		c) T	vne of	Hospital		<u> </u>	Net	vork	No	n Netv	vork	i				- /	if non	netwo	ork fill	Section	on F)				
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d) Name of the treating do	CIOI:		_			++			Destates	6 N			H	H	+	${}^{+}$	÷	+	┿		Diversi	T	+	+	+	믁	_			+	+	+
e) Qualification:								1)	Registra	tion ivo). With St	ite code:	_	ш					J	9)	Phone	INO.					!			!		
DETAILS OF PATIENT A	JMITTED		Ŧ	_	П	1 1		_	-			_					Ŧ	$\overline{}$	1			-		_	_	_	_				Ŧ	_
a) Name of Patient:	⊢	+	+	+	+	+				Щ	\dashv		┢	<u> </u>		╙┼	+	\dashv		Н	_				-	+	_			=	+	+
b) IP Registration No.:	⊨	\dashv	╬	+	┼┾	\dashv		c) Gende	r:	Male	-	Female	╄	l	d) Age:	_	+	<u> </u>	nonths	님) Date	of Birt	h:	L				_	믁	F	+
f) Date of Admission:		ᆜ			┷	Ш	9	g) Time:	Щ	Щ	: L		_	ŀ) Date of [_		+	1	Н	Щ	Ļ	4	ᅥ		i	i) Time	e:		ᆛ	: <u>L</u>	+
j) Type of Admission: E	mergency	L	P	lanned	닏	Day C	Care	Ma	aternity	Щ		k) I	f Mater	nity:	i. Date	of Delive	ery:		1			L		_		•	ii. Grav	vida S	tatus:	Ļ		+
I) Status at time of dischar	ge:	Disc	harged	to home	Ш	Di	ischar	rged to an	nother ho	spital	Ш	Dec	eased	Ш								m)	Total	claime	ed am	ount						
DETAILS OF AILMENT D	IAGNOSE	D (PRIM	ARY)																													
a)			ICD 10	Codes					Desc	ription			_	b)					ICI	O 10 P	CS			_				De	scripti	on		
i. Primary Diagnosis :						J []	i. Pi	ocedure 1																	
	_					_							_				_							Ļ								
ii. Additional Diagnosis	: L					┙┟							4	ii. P	rocedure 2	:	L							ŀ								
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iii. Co-morbidities :	Ш	Ш			\Box	┙┝							1	iii. F	Procedure 3	:	L			Ш				ŀ								
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iv. Co-morbidities :	_	ш				- J							1	iv. [Details of P	rocedure	·															
c) Pre authorization obtain	ad:					F	$\overline{}$	Vac	No) Pre-aut	」 Horizat	ion num	hor		ᅷ	1	Т			$\overline{}$	T	T	$\overline{}$	\neg						
e) If authorization by netw		I not ch'	ainad	iivo roo-	on:	F	_	Yes	No		- (, i i c -aul	ııvıIZdi	avii Hull	DGI.	_	_		_			_		_	_	_						
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f) Hospitalization due to in	•		es	No		i. If yes,				١		⊨	╣.			_	_			. 1		г	abuse		noi co			5	. I	_	. г	– 1
ii. If injurydue to Substance	abuse / a	cohol co	nsump	ion, Tes	t Conducted	to establi	ish thi			- 1	Ye	-	No	(if	yes, attach	reports)		iii. If Me	dico Le	gal:		'es	N	10		iv. Re	eporte	d to P	olice:		Yes	No
v. FIR No.						ш		٧	/i. If not r	eporte	d to poli	e, give re	eason:																			
CLAIM DOCUMENTS SU			(LIST																													
Claim For	n duly sign	ed												닏	Investig	ition rep	orts															
Original Pr	e-authoriza	ation req	uest											Ш	CT/ MR	/ USG/ F	IPE/ In	vestigati	on repo	rts												
Copy of th	e Pre-auth	orization	approv	al letter										Ш	Doctor's	referanc	e slip															
Copy of pl	ioto ID car	d of patie	ent veri	ied by h	ospital										ECG																	
Hospital di	scharge su	ımmary													Pharma	y bills																
Oparation	Theatre No	otes													MLC rep	ort & Po	lice FII	R														
Hospital m	ain bill													П	Original	death su	mmar	y from ho	spital, v	vhere a	pplicat	le										
Hospital b	eak-up bill														Any oth		speci	ify														
	eak-up bill													\Box			speci	ify														
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b) IP Registration Number c) Gender d) Age e) Date of Admission f) Time	Enter insurance provider registration number Indicate Gender of the patient Enter age of the patient	As allotted by the insurance provider Tick Male or Female Number of years and months
d) Age e) Date of Admission	Enter age of the patient	
e) Date of Admission	 	Number of years and months
*		ramos or your una monaro
f) Time	Enter date of admission	Use dd-mm-yy format
	Enter time of admission	Use hh:mm format
g) Date of Discharge	Enter date of discharge	Use dd-mm-yy format
h) Time	Enter time of discharge	Use hh:mm format
i) Type of Admission	Indicate type of admission of patient	Tick the right option
j) If Maternity	, i	
Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format
Gravida Status	Enter Gravida status if maternity	Use standard format
k) Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
	SECTION 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	Standard Format and Open text
Co-morbidities	Enter the ICD 10 Code and description of the co-morbidities	Standard Format and Open text
b) ICD 10 PCS	Enter the ICD TO Code and description of the co-morbidities	Standard Format and Open text
Procedure 1	Establish IOD 40 DOO and doorately a fifth first annual and	Observed Ferry Lond Occupation
Procedure 2	Enter the ICD 10 PCS and description of the first procedure	Standard Format and Open text
Procedure 3	Enter the ICD 10 PCS and description of the second procedure	Standard Format and Open text
Details of Procedure	Enter the ICD 10 PCS and description of the third procedure	Standard Format and Open text
c) Pre-authorization obtained	Enter the details of the procedure	Open text
d) Pre-authorization Number	Indicate whether pre-authorization obtained	Tick Yes or No
*	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 conducted to establish this	Indicate whether test conducted	Tick Yes or No
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
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
	SECTION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST	
Indicate which supporting documents are submitted		
_	SECTION E - DETAILS IN CASE OF NON NETWORK HOSPITAL	_
a) Address	Enter the full postal address	Include Street, City and Pin Code
b) Phone No.	Enter the phone number of hospital	Include STD code with telephone number
c) 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
d) Hospital PAN	Enter the permanent account number	As allotted 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 INSURED	now the right option. If others, please specify
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and		