

Bajaj Allianz General Insurance Company Limited.

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Toll free no:1800-209-5858

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**Relationship Beyond Insurance**

(To be filled in block letters)

CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT – PART A**TO BE FILLED IN BY THE INSURED**

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

DETAILS OF PRIMARY INSURED

a) Policy No:	0 G 2 6 2 0 0 1 8 4 3 3 0 0 0 0 1 9 6 1 	b) Sl. No/Certificate No:	_____
c) Company TPA ID No:	_____	d) Customer ID:	_____
e) Company Name:	Bajaj General Insurance Limited		
g) Name:	Balvant Jagannath Sabale		
h) Address:	Charang Baba Mala Nanduri Dumala Sangamner Ahmednagar		
City:	Sangamner	State:	_____
Phone No:	_____	Email ID:	_____

DETAILS OF INSURANCE HISTORY

a) Currently covered by any other Mediclaim / Health Insurance	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
b) date of commencement of first insurance without break	_____	_____	
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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date: D D M M Y Y Y Y
Diagnosis	_____		
e) Previously covered by any other Mediclaim / Health Insurance:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
f) If yes, Company Name	_____		

DETAILS OF INSURED PERSON HOSPITALIZED

a) Name of the Patient:	Surekha Balvant Sabale		
b) Health ID card no of the Patient:	_____		
c) Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>	d) Age: years _____ months _____	e) Date of Birth D D M M Y Y Y Y 	
f) Relationship of Primary insured: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Other <input type="checkbox"/> (Please Specify) _____			
g) Occupation: Service <input type="checkbox"/> Self Employed <input type="checkbox"/> Homemaker <input type="checkbox"/> Student <input type="checkbox"/> Retired <input type="checkbox"/> Other <input type="checkbox"/> (Please Specify) _____			
h) Address (if different from above)	_____		
City:	_____	State:	_____
i) Phone No:	_____	j) Email ID:	_____

DETAILS OF HOSPITALIZATION

a) Name of Hospital where Admitted:	_____		
b) Room Category occupied: Day Care <input type="checkbox"/> Single occupancy <input type="checkbox"/> Twin sharing <input type="checkbox"/> 3 or more beds per room <input type="checkbox"/>			
c) Hospitalisation due to: Injury <input type="checkbox"/> Illness <input type="checkbox"/> Maternity <input type="checkbox"/>			
d) Date of Injury/Disease first detected/Date of Delivery: D D M M Y Y Y Y 			
e) Date of admission D D M M Y Y Y Y Time: H H M M g) Date of Discharge D D M M Y Y Y Y Time: H H M M 			
i) Name of treating doctor _____ Diagnosis _____			
j) If injury give cause: Self <input type="checkbox"/> inflicted <input type="checkbox"/> Road Traffic Accident <input type="checkbox"/> Substance Abuse /Alcohol Consumption <input type="checkbox"/>			
i) If Medico legal: Yes <input type="checkbox"/> No <input type="checkbox"/>	ii) Reported to police: Yes <input type="checkbox"/> No <input type="checkbox"/>		
iii) MLC report and Police FIR attached: Yes <input type="checkbox"/> No <input type="checkbox"/>	j) System of Medicine _____		

SECTION A

SECTION B

SECTION C

SECTION D

DETAILS OF CLAIM

a) Details of the treatment expenses claimed

i. Pre-Hospitalisation Expenses: Rs. iii. Post-Hospitalisation Expenses: Rs. v. Ambulance Charges: Rs. ii. Hospitalisation Expenses Rs. iv. Health checkup cost Rs. vi. Others (code) Rs. Total Rs. vii. Pre-Hospitalisation period: days viii. Post Hospitalisation period: days b) Claim for Domiciliary Hospitalisation: Yes No (If yes, provide details in annexure)

c) Details of Lump sum / cash benefit claimed:

i. Hospital Daily Cash Rs. iii. Critical illness Benefit Rs. v. Pre/Post hospitalisation Rs.

lump sum benefit

ii. Surgical Cash Rs. iv. Convalescence Rs. vi. Others Rs. Total Rs. **Claim Documents Submitted – Check List**

- | | | |
|---|---|---|
| <input type="checkbox"/> Claim Form Duly Signed | <input type="checkbox"/> Copy of claim intimation if any | <input type="checkbox"/> Original Hospital Main Bill |
| <input type="checkbox"/> Original Hospital Breakup Bill | <input type="checkbox"/> Original Hospital Bill Payment Receipt | <input type="checkbox"/> Original Hospital Discharge SummaryPharmacy Bill |
| <input type="checkbox"/> Operation Theater Notes | <input type="checkbox"/> ECG | <input type="checkbox"/> Original Doctor's Prescriptions |
| <input type="checkbox"/> Original Doctors request for investigation reports (including CT/MRI/USG/HPE) | <input type="checkbox"/> Others | |
| <input type="checkbox"/> Cancelled blank cheque leaf with payee name printed. If name of the payee is not printed on the cheque leaf please attach copy of the first page of the bank passbook. | | |

DETAILS OF BILLS ENCLOSED

Sr.No	Bill No	Date						Issued by	Towards	Amount (Rs)					
1		D	D	M	M	Y	Y		Hospitalisation Main Bill						
2		D	D	M	M	Y	Y		Pre-Hospitalisation Bills: Nos						
3		D	D	M	M	Y	Y		Post-Hospitalisation Bills: Nos						
4		D	D	M	M	Y	Y		Pharmacy Bills						
5		D	D	M	M	Y	Y								
6		D	D	M	M	Y	Y								
7		D	D	M	M	Y	Y								
8		D	D	M	M	Y	Y								
9		D	D	M	M	Y	Y								
10		D	D	M	M	Y	Y								

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT (Submission of Cancelled Blank Cheque Leaf with Payee Name Printed OR Copy of the First page of the Bank Passbook is Mandatory)

- a) Name of the Account Holder (As per Bank Account): _____
- b) Account no (As appearing in the cheque book):
- c) Bank Name : _____
- d) Branch Name & Address: _____ :
- e) Account Type : Saving Current Cash Credit
- f) MICR No.
- g) IFSC Code:
- h) PAN:
- i) Cheque / DD Payable Details: _____

DECLARATION

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 Bajaj Allianz General Insurance Company Limited, 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: D D M M Y Y Y Y Place:

Signature of the Insured

GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled in by the insured)		
DATA ELEMENT	DESCRIPTION	FORMAT
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
c) Company TPA ID No.	Enter the TPA ID No	License number as allotted by IRDA and printed in TPA documents.
g) Name	Enter the full name of the policyholder	Surname, First name, Middle name
h) Address	Enter the full postal address	Include Street, City and Pin Code
SECTION B - DETAILS OF INSURANCE HISTORY		
a) Currently covered by any other Mediclaim / Health Insurance?	Indicate whether currently covered by another Mediclaim / Health Insurance?	Tick Yes or No
b) Date of Commencement of first Insurance without break	Enter the date of commencement of first insurance	Use dd-mm-yy format
c) Company Name Policy No. Sum Insured	Enter the full name of the insurance company Enter the policy number Enter the total sum insured as per the policy	Name of the organization in full As allotted by the insurance company In rupees
d) Have you been Hospitalized in the last four years since inception of the contract? Date Diagnosis	Indicate whether hospitalized in the last four years Enter the date of hospitalization Enter the diagnosis details	Tick Yes or No Use dd-mm-yy format Open Text
e) Previously Covered by any other Mediclaim/ Health Insurance?	Indicate whether previously covered by another Mediclaim / Health Insurance	Tick Yes or No
f) Company Name	Enter the full name of the insurance company	Name of the organization in full
SECTION C - DETAILS OF INSURED PERSON HOSPITALIZED		
a) Name of the Patient	Enter the full name of the patient	Surname, First name, Middle name
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 of patient	Use dd-mm-yy format
f) Relationship to primary Insured	Indicate relationship of patient with policyholder	Tick the right option. If others, please specify.
g) Occupation	Indicate occupation of patient	Tick the right option. If others, please specify.
h) Address	Enter the full postal address	Include Street, City and Pin Code
i) Phone No	Enter the phone number of patient	Include STD code with telephone number
j) 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/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
f) Time	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) If Injury give cause If Medico legal Reported to Police MLC Report & Police FIR attached	Indicate cause of injury Indicate whether injury is medico legal Indicate whether police report was filed Indicate whether MLC report and Police FIR attached	Tick the right option Tick Yes or No Tick Yes or No Tick Yes or No
j) System of Medicine	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 benefit 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
Indicate which bills are enclosed with the amounts in rupees		
SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT		
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
i) Cheque/ DD payable details	Enter the name of the beneficiary the cheque/	Name of the individual/
g) IFSC Code	DD should be made out to Enter the IFSC code of the bank branch	organization in full FSC code of the bank branch in full
h) PAN	Enter the permanent account number	As allotted by the Income Tax department
SECTION H - DECLARATION BY THE INSURED		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.		

(To be filled in block letters)

CLAIM FORM- PART B

TO BE FILLED IN BY THE HOSPITAL

The issue of this form is not to be taken as 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 :
b) Hospital ID : _____ c) Type of hospital : Network Non-Network (If non-network fill section E)
d) Name of treating doctor:
e) Qualification: _____ f) Registration No with State Code _____ g) Phone No:

DETAILS OF THE PATIENT ADMITTED

- a) Name of the patient: _____

b) IP registration Number: _____ c) Gender: Male Female d) Age : Years Months: e) Date of birth: D D M M Y Y

f) Date of admission: D D M M Y Y g) Time : H H M M h) Date of discharge: D D M M Y Y i) Time: H H M M

j) Type of Admission : Emergency Planned Day Care Maternity k) If Maternity i) Date of delivery D D M M Y Y ii)Gravida Status:

l) Status at time of discharge: Discharge to home Discharge to another hospital Deceased: m) Total claimed Amount:

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a)	ICD 10 Codes	Description	b)	ICD 10 PCS	Description
i) Primary Diagnosis:	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>	i) Procedure 1:	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>
ii) Additional Diagnosis:	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>	ii) Procedure 2:	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>
iii) Co-morbidities :	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>	iii) Procedure 3:	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>
iv) Co-morbidities :	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>	iv) Details of Procedure:	<input type="text"/>	

- d) Pre-Authorization Obtained: Yes No e) Pre-Authorization Number: _____

f) If authorization by network hospital no obtained, give reason: _____

g) 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) Medico Legal: Yes No
iv) Reported to Police: Yes No v) FIR no: _____ vi) if not reported to police give reason: _____

CLAIM DOCUMENTS -CHECK LIST

- | | |
|--|--|
| <input type="checkbox"/> Claim form duly signed
<input type="checkbox"/> Original Pre-Authorization request
<input type="checkbox"/> Copy of Pre-Authorization letter
<input type="checkbox"/> Copy of photo ID card of patient verified by hospital
<input type="checkbox"/> Hospital discharge summary
<input type="checkbox"/> Operation theatre notes
<input type="checkbox"/> Hospital main bill
<input type="checkbox"/> Hospital break up bill | <input type="checkbox"/> Ingestion reports
<input type="checkbox"/> CT/MR/USG/HPE investigation report
<input type="checkbox"/> Doctor's reference slip for investigation
<input type="checkbox"/> ECG
<input type="checkbox"/> Pharmacy bills
<input type="checkbox"/> MLC report & Police FIR
<input type="checkbox"/> Original death summary from hospital where applicable
<input type="checkbox"/> Any other, please specify |
|--|--|

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

- a) Address of hospital _____
City: _____ State: _____ Pin Code: _____ Phone No: _____ c) Registration no with State Code: _____
d) Hospital PAN: _____ e) Number of Inpatient beds: [] Facilities available in 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 the Claim Form is true and correct to the best of our knowledge and belief. If we have made any false and untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited.

Date : | D | D | M | M | Y | Y |

Place:



Signature and Seal of the Hospital Authority

GUIDANCE FOR FILLING CLAIM FORM - PART B (To be filled in by the hospital)		
DATA ELEMENT	DESCRIPTION	FORMAT
	SECTION A - DETAILS OF HOSPITAL	
a) Name of Hospital	Enter the name of hospital	Name of hospital in full
b) Hospital ID	Enter ID number of the hospital	As allocated by TPA
c) Type of Hospital	Indicate whether in network or non network hospital	Tick the right option
d) Name of Treating doctor	Enter the name of treating doctor	Name of doctor in full
e) Qualification	Enter the qualification of treating doctor	abbreviations of educational qualifications
f) Registration No with state code	Enter the registration no of treating doctor along with state code	As allocated by the medical council of India
g) Phone No	Enter the phone no of doctor	Include STD code with telephone number
	SECTION B - DETAILS OF THE PATIENT ADMITTED	
a) Name of the patient	Enter the name of hospital	Name of hospital in full
b) IP Registration number	Enter the insurance provide registration number	As allocated by the insurance provide
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 admission	Use dd-mm-yy format
f) Date of Admission	Enter date of admission	Use dd-mm-yy format
g) Time	Enter date 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		
Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format
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)
	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		
Procedure 1	Enter the ICD 10 PCS and description of the first procedure	Standard Format and Open text
Procedure 2	Enter the ICD 10 PCS and description of the second procedure	Standard Format and Open text
Procedure 3	Enter the ICD 10 PCS 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 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 HOSPITAL	
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign and stamp		