

**Bajaj Allianz General Insurance Company Limited.**

Regd. &amp; Head Office : GE Plaza, Airport Road, Yerawada, Pune 411 006

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Toll free no: 1800-209-5858

020-30305858



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 6 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 f) Employee No: \_\_\_\_\_

g) Name: B a l v a n t J a g a n n a t h S a b a l e \_\_\_\_\_

h) Address: C h a r a n g B a b a M a l l a N a n d u r i D u m a l a \_\_\_\_\_

S a n g l a m n e r A h e m e a d n a g a r \_\_\_\_\_

City: S a n g l a m n e r \_\_\_\_\_ State: \_\_\_\_\_ Pin Code: \_\_\_\_\_

Phone No: \_\_\_\_\_ Email ID: \_\_\_\_\_

**DETAILS OF INSURANCE HISTORY**

a) Currently covered by any other Medisclaim / Health Insurance ☐ Yes ☐ 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? ☐ Yes ☐ No Date: DD MM YY YY

Diagnosis \_\_\_\_\_

e) Previously covered by any other Medisclaim / Health Insurance: ☐ Yes ☐ 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 ☐ Female ☐ d) Age: years \_\_\_\_\_ months \_\_\_\_\_ e) Date of Birth DD MM YY YY

f) Relationship of Primary insured: Self ☐ Spouse ☐ Child ☐ Father ☐ Mother ☐ Other ☐ (Please Specify) \_\_\_\_\_

g) Occupation: Service ☐ Self Employed ☐ Homemaker ☐ Student ☐ Retired ☐ Other ☐ (Please Specify) \_\_\_\_\_

h) Address (if different from above) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Pin Code: \_\_\_\_\_

i) Phone No: \_\_\_\_\_ j) Email ID: \_\_\_\_\_

**DETAILS OF HOSPITALIZATION**

a) Name of Hospital where Admitted: \_\_\_\_\_

b) Room Category occupied: Day Care ☐ Single occupancy ☐ Twin sharing ☐ 3 or more beds per room ☐

c) Hospitalisation due to: Injury ☐ Illness ☐ Maternity ☐

d) Date of Injury/Date Disease first detected/Date of Delivery: DD MM YY YY

e) Date of admission DD MM YY YY Time: HH MM Date of Discharge DD MM YY YY Time: HH MM

i) Name of treating doctor \_\_\_\_\_ Diagnosis \_\_\_\_\_

j) 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 and Police FIR attached: Yes ☐ No ☐ j) System of Medicine \_\_\_\_\_

## DETAILS OF CLAIM

### a) Details of the treatment expenses claimed

i. Pre-Hospitalisation Expenses:	Rs.	<input type="text"/>	ii. Hospitalisation Expenses	Rs.	<input type="text"/>
iii. Post-Hospitalisation Expenses:	Rs.	<input type="text"/>	iv. Health checkup cost	Rs.	<input type="text"/>
v. Ambulance Charges:	Rs.	<input type="text"/>	vi. Others (code)	Rs.	<input type="text"/>
			Total	Rs.	<input type="text"/>
vii. Pre-Hospitalisation period:	days	<input type="text"/>	viii. Post Hospitalisation period:	days	<input type="text"/>

### 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.	<input type="text"/>	ii. Surgical Cash	Rs.	<input type="text"/>
iii. Critical illness Benefit	Rs.	<input type="text"/>	iv. Convalescence	Rs.	<input type="text"/>
v. Pre/Post hospitalisation lump sum benefit	Rs.	<input type="text"/>	vi. Others	Rs.	<input type="text"/>
			Total	Rs.	<input type="text"/>

### 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 Summary/Pharmacy 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):	<input type="text"/>
b) Account no ( As appearing in the cheque book):	<input type="text"/>
c) Bank Name :	<input type="text"/>
d) Branch Name & Address:	<input type="text"/>
e) Account Type : Saving <input type="checkbox"/> Current <input type="checkbox"/> Cash Credit <input type="checkbox"/>	
f) MICR No.	<input type="text"/>
g) IFSC Code:	<input type="text"/>
h) PAN:	<input type="text"/>
i) Cheque / DD Payable Details:	<input type="text"/>

## 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:           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) Sl. 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
<b>SECTION B - DETAILS OF INSURANCE HISTORY</b>		
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
<b>SECTION C - DETAILS OF INSURED PERSON HOSPITALIZED</b>		
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 telephon number
j) E-mail ID	Enter e-mail address of patient	Complete e-mail address
<b>SECTION D - DETAILS OF HOSPITALIZATION</b>		
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
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
<b>SECTION E - DETAILS OF CLAIM</b>		
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		
<b>SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT</b>		
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/ DD should be made out to	Name of the individual/ organization in full
g) IFSC Code	Enter the IFSC code of the bank branch	FSC code of the bank branch in full
h) PAN	Enter the permanent account number	As allotted by the Income Tax department
<b>SECTION H - DECLARATION BY THE INSURED</b>		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.		

## 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:

f) Date of admission:  g) Time :  h) Date of discharge :  i) Time:

j) Type of Admission : Emergency ☐ Planned ☐ Day Care ☐ Maternity ☐ k) If Maternity i) Date of delivery  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"/> <input type="text"/> <input type="text"/>	_____	i) Procedure 1:	<input type="text"/> <input type="text"/> <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"/> <input type="text"/> <input type="text"/>	_____	ii) Procedure 2:	<input type="text"/> <input type="text"/> <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"/> <input type="text"/> <input type="text"/>	_____	iii) Procedure 3:	<input type="text"/> <input type="text"/> <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"/> <input type="text"/> <input type="text"/>	_____	iv) Details of Procedure:	_____	_____

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

Place : \_\_\_\_\_

Signature and Seal of the Hospital Authority

SECTION A

SECTION B

SECTION C

SECTION D

SECTION E

SECTION F

GUIDANCE FOR FILLING CLAIM FORM - PART B (To be filled in by the hospital)		
DATA ELEMENT	DESCRIPTION	FORMAT
<b>SECTION A - DETAILS OF HOSPITAL</b>		
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
<b>SECTION B - DETAILS OF THE PATIENT ADMITTED</b>		
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)
<b>SECTION C - DETAILS OF AILMENT DIAGNOSED (PRIMARY)</b>		
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
<b>SECTION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST</b>		
Indicate which supporting documents are submitted		
<b>SECTION E - DETAILS IN CASE OF NON NETWORK HOSPITAL</b>		
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
<b>SECTION F - DECLARATION BY THE HOSPITAL</b>		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign and stamp		