Aditya Birla Health Insurance

Activ Health

OHRID- _____

ADITYA BIRLA HEALTH

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 (To be filled in block letters)

DETAILS OF PRIMARY INSURED: → SELF | EMPLOYEE DETAILS

a) Policy No: MENTION AS GENPACT

b) SI No / Certificate No. LEAVE IT BLANK

c) Company/ TPA ID No: UHID NUMBER OF E-CARDS

d) Name: RAM MANOHAR

e) Address: F-345| A, GALI NO-2,

City: GURUGRAM State: HARYANA Pin Code: 122012

f) Phone No: 9999999999 g) Email ID: XXX@Gmail.com

DETAILS OF INSURANCE HISTORY: → LEAVE THIS SECTION BLANK

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:

i) Policy No. ii) Sum Insured (Rs.)

d) Have you been hospitalized in the last four years since inception of the contract? ☐ Yes ☐ No

i) Date: D D M M Y Y Y Y ii) Diagnosis:

e) Previously covered by any other Mediclaim /Health insurance: ☐ Yes ☐ No

f) If yes, Company Name:

DETAILS OF INSURED PERSON HOSPITALIZED: → PATIENT

a) Name: LATA

b) Gender: ☐ Male: ☑ Female: c) Age: 26 years 02 months

d) Date of Birth: 21/06/1996

e) Relationship to Primary insured: ☐ Self ☑ Spouse ☐ Child ☐ Father ☐ Mother ☐ Other P A T I E N T

f) Occupation: ☐ Service ☐ Self Employed ☑ Homemaker ☐ Student ☐ Retired ☐ Other P A T I E N T

g) Address: (if different from above) SAME AS ABOVE

City: State: Pin Code:

h) Phone No: i) E-mail ID:

DETAILS OF HOSPITALIZATION:

a) Name of Hospital where Admitted: HOSPITAL NAME

b) Room Category Occupied: [X] Day care [✓] Twin sharing [X] 3 or more beds per room

c) Hospitalization due to: [ ] Injury [✓] Illness [ ] Maternity

d) Date of injury / Date Disease first detected / Date of Delivery: [ ]

e) Date of Admission: 26082022

f) Time: 9:00 AM

g) Date of Discharge: 28 08 2022

h) Time: 9:00 AM

i) If Injury give cause: [ ] Self inflicted [ ] Road Traffic Accident [ ] Substance Abuse / Alcohol Consumption

j) If Medico legal: [ ] Yes [ ] No

k) Reported to police: [ ] Yes [ ] No

l) MLC Report & Police FIR attached: [ ] Yes [ ] No

m) System of Medicine: [ ]

DETAILS OF CLAIM:

a. Details of the treatment expenses claimed:

i. Pre -hospitalization Expenses: Rs. 2,000/-

ii. Hospitalization Expenses: Rs. 30,000/-

iii. Post-hospitalization Expenses: Rs. 4,000/-

iv. Health-Check up Cost:Rs.

v. Ambulance Charges: Rs.

vi. Others (code): Rs.

vii. Total: Rs. 36,000/-

viii. Pre-hospitalization period: days

ix. 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.

vii. Total Rs.

Claim Documents Submitted - Check List:

[✓] i. Claim Form Duly signed [✓] ii. Copy of the claim intimation, if any

[✓] iii. Hospital Main Bill [✓] iv. Hospital Break-up Bill

[✓] v. Hospital Bill Payment Receipt [✓] vi. Hospital Discharge Summary:

[✓] vii. Pharmacy Bill [✓] viii. Operation Theatre Notes:

[✓] ix. ECG: [✓] x. Doctor's request for investigation:

[✓] xi. Investigation Reports (Including CT/ MRI / USG / HPE) [✓] xii. Doctor's Prescriptions:

[ ] xiii. Others:

DETAILS OF BILLS ENCLOSED:

Sl. No.	Bill No.	Date	Issued by	Towards	Amount (Rs)
1.				Hospital Main Bill	30,000/-
2.				Pre-hospitalization Bills: Nos	2,000/-
3.				Post-hospitalization Bills: Nos	4,000/-
4.				Pharmacy Bills	
5.					
6.					
7.					
8.					
9.				TOTAL —	36,000/-
10.					

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT:

a. Pan No: XXXXXXXXXX

b. Account No: XXXXXXXXXXX

c. Bank Name and Branch: XXXXXX

d. Cheque / DD Payable details:

e. IFSC Code: XXXXXXX

(IMPORTANT: PLEASE TURN OVER)

DECLARATION BY THE INSURED:

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 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: 28/08/22

Place: GURGAON

Signature of the Insured: RAM

GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled in by the Insured)		
DATA ELEMENT	DESCRIPTION	FORMAT
SECTION A - DETAILS OF PRIMARY INSURED		
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
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		
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-yyformat
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