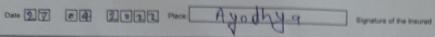
CI.AIM FORM - PART A' to 'CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND	PERSONAL ACCIDENT - PART A
The Lord Filled BY THE INSURED	(To be Filled III
DETAILS OF PRIMARY INSURED: a) Policy No DETAILS OF PRIMARY INSURED:	
c) Company/ TPA ID No: [CRITICALE No.]	
d) Name: DEBRUAR DE BRUAR DE B	
e) Address: DZZZZZZZZZZZZZZZZZZZZZZZZZZZZZZZZZZZ	
Pin Code 22BU23 Phone No. 99958W758B951C Company PARK 77 V.	DIESIALI. COM
DETAILS OF INSURANCE HISTORY:	0 (11-11-1
a) Currently covered by any other Mediclaim / Health Insurence: Yes No b) Date of commencement of first Insurance without break:	9回图团 "
9 11 yes, company name: OKULEVII BUILD IN SIDE Policy No. 4-9 TO	Date: MM VV
Sum insured (Ns.)	
Diagnosis: e) Previously covered by any other Me	diclaim /Health insurance :: Yes No
0 if yes, company name.	
DETAILS OF INSURED PERSON HOSPITALIZED:	
DI GROOM TO THE	E NAME
a) Balantinashi ta Dainan Jamas	
Demonstra	SECTION
g) Address (if different from above):	
Pho Code 224143 Phone No: 9953075097 Email D. RAMY2K.	(GMAIL · COM
DETAILS OF HOSPITALIZATION: :	
a) Name of Hospital where Admited: DEVALMEMORIAL MEDICAL HOSP	
b) Room Category occupied: Day care Single occupancy Twin sharing 3 or more beds per room	
c) Hospitalization due to: Injury Illness Maternity of Date of injury / Date Disease first detected /Date of Delivery:	(a) A) 7/me: (a) 2 : (b) 1/me: (a) 2 : (c) 1/me:
e) Date of Admission: The Date of Discharge Date Date of Discharge Date Date Date Date Date Date Date Dat	2 h) Time:
	Yes No
ii) Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine:	
DETAILS OF CLAIM:	
a) Details of the Treatment expenses claimed	
	Claim Documents Submitted - Check List:
L. Pre -hospitalization expenses Rs	Claim form duly signed Copy of the claim intimation, if any Hospital Main Bill
I. Pre -hospitalization expenses Rs	Claim form duly signed Copy of the claim instruction, if any Hospital Main Bill Hospital Break-up Bill
Rs. Ambulance Charges: R	Claim form duly signed Copy of the claim instruction, if any Hospital Main Bill Hospital Break-up Bill
L. Pre-hospitalization expenses Rs	Claim form duly signed Copy of the claim instruction, if any Hospital Main Bill Hospital Break-up Bill
L. Pre -hospitalization expenses Rs	Claim form duly signed Copy of the claim intimation, if any Hospital Main Bill Hospital Break-up Bill Hospital Bill Payment Receipt Hospital Discharge Summary Pharmacy Bill Operation Theater Notes
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L. Pre -hospitalization expenses Rs	Claim form duly signed Copy of the claim intimation, if any Hospital Main Bill Hospital Break-up Bill Hospital Bill Payment Receipt Hospital Discharge Summary Pharmacy Bill Operation Theater Notes EG Doctor's request for investigation
L. Pre -hospitalization expenses Rs	Claim form duly signed Copy of the claim intimation, if any Hospital Main Bill Hospital Break-up Bill Hospital Bill Payment Receipt Hospital Discharge Summary Pharmacy Bill Operation Theater Notes
II. Pre-hospitalization expenses Rs.	Claim form duly signed Copy of the claim intimation, if any Hospital Main Bill Hospital Breakup Bill Hospital Bill Payment Receipt Hospital Discharge Summary Pharmacy Bill Operation Theater Notes ECG Doctor's request for investigation Investigation Reports (Including CT
L. Pre -hospitalization expenses Rs	Claim form duly signed Copy of the claim intimation, if any Hospital Main Bill Hospital Break-up Bill Hospital Bill Payment Receipt Hospital Discharge Summary Pharmacy Bill Operation Theater Notes ECG Doctor's request for investigation Investigation Reports (Including CT MRI / USG / HPE) Doctor's Prescriptions Others
II. Pre-hospitalization expenses III. Post-hospitalization expenses III. Post-hospitalization expenses III. Post-hospitalization expenses III. Post-hospitalization expenses III. Health-Check up cost: III. Vi. Health-Check up cost: III. Vi. Others (code): III. Rs. III. Post-hospitalization period: III. Post-hospitalization period: III. Post-hospitalization period: III. Surgical Cash: III. Surgical Cash: III. Critical Illness benefit: III. Critical Illness bene	Claim form duly signed Copy of the claim intimation, if any Hospital Main Bill Hospital Break-up Bill Hospital Bill Payment Receipt Hospital Discharge Summary Pharmacy Bill Operation Theater Notes ECG Doctor's request for investigation Investigation Reports (Including CT MR / USG / MPE) Doctor's Prescriptions Others Amount (Rs)
II. Post-hospitalization expenses III. Health-Check up cost: III. Health-Check up cost: III. Viii. Pre -hospitalization period: III. Post-hospitalization period: III. Post-hospitalization period: III. Post-hospitalization period: III. Post-hospitalization period: III. Surgical Cash: III. Surgical Cash: III. Critical Illness benefit: III. Critical Illnes	Claim form duly signed Copy of the claim intimation, if any Hospital Main Bill Hospital Break-up Bill Hospital Bill Payment Receipt Hospital Discharge Summary Pharmacy Bill Operation Theater Notes EG Doctor's request for investigation Investigation Reports (Including CT MRI / USG / HPE) Doctor's Prescriptions Others Amount (Rs)
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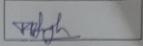
Aphah

(IMPORTANT: PLEASE TURN OVER)









	DATA ELEMENT	FOR FILLING CLAIM FORM - PART A (To be filled in by the insured DESCRIPTION	FORMAT
		SECTION A - DETAILS OF PRIMARY INSURED	FORMA
0	Policy No.	Enter the policy number	As allotted by the Insurance Company
5)	SI. No/ Certificate No.	Enter the social Insurance number or the certificate number of social health insurance scheme	As allotted by the oraganization
c)	Company TPA ID No.	Enter the TPA ID No.	Licence number as afforted by IROA and printer In TPA documents.
6)	Name	Enter the full name of the policyholder	Surname, First name, Middle name
6)	Address	Enter the full postal address	Include Street, City and Pin code
		SECTION B -DETAILS OF INSURANCE HISTORY	
8)	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-forrmat
6)	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
5)	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
6)	Previously covered by any other Medicialm / Health Insurance?	Indicate whether previously covered by another mediclaim / Health Insurance	Tick Yes or No
80	Company Name	Enter the full name of the Insurance Company	Name of the organization in full
		CTION C -DETAILS OF INSURED PERSON HOSPITALIZED	
(8)	Name	Enter the full name of the patient	Surname, First name, Middle name
(b)	Gender	Indicate Gender of the patient	Tick Male or Female
(0)		Enter age of the patient	Number of years and months
(d)	Age 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
(8)	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
(8)	Phone No	Enter the phone number of patient	Include STD code with telephone number
		Enter e-mail address of patient	Complete e-mail address
1)	E-mail ID	SECTION D - DETAILS OF HOSPITALIZATION	
	Name of Hospital where admited	Enter the name of hospital	Name of hospital in full
(E)		indicate the room category occupied	Tick the right option
(b)	Room category occupied	indicate reason of hospitalization	Tick the right option
(C)	Hospitalization due to Date of injury/Date Disease first detected / Date of	Enter the relevant date	Use dd-mm-yy format
	Delivery Set of admission	Enter date of admission	Use dd-mm-yy format
6)	Date of admission	Enter time of admission	Use hh-mm- format
7)	Time	Enter date of discharge	Use dd-mm-yy format
8)	Date of discharge	Enter time of discharge	Use hh-mm- format
h)	Time	indicate cause of injury	Tick the right option
1)	If injury give cause	indicate whether injury is medico legal	Tick Yes or No
	If Medico legal	Indicate whether police report was filed	Tick Yes or No
	Reported to Police MLC Report & Police FIR attached	indicate whether MLC report and Police FIR attached	Tick Yes or No
		Enter the system of medicine followed in treating the patient	Open Text
D	System of Medicene	SECTION E - DETAILS OF CLAIM	
	A desail Expenses	Enter the amount claimed as treatment expences	In rupees (Do not enter palse values)
8)	Details of Treatment Expences	indicate whether claim is for domiciliary hospitalization	Tick Yes or No
b)	Claim for Domiciliary Hospitalization	Enter the amount claimed as lump sum / cash benefit	In rupees (Do not enter paise values)
c)	Details of Lump sum/ Cash benifit claimed	indicate which supporting documents are submitted	Tick the right option
d)	Claim documents Submitted-Check List	SECTION F - DETAILS OF BILLS ENCLOSED	
9990	. We the executed to rupees		
	ficate which bills are enclosed with the amount in rupees	TION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT	
Inc		Enter the permanent account number	As allotted by the Income Tax Department
Inc		Enter the Bank account number	As allotted by the Bank
ind a)	PAN		
	Account Number	Enter the Bank name along with the branch	Name of the Bank in full
a)	Account Number Bank Name and Branch	Enter the name of the beneficiary the cheque / DD should be	
a) b)	Account Number		Name of the Bank in full Name of the individual / organization in full IFSC code of the Bank branch in full