

LIST OF DOCUMENTS REQUIRED FOR SETTLEMENT OF HOSPITALISATION CLAIMS

1. FOR CLAIMING HOSPITALISATION EXPENSES	
A	CLAIM FORM – PART A: DULY COMPLETED BY THE INSURED ON THE PRESCRIBED FORMAT - ORIGINAL
B	CLAIM FORM – PART B: DULY COMPLETED AND SIGNED BY THE HOSPITAL AUTHORITIES - ORIGINAL
C	ADMISSION NOTES – CERTIFIED COPY
D	TPA ID CARD – XEROX COPY
E	ANY OTHER ID PROOF LIKE VOTER ID/ DL/ PASSPORT ETC - COPY
F	ADDRESS PROOF - COPY
G	REFERRAL LETTER, IF ANY, TO HOSPITAL – CERTIFIED COPY
H	DETAILED DISCHARGE SUMMARY - ORIGINAL
I	DEATH SUMMARY (INSTEAD OF Discharge Summary) IF PATIENT HAS PASSED AWAY DURING HOSPITALISATION - ORIGINAL
J	INVESTIGATION REPORTS - IN ORIGINAL – FOR INVESTIGATIONS DONE DURING HOSPITALISATION
K	HISTOPATHOLOGY REPORT, IF ANY, IN ORIGINAL
L	CERTIFIED COPY OF OPERATION THEATRE (OT) NOTES – WHERE SURGERY IS PERFORMED
M	MLC REPORT/ FIR FOR ACCIDENT CASES – CERTIFIED COPY
N	STICKER FOR THE IMPLANTS USED - ORIGINAL
O	SUPPPORTING INVOICE FOR THE IMPLANTS USED – CERTIFIED COPY
P	HOSPITAL MAIN BILL - ORIGINAL
Q	BREAK-UP BILL FOR THE HOSPITAL MAIN BILL - ORIGINAL
R	DETAILED BILL FOR THE NON-ADMISSIBLE AMOUNTS COLLECTED FROM THE PATIENT
S	RECEIPT FOR THE AMOUNT COLLECTED FROM THE PATIENT
T	RECEIPT FOR THE CO-PAY COLLECTED FROM THE PATIENT
U	COPY OF THE PRE-AUTH DENIED LETTER, IF ANY, FOR CASHLESS DENIED
V	CONFIRMATION FROM THE HOSPITAL FOR NON-UTILISATION OF CASHLESS FACILITY, IF CASHLESS SANCTIONED
W	PRESCRIPTIONS FOR MEDICINES PURCHASED DURING HOSPITALISATION
X	PHARMACY BILLS IN ORIGINAL FOR MEDICINES PURCHASED DURING HOSPITALISATION
Y	LIST OF BILLS SUBMITTED WITH THE AMOUNT UNDER EACH BILL
Z	DOCUMENTS FOR NATIONAL ELECTRONIC FUND TRANSFER (NEFT)
	a. NEFT FORMAT GIVING DETAILS OF BANK ACCOUNT CLAIM AMOUNT TO BE TRANSFERRED
	b. A COPY OF THE PAGE OF BANK PASS BOOK CONTAINING A/C NUMBER & NAME/ ADDRESS OF A/C HOLDER.
	c. A CANCELLED CHEQUE FOR THE ABOVE ACCOUNT IN TO WHICH CLAIM AMOUNT HAS TO BE TRANSFERRED
AA	COVERING LETTER STATING YOUR COMPLETE CURRENT ADDRESS, CONTACT NUMBER AND THE LIST OF DOCUMENTS ATTACHED
AB	ANY OTHER DOCUMENT THAT THE CLAIM PROCESSING TEAM/ TPA REQUESTS
2. FOR CLAIMING PRE-HOSPITALISATION EXPENSES	
a	CLAIM FORM - PART A DULY COMPLETED AND SIGNED
b	OPD CONSULTATION PAPER, IF ANY – ORIGINAL
c	CONSULTATION BILL/ CASH RECEIPT, IF ANY
d	PRESCRIPTION FOR MEDICINES PURCHASED PRIOR TO HOSPITALISATION
e	PHARMACY CASH BILLS FOR MEDICINES PURCHASED PRIOR TO HOSPITALISATION
f	INVESTIGATION REPORTS - IN ORIGINAL – FOR INVESTIGATIONS DONE PRIOR TO ADMISION, IF ANY
g	CASH BILLS FOR THE INVESTIGATIONS DONE PRIOR TO HOSPITALISATION
h	REFERENCE LETTER FOR INVESTIGATION CONDUCTED PRIOR TO HOSPITALISATION

i	DOCUMENTS FOR NATIONAL ELECTRONIC FUND TRANSFER (NEFT) AS IN ITEM 1 - 'Z' ABOVE
j	COVERING LETTER STATING YOUR COMPLETE CURRENT ADDRESS, CONTACT NUMBER & LIST OF DOCUMENTS ATTACHED
3. FOR CLAIMING POST-HOSPITALISATION EXPENSES	
a	CLAIM FORM – PART A DULY COMPLETED AND SIGNED
b	OPD CONSULTATION PAPER, IF ANY – ORIGINAL
c	CONSULTATION BILL/ CASH RECEIPT, IF ANY
d	PRESCRIPTION FOR MEDICINES PURCHASED - POST-DISCHARGE
e	PHARMACY BILLS FOR MEDICINES PURCHASED - POST-DISCHARGE
f	INVESTIGATION REPORTS - IN ORIGINAL – FOR INVESTIGATIONS DONE - POST-DISCHARGE, IF ANY
g	CASH BILLS FOR THE INVESTIGATIONS DONE - POST-DISCHARGE
h	REFERENCE LETTER FOR INVESTIGATION CONDUCTED - POST-DISCHARGE
i	DOCUMENTS FOR NATIONAL ELECTRONIC FUND TRANSFER (NEFT) AS IN ITEM 1 - 'Z' ABOVE
j	COVERING LETTER STATING YOUR COMPLETE CURRENT ADDRESS, CONTACT NUMBER AND THE LIST OF DOCUMENTS ATTACHED
4. FOR HOSPITALS CLAIMING CASHLESS HOSPITALISATION EXPENSES APPROVED	
A	CLAIM FORM – PART A: DULY COMPLETED BY THE INSURED ON THE PRESCRIBED FORMAT - ORIGINAL
B	CLAIM FORM – PART B: DULY COMPLETED AND SIGNED BY THE HOSPITAL AUTHORITIES - ORIGINAL
C	ADMISSION NOTES – CERTIFIED COPY
D	TPA ID CARD – XEROX COPY
E	ANY OTHER ID PROOF LIKE VOTER ID/ DL/ PASSPORT ETC - COPY
F	ADDRESS PROOF - COPY
G	PRE-AUTHORISATION REQUEST IN ORIGINAL DULY SIGNED BY THE INSURED AND THE HOSPITAL
H	PRE-AUTHORISATION APPROVAL LETTER COPY
I	REFERRAL LETTER, IF ANY, TO HOSPITAL – CERTIFIED COPY
J	DETAILED DISCHARGE SUMMARY - ORIGINAL
K	DEATH SUMMARY (INSTEAD OF Discharge Summary) IN CASE THE PATIENT HAS PASSED AWAY DURING HOSPITALISATION - ORIGINAL
L	INVESTIGATION REPORTS - IN ORIGINAL – FOR INVESTIGATIONS DONE DURING HOSPITALISATION
M	HISTOPATHOLOGY REPORT, IF ANY, IN ORIGINAL
N	CERTIFIED COPY OF OPERATION THEATRE (OT) NOTES – WHERE SURGERY IS PERFORMED
O	MLC REPORT/ FIR FOR ACCIDENT CASES – CERTIFIED COPY
P	STICKER FOR THE IMPLANTS USED - ORIGINAL
Q	SUPPORTING INVOICE FOR THE IMPLANTS USED – CERTIFIED COPY
R	HOSPITAL MAIN BILL - ORIGINAL
S	BREAK-UP BILL FOR THE HOSPITAL MAIN BILL - ORIGINAL
T	DETAILED BILL FOR THE NON-ADMISSIBLE AMOUNTS COLLECTED FROM THE PATIENT
U	RECEIPT FOR THE AMOUNT COLLECTED FROM THE PATIENT FOR THE NON-ADMISSIBLE AMOUNTS
V	RECEIPT FOR THE CO-PAY COLLECTED FROM THE PATIENT
W	PRESCRIPTIONS FOR MEDICINES PURCHASED DURING HOSPITALISATION
X	PHARMACY BILLS IN ORIGINAL FOR MEDICINES PURCHASED DURING HOSPITALISATION
Y	LIST OF BILLS SUBMITTED WITH THE AMOUNT UNDER EACH BILL
Z	ANY OTHER DOCUMENT THAT THE CLAIM PROCESSING TEAM/ TPA REQUESTS

NOTE: (1) YOU SHOULD SUBMIT THE ABOVE DOCUMENTS ALONG WITH A COVERING LETTER (2) IF YOU ARE SUBMITTING PRE &/OR POST-HOSPITALISATION CLAIMS SEPARATELY YOU SHOULD SUBMIT THE CLAIM FORM DULY COMPLETED (3) ALSO SUBMIT THIS CHECKLIST

CLAIM FORM - PART A' to 'CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT - PART A

TO BE FILLED BY THE INSURED

(To be Filled in block letters)

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

SECTION A

SECTION B

SECTION C

SECTION D

SECTION E

SECTION F

SECTION G

DETAILS OF PRIMARY INSURED:

a) Policy No.:

b) Sl. No/ Certificate no.

c) Company/ TPA ID No:

d) Name:

e) Address:

City:

State:

Pin Code

Phone No:

Email ID:

DETAILS OF INSURANCE HISTORY:

a) Currently covered by any other Medicaclaim / Health Insurance:

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:

Diagnosis:

e) Previously covered by any other Medicaclaim /Health insurance :

Yes

No

f) If yes, company name:

DETAILS OF INSURED PERSON HOSPITALIZED: :

a) Name:

b) Gender

Male

Female

c) Age years

Months

d) Date of Birth

e) Relationship to Primary insured:

Self

Spouse

Child

Father

Mother

Other

(Please Specify)

f) Occupation

Service

Self Employed

Home Maker

Student

Retired

Other

(Please Specify)

g) Address (if diffrent from above) :

City:

State:

Pin Code

Phone No:

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) Hospitalization due to:

Injury

Illness

Maternity

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

e) Date of Admission:

f) Time

g) Date of Discharge:

h) Time:

i) If injury give cause:

Self inflicted

Road Traffic Accident

Substance Abuse / Alcohol Consumption

I) If Medico legal

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

i. Pre -hospitalization expenses

Rs.

ii. Hospitalization expenses

Rs.

iii. Post-hospitalization expenses

Rs.

iv. Health-Check up cost:

Rs.

v. Ambulance Charges:

Rs.

vi. Others (code):

Rs.

Total

Rs.

vii. Pre -hospitalization period:

days

viii. 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.

Total

Rs.

Claim Documents Submitted - Check List:

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

DETAILS OF BILLS ENCLOSED:

Sl. No.	Bill No.	Date	Issued by	Towards	Amount (Rs)
1.		D D M M Y Y		Hospital main Bill	
2.		D D M M Y Y		Pre-hospitalization Bills: Nos	
3.		D D M M Y Y		Post-hospitalization 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::

a) PAN:

b) Account Number:

c) Bank Name and Branch:

d) Cheque / DD Payable details:

e) IFSC Code:

(IMPORTANT: PLEASE TURN OVER)

DECLARATION BY THE INSURED:

I hereby declare that the information furnished in the 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 Place: Signature of the Insured

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.	Licence 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 Mediciam / Health Insurance?	Indicate whether currently covered by another Mediciam / 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	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
Date	Enter the date of Hospitalization	Use mm-yy format
Diagnosis	Enter the diagnosis details	Open Text
e) Previously covered by any other Mediciam / 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	Enter the full name of the patient	Surname, First name, Middle name
b) Gender	Indicate Gender of the patient	Tick Male or Female
c) Age	Enter age of the patient	Number of years and months
d) 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
f) 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
h) Phone No	Enter the phone number of patient	Include STD code with telephone number
i) 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/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	Indicate cause of injury	Tick the right option
If 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
MLC Report & Police FIR attached	Indicate whether MLC report and Police FIR attached	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
SECTION F - DETAILS OF BILLS ENCLOSED		
Indicate which bills are enclosed with the amount in rupees		
SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT		
a) PAN	Enter the permanent account number	As allotted by the Income Tax Department
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
c) 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
c) IFSC Code	Enter the IFSC code of the Bank branch	IFSC code of the Bank branch in full
SECTION H - DECLARATION BY THE INSURED		
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 an 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:
a) Hospital ID: c) Type of Hospital: Network : ☐ Non Network : ☐ (if non network fill section E)
c) Name of the 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"/>	i. Procedure 1:	<input type="text"/>	<input type="text"/>
ii. Additional Diagnosis:	<input type="text"/>	<input type="text"/>	ii. Procedure 2:	<input type="text"/>	<input type="text"/>
iii. Co-morbidities:	<input type="text"/>	<input type="text"/>	iii. Procedure 3:	<input type="text"/>	<input type="text"/>
iv. Co-morbidities:	<input type="text"/>	<input type="text"/>	iv. Details of Procedure:	<input type="text"/>	<input type="text"/>

c) Pre-authorization obtained: ☐ Yes ☐ No d) Pre-authorization Number:
e) If authorization by network hospital not obtained, give reason:
f) 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. If Medico legal: ☐ Yes ☐ No iv. Reported to Police ☐ Yes ☐ No
v. FIR No. vi. If not reported to police give reason:

CLAIM DOCUMENTS SUBMITTED - CHECK LIST

- | | |
|--|--|
| <input type="checkbox"/> Claim Form duly signed | <input type="checkbox"/> Investigation reports |
| <input type="checkbox"/> Original Pre-authorization request | <input type="checkbox"/> CT/MR/USG/HPE investigation reports |
| <input type="checkbox"/> Copy of the Pre-authorization approval 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 reports & 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 the Hospital
City: State:
Pin Code: b) Phone No. c) Registration No. with State Code:
d) Hospital PAN: e) Number of inpatient beds f) Facilities available in the 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 this Claim Form is true & correct to the best of our knowledge and belief. If we have made any false or 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
SECTION A - DETAILS OF HOSPITAL		
a) Name of the hospital:	Enter the name of hospital	Name of the hospital in full
b) Hospital ID	Enter ID number of hospital	As allocated by the TPA
c) Type of Hospital	Indicate whether in network or non network hospital	Tick the right option
c) Name of treating doctor	Enter the name of the treating doctor	Name of doctor in full
e) Qualification	Enter the qualification of the treating doctor	Abbreviations of educational qualifications
f) 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
g) Phone No.	Enter the phone number of doctor	Include STD code with telephone number
SECTION B - DETAILS OF THE PATIENT ADMITTED		
a) Name of Patient	Enter the name of patient	Name of patient in full
b) IP registration Number	Enter insurance provider registration number	As allotted by the insurance provider
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	Use dd-mm-yy format
f) Date of Admission	Enter date of admission	Use dd-mm-yy format
g) Time	Enter Time 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		
i. Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format
ii. 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 Code and description of the first procedure	Standard Format and Open text
Procedure 2	Enter the ICD 10 Code and description of the second procedure	Standard Format and Open text
Procedure 3	Enter the ICD 10 Code 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 Hospital obtained from local body like City Corporation / Municipality	As allocated by the City Corporation / Municipality
d) Hospital PAN	Enter the permanent account number	As allocated 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		

ELECTRONIC CLEARING SERVICE (CREDIT CLEARING) MANDATE FORM

For Claim under Policy No _____

1. (A) CARDHOLDER'S NAME

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(B) ADDRESS

(C) TELEPHONE / MOBILE No:

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(D) E-MAIL ID:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

2. TTK ID No

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

3. PARTICULARS OF BANK ACCOUNT

A. BANK NAME

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

B. BRANCH NAME

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

C. ADDRESS

D. 9 DIGIT CODE NUMBER OF THE BANK & BRANCH APPEARING ON THE MICR CHEQUE ISSUED BY THE BANK

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E. ACCOUNT TYPE (SAVINGS ACCOUNT/ CURRENT ACCOUNT)

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F. ACCOUNT NUMBER (AS APPEARING ON THE CHEQUE BOOK)

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

G. BANK ACCOUNT HOLDER NAME

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

4. DATE OF EFFECT:

--	--	--	--	--	--	--	--

INFORMATION FOR PAYMENT THROUGH RTGS OR NEFT

5. IFSC CODE (INDIAN FINANCIAL SYSTEM CODE)

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

6. NEFT CODE (NATIONAL ELECTRONIC FUNDS TRANSFER CODE)

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

By submission of the above, I authorise M/s Vidal Health TPA Private Ltd (formerly known as TTK Healthcare TPA Pvt Ltd) / the Insurance Company to settle the claim under reference through direct payment by ECS. I hereby declare & confirm that the particulars given above are correct and complete. I agree that I shall not hold the TPA/ Insurance Company responsible for delay or non-receipt of payment for any reason whatsoever after issue of instructions for transfer of payment by Insurer/ TPA based on the above.

Date:

Place:

Signature of the Insured