****

**PART – A CLAIM FORM**

# 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)

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **DETAILS OF PRIMARY INSURED** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a) Policy No. | | |  |  |  |  |  |  |  |  |  |  |  |  |  | b) SI. No./Certificate No. | | | | | |  |  |  |  |  |  |  |  |  |
| c) Company/TPA ID No. | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| d) Name |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| e) Address |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| City | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| State | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Pin Code | | |  |  |  |  |  |  |
| Ph. No. | |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Email ID | | |  | | | | | | | | | | |

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| **DETAILS OF INSURANCE HISTORY** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a) Currently covered by any other Mediclaim/Health Insurance | | | | | | | | | | | | | | | | | | | | | Yes | |  | No | |  |
| b) If yes, Company Name |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Policy No. |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Sum Insured (`) | | | | |  |  |  |  |  |  |  |
| c) Date of commencement of first Insurance without break | | | | | | | | | | | | | DD / MM / YYYY | | | | | | (Copies of Policies to be attached) | | | | | | | |
| d) Have you been hospitalized in the last 4 years? (since inception of the contract) | | | | | | | | | | | | Yes | |  | No | |  | Date | | | DD / MM / YYYY | | | | | |
| Diagnosis | | | |  | | | | | | | | | | |
| e) Have you been covered by any other Mediclaim/Health Insurance in last 4 years | | | | | | | | | | | | | | | | | | | | | Yes | |  | No | |  |
| f) If yes, Company Name |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| **DETAILS OF INSURED PERSON HOSPITALIZED** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a) Name | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| b) Gender | | Male | |  | Female | | |  | c) Age | | | years | |  | | months | |  | | d) Date of Birth | | | | DD / MM / YYYY | | | | | |
| e) Relationship to Primary insured | | | | | Self | | | |  | Spouse | | | |  | Child | | | |  | Father | | | |  | Mother | | | |  |
| Other | | | |  | (Please Specify) | | | |  | | | | | | | | | | | | | | | |
| f) Occupation | | | | | Service | | | |  | Self-Employee | | | |  | Homemaker | | | |  | Student | | | |  | Retired | | | |  |
| Other | | | |  | (Please Specify) | | | |  | | | | | | | | | | | | | | | |
| Address (if different from above) | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | City |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| State |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Pin Code | | |  |  |  |  |  |  |
| Ph. No. |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Email ID | | |  | | | | | | | | | | |

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| **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 of Disease first detected/Date of Delivery | | | | | | | | | | | | | | | | | | | | | | | DD / M M / YYYY | | | | | |
| e) Date of Admission | DD / MM / YYYY | | | | | f) Time | | HH | MM | g) Date of Discharge | | | | | | DD / MM / YYYY | | | | | | | h) Time | | | | HH | MM |
| i) 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 & Police FIR attached | | | | | | | | | | | | | | Yes | |  | No | |  |
| j) System of Medicine | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| k) Date of Surgery | | | DD / M M / YYYY | | | | | | l) Claim Intimated | | | | | | | | | | | | | | Yes | |  | No | |  |
| i. Intimated to whom | | | SBU | |  | Intermediaries | | | | | |  | Call Centre | | | | |  | Health Claims Team | | | | | | | | |  |
| ii. Intimation No. & date | | |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  | |  | DD / MM / YYYY | | | | | |
| iii. If not Intimated, reason? | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **DETAILS OF CLAIM** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a) Details of the treatment expenses claimed | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| i. Pre-hospitalization Expenses | | ` |  |  |  |  |  |  |  | | ii. Hospitalization Expenses | | | | | | | | | | ` |  |  |  |  |  |  |  |
| iii. Post-hospitalization expenses | | ` |  |  |  |  |  |  |  | | iv. Health-Checkup Cost | | | | | | | | | | ` |  |  |  |  |  |  |  |

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| v. Ambulance Charges | ` |  |  |  |  |  |  |  | vi. Others (code) | |  |  |  | ` |  |  |  |  |  |  |  |
| vii. Pre-hospitalization period | Days | | | | |  |  |  | **Total** | | | | | ` |  |  |  |  |  |  |  |
|  | | | | | | | | | 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 | ` |  |  |  |  |  |  |  | ii. Surgical Cash | | | | | ` |  |  |  |  |  |  |  |
| iii. Critical Illness Benefit | ` |  |  |  |  |  |  |  | iv. Convalescence | | | | | ` |  |  |  |  |  |  |  |
| v. Pre/Post hospitalization Lump sum benefit | ` |  |  |  |  |  |  |  | vi. Others | |  |  |  | ` |  |  |  |  |  |  |  |
|  | | | | | | | | | **Total** | | | | | ` |  |  |  |  |  |  |  |
| **Claim Documents Submitted - Check List** | | | | | | | | | | Operation Theatre Notes | | | | | | | | | | |  |
| Claim Form Duly signed | | | | | | | | |  | ECG | | | | | | | | | | |  |
| Copy of the claim intimation | | | | | | | | |  | Doctor’s request for investigation | | | | | | | | | | |  |
| Hospital Main Bill | | | | | | | | |  | Investigation Reports (CT/MRI/USG/HPE) | | | | | | | | | | |  |
| Hospital Break - up Bill | | | | | | | | |  | Doctor’s Prescriptions | | | | | | | | | | |  |
| Hospital Bill Payment Receipt | | | | | | | | |  | Pre-Hosp. Bills | | | | | | | | | | |  |
| Hospital Discharge Summary | | | | | | | | |  | Post-Hosp. Bills | | | | | | | | | | |  |
| Pharmacy Bill | | | | | | | | |  | Others | | | | | | | | | | |  |

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| **DETAILS OF BILLS ENCLOSED** | | | | | | | | | | | | | |
| SI. No. | Bill No. | Date | Issued by | Towards (Hospitalization/Pre-hospitalization/ Post-hospitalization | Amount (`) | | | | | | | | |
| 1 |  | DD / MM / YYYY |  |  |  |  |  |  | |  | |  |  |
| 2 |  | DD / MM / YYYY |  |  |  |  |  |  | |  | |  |  |
| 3 |  | DD / MM / YYYY |  |  |  |  |  |  | |  | |  |  |
| 4 |  | DD / MM / YYYY |  |  |  |  |  |  | |  | |  |  |
| 5 |  | DD / MM / YYYY |  |  |  |  |  |  | |  | |  |  |
| 6 |  | DD / MM / YYYY |  |  |  |  |  |  | |  | |  |  |
| 7 |  | DD / MM / YYYY |  |  |  |  |  |  | |  | |  |  |
| 8 |  | DD / MM / YYYY |  |  |  |  |  |  | |  | |  |  |
| 9 |  | DD / MM / YYYY |  |  |  |  |  |  | |  | |  |  |
| 10 |  | DD / MM / YYYY |  |  |  |  |  |  | |  | |  |  |
| Do you want to opt for Automatic Reinstatement of Sum Insured in the event of a claim? If, Yes, applicable premium at short period rates would be deducted from the claim amount due to you. This reinstated sum will not be available for the same hospitalization. It will be available for treatment  (other than certain chronic diseases) including the same illness or disease but separate independent case of hospitalization | | | | | | | | | | | | | |
| which are not case of relapse within 45 days of first hospitalization. Please contact the agent/our office for further details: | | | | | | | Yes | |  | | No | |  |

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| **DETAILS OF PRIMARY INSURED’S BANK ACCOUNT (Please submit a cancelled cheque copy for NEFT)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a) PAN |  |  |  |  |  |  |  |  |  |  | b) Account Number | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| c) Bank Name and Branch | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| d) Cheque/DD Payable details | | | | | | |  |  |  |  |  |  |  |  |  |  | e) IFSC Code | | | | |  |  |  |  |  |  |  |  |  |  |

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| --- | --- | --- |
| 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. | | |
| **DECLARATION BY THE INSURED** |  |  |
|  |  |  |

## Place: Date: DD/ MM/ YYYY Signature of the Insured

**Important:**

## Please submit copy of valid Photo ID.

1. For claimed amount above 1 lac, it is mandatory to submit the KYC (Know your customer) form.

**A purple and black logo

Description automatically generated**

### DETAILS OF HOSPITAL

**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)**



1. Name of the hospital:

**SECTION A**

1. Hospital ID:
2. Type of Hospital: Network 

Non Network 

(If non network fill section E)

1. Name of the treating doctor:



S U R N A M E

F I R S T

N A M E

M I D D L E

N A M E

1. Qualification:
2. Registration No. with State Code:
3. Phone No.

### DETAILS OF THE PATIENT ADMITTED

**SECTION B**



1. Name of the Patient:



M M



S U R N A M E

F I R S T

N A M E

M I D D L E

N A M E



D D

1. IP Registration Number: 

f) Date of Admission:



D D



M M



Y Y



D D



M M



Y Y

c) Gender: Male 

g) Time: :



H H

Female 



H H



M M



M M

d) Age: Years

h) Date of Discharge:



Y Y

Months



D D

e) Date of birth:



M M



Y Y



M M



Y Y

i ) Time: :

1. Type of Admission: Emergency 

Planned 

Day Care

Maternity 

1. If Maternity i. Date of Delivery:

ii. Gravida Status:

1. Status at time of discharge: Discharge to home 

### DETAILS OF AILMENT DIAGNOSED (PRIMARY)

Discharge to another hospital

Deceased

1. Total claimed amount



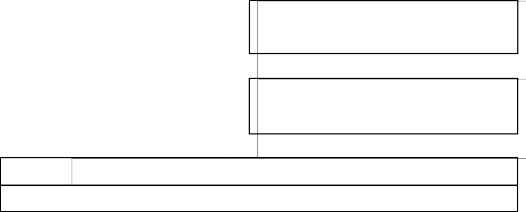
1. ICD 10 Codes
   1. Primary Diagnosis: 
   2. Additional Diagnosis:
   3. Co-morbidities:
   4. Co-morbidities:

Description

1. ICD 10 PCS Description



1. Procedure 1:
2. Procedure 2:



:

**SECTION C**

1. Procedure 3:
2. Details of Procedure



d) Pre-authorization obtained:

|  |
| --- |
|  |
|  |
|  |
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|  |
|  |

 Yes

 No e) Pre-authorization Number:

1. If authorization by network hospital not obtained, give reason:
2. 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



 Claim Form duly signed

 Original Pre-authorization request

 Copy of the Pre-authorization approval letter

 Copy of photo ID card of patient verified by hospital  Hospital Discharge summary

 Operation Theatre notes  Hospital main bill

 Hospital break-up bill

 Investigation reports

 CT/MR/USG/HPE investigation reports  Doctor’s reference slip for investigation  ECG

**SECTION D**

 Pharmacy bills

 MLC report & Police FIR

 Original death summary from hospital where applicable Any other, please specify

**DETAILS IN CASE OF NON NETWORK HOSPITAL** (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)



a) Address of the Hospital: 

**SECTION E**



City:  State: 

Pin Code: b)Phone No. c) Registration No. with State Code:

1. Hospital PAN:
2. Number of Inpatient beds
3. Facilities available in the hospital: i. OT :

 Yes

 No ii. ICU :

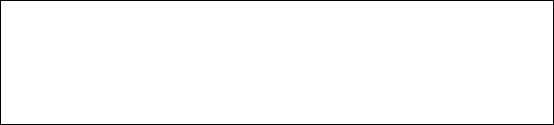
 Yes  No

iii. Others :

### DECLARATION BY THE HOSPITAL (PLEASE READ VERY CAREFULLY)

**SECTION F**



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.



D D



M M



Y Y



Date:

Place:

Signature and Seal of the Hospital Authority:

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|  |  |  |
| --- | --- | --- |
| **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 hospital | As allocated by the 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 the treating doctor | Name of doctor in full |
| e) Qualification | Enter the qualifications 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 hospital | Name of hospital 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 admission | 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 |  |  |
| 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 | | |

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