(To be filled in block letters)

DETAILS OF PRIMARY INSURED:	
a) Policy No:	
c) Company/ TPA ID No:	
d) Name: SURNAME FIRST NAME MIDDL	
e) Address :	
City: State: State:	
Pin Code: Phone No: Email ID:	
DETAILS OF INSURANCE HISTORY:	
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 (Copies of Policies to be attached)
c) If yes, company name: Policy No. Policy No.	
Sum Insured (Rs.) d) Have you been hospitalized in the last 4 years? Yes No Date: M M YYY Diagnosis:	
e) Previously covered by any other Mediclaim / Health insurance : Yes No f) If yes, Company Name	
DETAILS OF INSURED PERSON HOSPITALIZED:	
a) Name: SURNAME FIRST NAME MIDDL	E N A M E
b) Gender: Male Female c) Age: years Y Y months M M d) Date of Birth: D D M M Y Y	
e) Relationship to Primary insured: Self Spouse Child Father Mother Other (Please Specify)	
f) Occupation: Service Self Employed Homemaker Student Retired Other (Please Specify)	
g) Address (if different from above):	
City: State: Sta	
Pin Code: Phone No: E-mail 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:	M M Y Y h) Time: H H : M M
e) Date of Admission: DD MM YYY f) Time: HHH: MMM g) Date of Discharge: DD MM MYYY i) If Injury give cause: Self inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption i. If Medico legal:	h) Time:
, ,,,,	
ii. Reported to police: Yes No iii. MLC Report & Police FIR attached: Yes No j) System of Medicine:	
ii. Reported to police: Yes No iii. MLC Report & Police FIR attached: Yes No j) System of Medicine: DETAILS OF CLAIM:	
DETAILS OF CLAIM:	
DETAILS OF CLAIM:	m Documents Submitted- Check List: Claim Form Duly signed
DETAILS OF CLAIM: a) Details of the treatment expenses claimed Claim	m Documents Submitted- Check List:
DETAILS OF CLAIM: a) Details of the treatment expenses claimed i. Pre-hospitalization Expenses: Rs.	m Documents Submitted- Check List: Claim Form Duly signed Copy of the claim intimation Hospital Main Bill
DETAILS OF CLAIM: a) Details of the treatment expenses claimed i. Pre-hospitalization Expenses: Rs. ii. Hospitalization Expenses: Rs.	m Documents Submitted- Check List: Claim Form Duly signed Copy of the claim intimation Hospital Main Bill Hospital Break-up Bill
DETAILS OF CLAIM: a) Details of the treatment expenses claimed i. Pre-hospitalization Expenses: Rs.	m Documents Submitted- Check List: Claim Form Duly signed Copy of the claim intimation Hospital Main Bill Hospital Break-up Bill
DETAILS OF CLAIM: a) Details of the treatment expenses claimed Claim i. Pre-hospitalization Expenses: Rs. ii. Hospitalization Expenses: Rs. Iii. III. III. III. III. III. III. III	m Documents Submitted- Check List: Claim Form Duly signed Copy of the claim intimation Hospital Main Bill Hospital Break-up Bill Hospital Bill Payment Receipt Hospital Discharge Summary
DETAILS OF CLAIM: a) Details of the treatment expenses claimed i. Pre-hospitalization Expenses: iii. Post-hospitalization Expenses: v. Ambulance Charges: Rs.	m Documents Submitted- Check List: Claim Form Duly signed Copy of the claim intimation Hospital Main Bill Hospital Break-up Bill Hospital Bill Payment Receipt Hospital Discharge Summary
DETAILS OF CLAIM: a) Details of the treatment expenses claimed i. Pre-hospitalization Expenses: iii. Post-hospitalization Expenses: v. Ambulance Charges: Rs.	m Documents Submitted- Check List: Claim Form Duly signed Copy of the claim intimation Hospital Main Bill Hospital Break-up Bill Hospital Bill Payment Receipt Hospital Discharge Summary Pharmacy Bill Operation Theatre Notes
DETAILS OF CLAIM: a) Details of the treatment expenses claimed i. Pre-hospitalization Expenses: iii. Post-hospitalization Expenses: v. Ambulance Charges: Rs.	m Documents Submitted- Check List: Claim Form Duly signed Copy of the claim intimation Hospital Main Bill Hospital Break-up Bill Hospital Bill Payment Receipt Hospital Discharge Summary Pharmacy Bill Operation Theatre Notes ECG Doctor's request for investigation
DETAILS OF CLAIM: a) Details of the treatment expenses claimed i. Pre-hospitalization Expenses: Rs.	m Documents Submitted- Check List: Claim Form Duly signed Copy of the claim intimation Hospital Main Bill Hospital Break-up Bill Hospital Bill Payment Receipt Hospital Discharge Summary Pharmacy Bill Operation Theatre Notes ECG Doctor's request for investigation Investigation Reports (Including CT /MRI / USG / HPE)
DETAILS OF CLAIM: a) Details of the treatment expenses claimed i. Pre-hospitalization Expenses: Rs.	m Documents Submitted- Check List: Claim Form Duly signed Copy of the claim intimation Hospital Main Bill Hospital Break-up Bill Hospital Bill Payment Receipt Hospital Discharge Summary Pharmacy Bill Operation Theatre Notes ECG Doctor's request for investigation Investigation Reports (Including CT //RI / USS / HPE) Doctor's Prescriptions
DETAILS OF CLAIM: a) Details of the treatment expenses claimed i. Pre-hospitalization Expenses: iii. Post-hospitalization Expenses: Rs.	m Documents Submitted- Check List: Claim Form Duly signed Copy of the claim intimation Hospital Main Bill Hospital Break-up Bill Hospital Discharge Summary Pharmacy Bill Operation Theatre Notes ECG Doctor's request for investigation Investigation Reports (Including CT //RI / USS / HPE) Doctor's Prescriptions Others
DETAILS OF CLAIM: a) Details of the treatment expenses claimed i. Pre-hospitalization Expenses: Rs.	m Documents Submitted- Check List: Claim Form Duly signed Copy of the claim intimation Hospital Main Bill Hospital Break-up Bill Hospital Bill Payment Receipt Hospital Discharge Summary Pharmacy Bill Operation Theatre Notes ECG Doctor's request for investigation Investigation Reports (Including CT //RI / USS / HPE) Doctor's Prescriptions
DETAILS OF CLAIM: a) Details of the treatment expenses claimed i. Pre-hospitalization Expenses: iii. Post-hospitalization Expenses: Rs.	m Documents Submitted- Check List: Claim Form Duly signed Copy of the claim intimation Hospital Main Bill Hospital Break-up Bill Hospital Discharge Summary Pharmacy Bill Operation Theatre Notes ECG Doctor's request for investigation Investigation Reports (Including CT //MR / USG / HPE) Doctor's Prescriptions Others
DETAILS OF CLAIM: a) Details of the treatment expenses claimed i. Pre-hospitalization Expenses: iii. Post-hospitalization Expenses: v. Ambulance Charges: v. Pres-hospitalization period: days viii. Post-hospitalization period: days viii. Post	m Documents Submitted- Check List: Claim Form Duly signed Copy of the claim intimation Hospital Main Bill Hospital Break-up Bill Hospital Discharge Summary Pharmacy Bill Operation Theatre Notes ECG Doctor's request for investigation Investigation Reports (Including CT //MR / USG / HPE) Doctor's Prescriptions Others
DETAILS OF CLAIM:	m Documents Submitted- Check List: Claim Form Duly signed Copy of the claim intimation Hospital Main Bill Hospital Break-up Bill Hospital Bill Payment Receipt Hospital Discharge Summary Pharmacy Bill Operation Theatre Notes ECG Doctor's request for investigation Investigation Reports (Including CT / MRI / USG / HPE) Doctor's Prescriptions Others
Details of the treatment expenses claimed	m Documents Submitted- Check List: Claim Form Duly signed Copy of the claim intimation Hospital Main Bill Hospital Break-up Bill Hospital Discharge Summary Pharmacy Bill Operation Theatre Notes ECG Doctor's request for investigation Investigation Reports (Including CT //MR / USG / HPE) Doctor's Prescriptions Others
Details of the treatment expenses claimed Claim	m Documents Submitted- Check List: Claim Form Duly signed Copy of the claim intimation Hospital Main Bill Hospital Break-up Bill Hospital Bill Payment Receipt Hospital Discharge Summary Pharmacy Bill Operation Theatre Notes ECG Doctor's request for investigation Investigation Reports (Including CT / MRI / USG / HPE) Doctor's Prescriptions Others
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Details of the treatment expenses claimed	m Documents Submitted- Check List: Claim Form Duly signed Copy of the claim intimation Hospital Main Bill Hospital Break-up Bill Hospital Discharge Summary Pharmacy Bill Operation Theatre Notes ECG Doctor's request for investigation Investigation Reports (Including CT //MR / USS / HPE) Doctor's Prescriptions Others
Details of the treatment expenses claimed	m Documents Submitted- Check List: Claim Form Duly signed Copy of the claim intimation Hospital Main Bill Hospital Break-up Bill Hospital Bill Payment Receipt Hospital Discharge Summary Pharmacy Bill Operation Theatre Notes ECG Doctor's request for investigation Investigation Reports (Including CT / MRI / USG / HPE) Doctor's Prescriptions Others
Details of the treatment expenses claimed	m Documents Submitted- Check List: Claim Form Duly signed Copy of the claim intimation Hospital Main Bill Hospital Break-up Bill Hospital Discharge Summary Pharmacy Bill Operation Theatre Notes ECG Doctor's request for investigation Investigation Reports (Including CT //MR / USS / HPE) Doctor's Prescriptions Others

SECTION H

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, 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: D D	M	Y Y Place:	Signature of the Insured	

		FILLING CLAIM FORM – PART A (To be filled in by the insure	
	DATA ELEMENT	DESCRIPTION	FORMAT
		SECTION A - DETAILS OF PRIMARY INSURED	I
a)	Policy No.	Enter the policy number	As allotted by the insurance company
b)	SI. 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
	s	ECTION B - DETAILS OF INSURANCE HISTORY	
a)	Currently covered by any other Mediclaim / Health	Indicate whether currently covered by another Mediclaim /	Tick Yes or No
b)	Insurance? Date of Commencement of first Insurance without break	Health Insurance Enter the date of commencement of first insurance	Use dd-mm-yy format
c)	Company Name	Enter the date of commencement of hist histrance Enter the full name of the insurance company	Name of the organization in full
·)			-
	Policy No. Sum Insured	Enter the policy number	As allotted by the insurance company
1/		Enter the total sum insured as per the policy	In rupees
i)	Have you been Hospitalized in the last 4 years Date	Indicate whether hospitalized in the last 4 years Enter the date of hospitalization	Tick Yes or No Use mm-yy format
			**
9)	Diagnosis Previously Covered by any other Mediclaim/ Health Insurance?	Enter the diagnosis details Indicate whether previously covered by another Mediclaim / Health Insurance	Open Text Tick Yes or No
f)	Company Name	Enter the full name of the insurance company	Name of the organization in full
		DN C - DETAILS OF INSURED PERSON HOSPITALIZED	Name of the organization in full
a)	Name	Enter the full name of the patient	Surname, First name, Middle name
0)	Gender	Indicate Gender of the patient	Tick Male or Female
;)	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
)	Occupation	Indicate occupation of patient	Tick the right option. If others, please specify
<i>)</i> 3)	Address	Enter the full postal address	Include Street, City and Pin Code
1)	Phone No	Enter the phone number of patient	Include STD code with telephone number
)	E-mail ID	Enter e-mail address of patient	Complete e-mail address
	E-IIIaii ID	SECTION D - DETAILS OF HOSPITALIZATION	Complete e-mail address
a)	Name of Hospital where admitted	Enter the name of hospital	Name of hospital in full
))	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
)	Time	Enter time of admission	Use hh:mm format
<u>/</u>])	Date of discharge	Enter date of discharge	Use dd-mm-yy format
1)	Time	Enter time of discharge	Use hh:mm format
)	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
	System of Medicine	Enter the system of medicine followed in treating the patient	Open Text
)		, and a substitution of the substitution of th	
)	•	SECTION E - DETAILS OF CLAIM	
a)	Details of Treatment Expenses	T	In rupees (Do not enter paise values)
a)	Details of Treatment Expenses Claim for Domiciliary Hospitalization	Enter the amount claimed as treatment expenses	In rupees (Do not enter paise values) Tick Yes or No
a) o)	Claim for Domiciliary Hospitalization	Enter the amount claimed as treatment expenses Indicate whether claim is for domiciliary hospitalization	Tick Yes or No
a) o)	· · · · · · · · · · · · · · · · · · ·	Enter the amount claimed as treatment expenses	
a) o)	Claim for Domiciliary Hospitalization Details of Lump sum/ cash benefit claimed	Enter the amount claimed as treatment expenses Indicate whether claim is for domiciliary hospitalization Enter the amount claimed as lump sum/ cash benefit Indicate which supporting documents are submitted	Tick Yes or No In rupees (Do not enter paise values)
a) o) c)	Claim for Domiciliary Hospitalization Details of Lump sum/ cash benefit claimed Claim Documents Submitted-Check List	Enter the amount claimed as treatment expenses Indicate whether claim is for domiciliary hospitalization Enter the amount claimed as lump sum/ cash benefit	Tick Yes or No In rupees (Do not enter paise values)
a) o) c)	Claim for Domiciliary Hospitalization Details of Lump sum/ cash benefit claimed Claim Documents Submitted-Check List ate which bills are enclosed with the amounts in rupees	Enter the amount claimed as treatment expenses Indicate whether claim is for domiciliary hospitalization Enter the amount claimed as lump sum/ cash benefit Indicate which supporting documents are submitted SECTION F - DETAILS OF BILLS ENCLOSED	Tick Yes or No In rupees (Do not enter paise values)
a) b) c) d)	Claim for Domiciliary Hospitalization Details of Lump sum/ cash benefit claimed Claim Documents Submitted-Check List ate which bills are enclosed with the amounts in rupees SECTION	Enter the amount claimed as treatment expenses Indicate whether claim is for domiciliary hospitalization Enter the amount claimed as lump sum/ cash benefit Indicate which supporting documents are submitted SECTION F - DETAILS OF BILLS ENCLOSED G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT	Tick Yes or No In rupees (Do not enter paise values) Tick the right option
a) b) c) d) ndic	Claim for Domiciliary Hospitalization Details of Lump sum/ cash benefit claimed Claim Documents Submitted-Check List Late which bills are enclosed with the amounts in rupees SECTION PAN	Enter the amount claimed as treatment expenses Indicate whether claim is for domiciliary hospitalization Enter the amount claimed as lump sum/ cash benefit Indicate which supporting documents are submitted SECTION F - DETAILS OF BILLS ENCLOSED G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT Enter the permanent account number	Tick Yes or No In rupees (Do not enter paise values) Tick the right option As allotted by the Income Tax department
a) b) c) d) lndic a)	Claim for Domiciliary Hospitalization Details of Lump sum/ cash benefit claimed Claim Documents Submitted-Check List Late which bills are enclosed with the amounts in rupees SECTION PAN Account Number	Enter the amount claimed as treatment expenses Indicate whether claim is for domiciliary hospitalization Enter the amount claimed as lump sum/ cash benefit Indicate which supporting documents are submitted SECTION F - DETAILS OF BILLS ENCLOSED G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT Enter the permanent account number Enter the bank account number	Tick Yes or No In rupees (Do not enter paise values) Tick the right option As allotted by the Income Tax department As allotted by the bank
a) b) c) dd) indica a) b)	Claim for Domiciliary Hospitalization Details of Lump sum/ cash benefit claimed Claim Documents Submitted-Check List Late which bills are enclosed with the amounts in rupees SECTION PAN Account Number Bank Name and Branch	Enter the amount claimed as treatment expenses Indicate whether claim is for domiciliary hospitalization Enter the amount claimed as lump sum/ cash benefit Indicate which supporting documents are submitted SECTION F - DETAILS OF BILLS ENCLOSED G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT Enter the permanent account number	Tick Yes or No In rupees (Do not enter paise values) Tick the right option As allotted by the Income Tax department As allotted by the bank Name of the Bank in full
a) b) d) Indica a) b) c) d)	Claim for Domiciliary Hospitalization Details of Lump sum/ cash benefit claimed Claim Documents Submitted-Check List Late which bills are enclosed with the amounts in rupees SECTION PAN Account Number Bank Name and Branch Cheque/ DD payable details	Enter the amount claimed as treatment expenses Indicate whether claim is for domiciliary hospitalization Enter the amount claimed as lump sum/ cash benefit Indicate which supporting documents are submitted SECTION F - DETAILS OF BILLS ENCLOSED G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT Enter the permanent account number Enter the bank account number Enter the bank name along with the branch Enter the name of the beneficiary the cheque/ DD should be made out to	Tick Yes or No In rupees (Do not enter paise values) Tick the right option As allotted by the Income Tax department As allotted by the bank Name of the Bank in full Name of the individual/ organization in full
))))))	Claim for Domiciliary Hospitalization Details of Lump sum/ cash benefit claimed Claim Documents Submitted-Check List Late which bills are enclosed with the amounts in rupees SECTION PAN Account Number Bank Name and Branch Cheque/ DD payable details IFSC Code	Enter the amount claimed as treatment expenses Indicate whether claim is for domiciliary hospitalization Enter the amount claimed as lump sum/ cash benefit Indicate which supporting documents are submitted SECTION F - DETAILS OF BILLS ENCLOSED G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT Enter the permanent account number Enter the bank account number Enter the bank name along with the branch Enter the name of the beneficiary the cheque/ DD should be	Tick Yes or No In rupees (Do not enter paise values) Tick the right option As allotted by the Income Tax department As allotted by the bank Name of the Bank in full

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)

a) Name of the hospital:	100000000000000000000000000000000000000			
b) Hospital ID: c) Type of Hospital:	Network Non Network (If non network fill section E)			
d) Name of the treating doctor: SURNAME FIRST				
e) Qualification: f) Registration No. with State Code: g) Phone No.				
DETAILS OF THE PATIENT ADMITTED				
a) Name of the Patient:	NAME MIDDLE NAME			
b) IP Registration Number: C) Gender: Male Female] d) Age: Years Y Y Months M e) Date of birth: D D M M Y Y			
f) Date of Admission: DD MM YY g) Time: HH: MM	d) Age: Years Y Y Months M M e) Date of birth: D D M M Y Y i) Time: H H : M M Y Y i) Time: H H : M M Y Y ii. Gravida Status:			
j) Type of Admission: Emergency Planned Day Care Maternity k) If Ma	ternity i. Date of Delivery: D D M M Y Y ii. Gravida Status: D D			
I) Status at time of discharge: Discharge to home Discharge to another home	spital Deceased D			
DETAILS OF AILMENT DIAGNOSED (PRIMARY)				
a) ICD 10 Codes Description	b) ICD 10 PCS Description			
i. Primary Diagnosis:	i. Procedure 1:			
ii. Additional Diagnosis:	ii. Procedure 2:			
iii. Co-morbidities:	iii. Procedure 3:			
iv. Co-morbidities:	iv. Details of Procedure:			
c) Present ailment is a complication of PED? Yes No (If Yes, specify details)				
d) Pre-authorization obtained: Yes No e) Pre-authorization	n Number			
f) If authorization by network hospital not obtained, give reason:				
	Road Traffic Accident Substance abuse / alcohol consumption			
g) Hospitalization due to Injury: Yes No i. If Yes, give cause Self-inflicted				
ii. If Injury due to Substance abuse / alcohol consumption, Test Conducted to establish this: Yes No				
v. FIR no vi. If not reported to police give reason:				
CLAIM DOCUMENTS SUBMITTED - CHECK LIST				
Claim Form duly signed	☐ Investigation reports ☐ CTMRILISGIFIED investigation reports			
_	☐ Investigation reports ☐ CTMRILISGIFIED investigation reports			
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	☐ Investigation reports ☐ CTMRILISGIFIED investigation reports			
Claim Form duly signed Original Pre-authorization request Copy of the Pre-authorization approval letter	Investigation reports CT/MR/USG/HPE investigation reports Doctor's reference slip for investigation ECG Pharmacy bills MLC report & Police FIR			
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	Investigation reports CT/MR/USG/HPE investigation reports Doctor's reference slip for investigation ECG Pharmacy bills MLC report & Police FIR Original death summary from hospital where applicable			
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 Pharmacy bills MLC report & Police FIR Original death summary from hospital where applicable Any other, please specify			
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	Investigation reports CT/MR/USG/HPE investigation reports Doctor's reference slip for investigation ECG Pharmacy bills MLC report & Police FIR Original death summary from hospital where applicable Any other, please specify			
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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 DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL) a) Address of the Hospital: City: Pin Code: Disphance No.	Investigation reports CT/MR/USG/HPE investigation reports Doctor's reference slip for investigation ECG Pharmacy bills MLC report & Police FIR Original death summary from hospital where applicable Any other, please specify AL) State: C Registration No.: C Regist			
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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 DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL) a) Address of the Hospital: City: Pin Code: Diphone No. Diphone No	Investigation reports CT/MR/USG/HPE investigation reports Doctor's reference slip for investigation ECG Pharmacy bills MLC report & Police FIR Original death summary from hospital where applicable Any other, please specify AL) State: CR CR CR CR CR CR CR C			
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	GUIDANCE FOR	R FILLING CLAIM FORM – PART B (To be filled in by the hospit	al)
	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 nospital	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
	S	ECTION 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 Admission	Enter date of admission	Use dd-mm-yy format
)	Time	Enter time of admission	Use hh:mm format
g)	Date of Discharge	Enter date of discharge	Use dd-mm-yy format
n)	Time	Enter time of discharge	Use hh:mm format
)	Type of Admission	Indicate type of admission of patient	Tick the right option
)	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
k)	Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
	SECTI	ON 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
o)	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
:)	Present Ailment is a Complication of PED	Indicate whether present ailment is a complication of some pre- existing disease	Tick Yes or No
i)	Pre-authorization obtained	Indicate whether pre-authorization obtained	Tick Yes or No
)	Pre-authorization Number	Enter pre-authorization number	As allotted by TPA
)	If authorization by network hospital not obtained, give reason	Enter reason for not obtaining pre-authorization number	Open text
)	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
		ION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST	
ndi	cate which supporting documents are submitted		
		ON E – DETAILS IN CASE OF NON NETWORK HOSPITAL	
a)	Address	Enter the full postal address	Include Street, City and Pin Code
)	Phone No.	Enter the phone number of hospital	Include STD code with telephone number
:)	Registration No.	Enter the registration number of patient	As allocated by the Hospital
d)	PAN	Enter the permanent account number	As allotted by the Income Tax department
е)	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 specifi
		SECTION F - DECLARATION BY THE INSURED	
Rea	d declaration carefully and mention date (in dd:mm:yy forn	nat), place (open text) and sign.	
		SECTION G - DECLARATION BY THE HOSPITAL	
lea	d declaration carefully and mention date (in dd:mm:yy forn	nat), place (open text) and sign and stamp	