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)

SECTION A

DETAILS OF HOSPITAL

a) Name of the hospital: GIRIVAAS DENTAL CLINIC

a) Hospital ID:

c) Type of Hospital: Network ☐ Non Network ☑ (if non network fill section E)

c) Name of the treating doctor: K S SUBASH SUBRAMANIAN

e) Qualification: B.D.S. f) Registration No. with State Code: 7342 g) Phone No: 9443173754

SECTION B

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient: SARUNMATHI S

b) IP Registration Number: c) Gender: Male ☐ Female ☑ d) Age: Years 24 Months MM e) Date of birth: 09 06 00

f) Date of Admission: DD MM YY g) Time: HH MM h) Date of Discharge: DD MM YY i) Time: HH MM

j) Type of Admission: Emergency ☐ Planned ☑ Day Care ☐ Maternity ☐ k) If Maternity i) Date of Delivery: DD MM YY ii) Gravida Status:

l) Status at time of discharge: Discharge to home ☐ Discharge to another hospital ☐ Deceased ☐ m) Total claimed amount: 1360

SECTION C

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) 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:

SECTION D

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
- ☑ Pharmacy bills
- ☐ MLC reports & Police FIR
- ☐ Original death summary from hospital where applicable
- ☐ Any other, please specify

SECTION E

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

a) Address of the Hospital: GIRIVAAS DENTAL CLINIC

40/19 KMA COMPLEX MUTHANANTHAPURAM

City: KOVILPATTI State: TAMILNADU

Pin Code: 628502 b) Phone No: 4632211257 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:

SECTION F

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: 06 12 24

Place: KOVILPATTI

கிரிவாஸ் பல் மருத்துவமனை ISO 9001 : 2008 ✆ 04632 - 222257 கோவில்பட்டி - 628 502.

Signature and Seal of the Hospital Authority:

Dr.K.SUBASH SUBRAMONIAN, B.D.S.,
DENTAL SURGEON
GIRIVAAS DENTAL CLINIC,
KOVILPATTI - 628502.