UnitedHealthcare PARIVAR

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 submit 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: KIMS HOSPITALS [illegible] (If non network fill section E)
b) Hospital ID: c) Type of Hospital: Network / Non Network
d) Name of the treating doctor: DR. PARAS [illegible]
e) Qualification: f) Registration No. with State Code: g) Phone No.

SECTION B

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient: Mr. [illegible]
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:

SECTION C

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a)	ICD10 Codes	Description
i. Primary Diagnosis:		
ii. Additional Diagnosis:		
iii. Co-morbidities:		
iv. Co-morbidities:		

Rp Final Bill Enclosed

b)	ICD 10 PCS	Description
i. Procedure1		
ii. Procedure2		
iii. Procedure3:		
iv. Details of Procedure:		

c) Pre-authorization obtained: Yes / No d) Pre-authorization Number:
c1) 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 report & Police FIR
- Original death summary from hospital where applicable
- Any other, please specify

Discharge Summary Enclosed

SECTION E

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

a) Address of the hospital:
State:
City:
Pin Code: b) Phone No. c) Registration No. with State Code:
d) Hospital PAN: e) No 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 statement, or suppression or concealment of any material fact, our right to claim under this claim shall be forfeited.

Date: 08 01 21
Place: Hyderabad

KIMS Hospitals Enterprises Pvt. Ltd. Kondapur

Signature and Seal of the Hospital Authority: