STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED

Regd. & Corporate Office: 1, New Tank Street, Valluvar Kottam High Road, Nungambakkam, Chennai - 600 034.
15, Balaji Complex, Whites Lane, 1st Floor, Royapettah, Chennai - 600 014.
Ph: 044 2888 6495
CIN : U66010TN2005PLC056649 Email:support@starhealth.in Website: www.starhealth.in IRDAI Regn. No: 129

STAR Personal & Caring | Health Insurance
The Health Insurance Specialist

CLAIM FORM - PART - A

TO BE FILLED IN BY THE INSURED The issue of this Form is not to be taken as an admission of liability Claim No. ____________
(To be filled in block letters)

SECTION A

DETAILS OF PRIMARY INSURED:

a) Policy No: ____________ b) Sl. No/ Certificate No: ____________

c) Company/ TPA ID No: ____________

d) Name : ____________

e) Address : ____________

City: ____________ State: ____________

SECTION B

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 Y (Copies of Policies to be attached)

c) If yes, company name: ____________ Policy No. ____________

Sum Insured (Rs.) ____________ d) Have you been hospitalized in the last 4 years? Yes No Date: ____/____/____ Diagnosis: ____________

e) Previously covered by any other Mediclaim / Health insurance : Yes ☐ No ☐ f) If yes, Company Name ____________

SECTION C

DETAILS OF INSURED PERSON HOSPITALIZED:

a) Name: ____________

b) Gender: Male ☐ Female ☐ c) Age: years Y Y months M M d) Date of Birth: ____/____/____

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: ____________

Pin Code: ____________ Phone No: ____________ Email ID : ____________

SECTION D

DETAILS OF HOSPITALIZATION:

a) Name of Hospital where Admitted: ____________ No. of IP Beds: ____________

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: ☐ Yes ☐ No iii. MLC Report & Police FIR attached: ☐ Yes ☐ No j) System of Medicine: ____________

SECTION E

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
- ☐ Hospital Main Bill
- ☐ Hospital Break-up Bill
- ☐ Hospital Bill Payment Receipt
- ☐ Hospital Discharge Summary
- ☐ Pharmacy Bill
- ☐ Operation Theatre Notes
- ☐ Doctor's request for investigation
- ☐ ECG
- ☐ Investigation Reports (Including CT / MRI / USG / HPE)
- ☐ Doctor's Prescriptions
- ☐ Others

SECTION F

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			

SECTION G

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT:

a) PAN: ☐☐☐☐☐☐☐☐☐☐ b) Bank Account Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

c) Bank Name and Branch: ____________

d) Cheque/ DD Payable details: ____________ e) IFSC Code: ____________

(IMPORTANT: PLEASE TURN OVER)

STAR Personal & Caring Health Insurance
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DECLARATION BY THE INSURED:

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.

SECTION H

Date: D D M M Y Y 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)	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
	SECTION B - DETAILS OF INSURANCE HISTORY		
a)	Currently covered by any other Mediclaim / Health Insurance?	Indicate whether currently covered by another Mediclaim / 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 4 years	Indicate whether hospitalized in the last 4 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 Mediclaim/ 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 amounts 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
d)	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
e)	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.			