

# **IFFCO-TOKIO General Insurance Company Limited**

### **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 (To be filled in block letters)

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a) Policy No		L													b) \$	SI. N	lo./C	ertificat	e No	).							
c) Company	/TPA ID I	No.																	$\perp$								
d) Name																			$\perp$								_
e) Address																											
	City																										
	State																			F	in Co	ode					
	Ph. No.															E	mail	ID									
								[	DET	AILS	S OF	INS	SUR	ANG	CE H	HIST	OR'	Y									
a) Currently	covered	by ar	ny ot	her I	Medi	clain	n/He	alth l	Insur	ance	<del></del>												Y	es es		No	
b) If yes, Co	mpany N	lame																									
Policy No	-																	Sum I	nsure	ed (₹)							
c) Date of co	ommence	emen	t of f	irst I	nsura	ance	with	out	breal	k	•			•	•	DI	<u> </u>	<u>1M7_Y</u>	YYY		(Co	pies	of P	olicie	s to	be attac	hed)
d) Have you	been ho	spita	lized	l in th	ne las	st 4	years	s? (s	ince	ince	ption	of t	he		Ye	es		No			Dat	Э	D				
contract)											ı	Diag	nosis	5					<u>DD / MM / YYYY</u>								
e) Have you	other	Ме	dicla	im/H	ealth	Ins	uran	ce in	last	4 ye	ars								Y	'es		No					
f) If yes, Co	mpany N	lame																									
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a) Nama			<u> </u>	Г			DE	IAIL	-30	 	130	KEL	<i>,</i> PC	KO		103	PIII	ALIZE	ָ ע		Τ_	Т	Т	Т	Г		1
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insured										<u> </u>	use	C	-:e.v		Chil	a				ather				Mot	ner		
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f) Occupatio	n				Serv					_	Emp				Hor	nem	aker		5	luaen	τ			Ret	irea		
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	City														-				+	-	· 0	Ļ	H	-	-		
	State															_	L.,			F	in Co	ode					
Ph. No.																E	mail	וט									
									DE	TAI	LS C	OF H	HOS	PIT/	ALIZ	ATI	ON										
a) Name of	Hospital	wher	e Ad	mitte	ed																						
b) Room Category occupied						Day	/ Car	е			Sing	gle o	ccup	ancy	/		Twi	n shari	ng		3 0	r mo	re be	eds p	er ro	om	
c) Hospitalization due to						Inju	ry									ı	llnes	s					М	aterr	nity		
d) Date of Injury/Date of Disease first							ted/[	Date	of D	elive	ry												D	<u>D/N</u>	<u> </u>	YYYY	
e) Date of Admission DD / MM							Y		f) T	ime	НН		g) [	Date	of D	ischa	arge	DD /	MM	/ <u>YY</u>	ΥY			h) <sup>-</sup>	Γime	НН	MM
i) If injury g	ive cause	)				Self	f infli	cted				Roa	ad Tr	affic	Acci	dent											
Substance Abuse/Alcohol consump						on						i	i. if	Medi	ico le	egal							Y	'es		No	
ii. Reported to police						Y	es		N	lo		i	iii. M	LC R	Repor	t & P	olice	FIR att	ache	d			Y	'es		No	
j) System of Medicine																											
k) Date of Surgery						DI	<u> </u>	<u>/IM</u> /	YYY	Y		I) C	laim	Intin	nate	d							Y	'es		No	
i. Intimated to whom						SI	3U			Inter	medi	aries	es Call Centre Hea						Healt	h Cl	aims	Team					
ii. Intimat	tion No. 8	& date	е																					DD	/ <u>M</u> N	I YYY	Υ
iii. If not Intimated, reason?																											

a) Details of the treatment expenses claimed  I. Prot-hospitalization expenses {		DETAILS OF CLAIM																												
iii. Post-hospitalization expenses	a) Detai	ls of the treat	ment expenses	s cla	ime	d																								
III. Post-hospitalization expenses														ii. Hospitalization Expenses ₹																
vi. Prer-hospitalization period days   Total   vii. Others (code)   ₹   vii. Pre-hospitalization period days   viii. Post hospitalization period days   viii. Prost hospitalization period days   viii. Post hospitalization for period p	iii P	· · · · · · · · · · · · · · · · · · ·																		₹	:									
Viii. Pre-hospitalization period   days   Total   Viii. Post hospitalization period   days   Details of Lump sunvicash benefit claimed   Viii. Post hospitalization period   days   Details of Lump sunvicash benefit claimed   Viii. Surgical Cash   Viii. Surgical Cash   Viii. Surgical Cash   Viii. Convalencence   Viii. Surgical Cash   Viii. Convalencence   Viii. Convalencencence   Viii. Convalencencence   Viii. Convalencencence   Viii. Convalencencence   Viii. Convalencencence   Viii. Convalencencencencencencencencencencencencence		•	•	_	_	-											7 00.	,	Т	_	+									
Vill. Post hospitalization period   days				+		day			$\vdash$			To		Others	(cour	<u>-)</u>				_	+									
b) Claim for Domiciliary Hospitalization	VII. F	re-nospitaliza	illon penou			uay						10																		
c) Details of Lump sum/cash benefit claimed  i. Hospital Daily Cash	h) Claim	for Dominilia						Ι		\.\.	Т	/15																		
iii. Critical Illness Benefit  v. Pre/Post hospitalization Lump  sum benefit  Claim Form Duty signed  The Post-Hosp signed in Free Pote Signed  The Post-Hosp signed in Free Pote Signed  The Post-Hosp							es		<u> </u>	NO		(11	yes	s, provide	uela	iiis ii	anı	exui	e)											
iii. Critical Iliness Benefit		<u> </u>		$\neg$	т —	a T		I	_	_	_									Τ.		Т	1		Г					
v. Pre/Post hospitalization Lump				-	-	-			-	-	-		II.							-										
Sum benefit   Total   R				+	-	-			-						escei	nce	_			_										
Claim Documents Submitted - Check List  Claim Form Duly signed  ECG  Copy of the claim intimation  Doctor's request for investigation  Hospital Bireak - up Bill  Hospital Bireak - up Bill  Hospital Bireak - up Bill  Doctor's Prescriptions  Pre-Hosp. Bills  Hospital Bill Payment Receipt  Pre-Hosp. Bills  Phosmary Bill  Others  DETAILS OF BILLS ENCLOSED  SI. No.  Bill No.  Date  Issued by  Towards (Hospitalization/Pre-hospitalization/ Post-hospitalization/Pre-hospitalization/ Post-hospitalization/Pre-hospitalization/ Post-hospitalization/Pre-hospitalization/ Post-hospitalization/Pre-hospitalization/ Post-hospitalization/Pre-hospitalization/ Post-hospitalization/Pre-hospitalization/ Post-hospitalization/Pre-hospitalizat			talization Lump	.  ₹								vi. Others ₹																		
Claim Form Duly signed												To	otal							₹										
Copy of the claim intimation Hospital Main Bill Hospital Break - up Bill Hospital Break - up Bill Doctor's Prescriptions Doctor's Prescriptions Hospital Bill Payment Receipt Pre-Hosp, Bills Post-Hosp, Bills Pharmacy Bill Discharge Summary Post-Hosp, Bills Detrails Of Bills Sence Dotters  DETAILS OF Bills Sence Dotters  DETAILS OF Bills Sence Dotters  SI. No. Bill No. Date Issued by Towards (Hospitalization/Pre-hospitalization/ Post-hospitalization/ Post-hospitalization/ Post-hospitalization/ Post-hospitalization  1	Claim Do	ocuments Su	ubmitted - Che	eck	List	:							C	Operation	Thea	atre I	Vote	s												
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Hospital Break - up Bill Hospital Bill Payment Receipt Hospital Discharge Summary Post-Hosp. Bills Dotters  DETAILS OF BILLS ENCOSED SI. No. Bill No. Date Issued by Towards (Hospitalization/Pre-hospitalization/Post-hosp	Copy of t	the claim intin	nation											octor's r	eque	st fo	rinve	estiga	ation											
Hospital Bill Payment Receipt Hospital Discharge Summary Pharmacy Bill  DETAILS OF BILLS ENCLOSED SI. No. Bill No. Date Issued by Towards (Hospitalization/Pre-hospitalization/ Post-hospitalization)  1	Hospital	Main Bill											lı	nvestigat	on R	epor	ts (C	T/MI	RI/U	SG/I	HPE)									
Post-Hosp. Bills   Details of Bills   Details of Bills	Hospital	Break - up Bi	II										С	Ooctor's F	resc	riptic	ns													
Post-Hosp. Bills   Details of Bills   Details of Bills													F	Pre-Hosp	Bills															
Pharmacy Bill  DETAILS OF BILLS ENCLOSED  SI. No. Bill No. Date Issued by Towards (Hospitalization/Pre-hospitalization/ Post-hospitalization/ Post-hospita				-									_																	
SI. No. Bill No. Date Issued by Towards (Hospitalization/Pre-hospitalization/ Post-hospitalization/ Post-hospitalization/ Post-hospitalization/ Post-hospitalization/ Post-hospitalization Post-hospit																														
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Post-hospitalization    1								DE.	TAIL	LS C	)F	BILL	S I	ENCLO	SED															
2 DD / MM / YYYY  3 DD / MM / YYYY  4 DD / MM / YYYY  5 DD / MM / YYYY  6 DD / MM / YYYY  7 DD / MM / YYYY  9 DD / MM / YYYY  10 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:  DETAILS OF PRIMARY INSURED'S BANK ACCOUNT (Please submit a cancelled cheque copy for NEFT)  a) PAN	SI. No.	Bill No.	Date	е			Is	sue	d by		Т	owar	ds (					spital	izatio	on/			Am	ount	(₹)					
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 1	1		DD / MM	/ <u>Y</u>	YYY	_																								
4 DD / MM / YYYY 5 DD / MM / YYYY 6 DD / MM / YYYY 8 DD / MM / YYYY 10 DD / MM / YYY	2		DD / MM	/ <u>Y</u>	YYY	_																								
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5	4		DD / MM	/ Y	YYY	1																								
6 DD / M/ / YYYY 8 DD / M/ / YYYY 9 DD / M/ / YYYY 10 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:    DETAILS OF PRIMARY INSURED'S BANK ACCOUNT (Please submit a cancelled cheque copy for NEFT)   a) PAN	5																													
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DETAILS OF PRIMARY INSURED'S BANK ACCOUNT (Please submit a cancelled cheque copy for NEFT)  a) PAN																							Voc	$\top$		No				
a) PAN   b) Account Number   c) Bank Name and Branch   d) Cheque/DD Payable details   e) IFSC Code   e) IFSC Code   line of the length of the	wnich are	e not case of	relapse within	45 C	ays	OT TIP	st no	spita	aliza	tion.	PIE	ease	con	tact the a	gent/	our	опіс	e tor	rurtn	er a	etalis		168	<b>'</b>		INO				
a) PAN   b) Account Number   c) Bank Name and Branch   d) Cheque/DD Payable details   e) IFSC Code   e) IFSC Code   line of the length of the		DETAILS	OF PRIMAR	Y II	NSL	JRED	)'S E	BAN	IK A	ACC	OU	JNT	(Ple	ease su	bmit	ас	anc	elle	d ch	equ	ie co	рру	for I	NEF.	T)					
C) Bank Name and Branch d) Cheque/DD Payable details  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 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/	a) PAN														T			T												
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receipts for the purpose of this claim & that I will not be making any supplementary claim except the pre/post-hospitalization claim, if any.	or untru	e statement, sement shall	suppression or be forfeited. I a	r co Ilso	nce:	almer sent 8	nt of a	any horiz	mate ze Tl	erial PA/Ir	fac ısuı	t with	n re	spect to mpany, to	quest see	tions k ne	ask cess	ed in ary r	rela nedio	ition cal ir	to th	is cla ation	aim, n/doc	my r ume	ight nts fi	to cla	aim any			
	receipts	for the purpo	se of this claim	1 & t	that	l will	not b	e m	akin	g an	y sı	upple	mei	ntary clai	m ex	cept	the p	ore/p	ost-h	osp	italiza	ation	clain	n, if a	any.					
Place: Date: DD/MM/YYYY Signature of the Insured	Place: _								Da	ate: _	DD	<u>/MM</u> /	ΥΥ	YY						Sig	ınatuı	e of	the I	nsure	ed	_				

- Important:

  1. Please submit copy of valid Photo ID.

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

# **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 (To be filled in block letters)

#### Please include the original preauthorization request form in lieu of PART A

DETAILS OF HOSPITAL																													
a)	Name of the Hospi																												
b)	Hospital ID							c) 1	Гуре	of H	lospi	ital	Net	work			Nor	Net	work	(		(If n	on n	etwo	ork f	ill sec	tion	E)	
d)	Name of the treating																												
e)	Qualification		stration No. State Code								g) Ph No.																		
	I		_			ı	DE	:TA	ILS	OF	THE	: PA	TIEN	ATA	DM	ITT	ED			1	1	ı	1	l I	Ι		Γ		
a)	Name of the Patier		┡															L			_	L	_						
b)	IP Registration Nur	nber	L								<u> </u>	Gen		Ma	ale		Fen	nale		d) /	Age		ars			Month	1		
e)	Date of birth								f) I	Date	of A	dmis	ssion			DD	/ <u>MN</u>	<u>/// Y</u>	YYY			g)	Time	<del>.</del>	ŀ	-IH	M	IM	
h)	n) Date of Discharge DD / MM / YYYY									Time	;						Н	Н	IV	M									
j)										Planned								Care	<del></del>					Mate	ernit	у			
k)	If Maternity		i. I	Date c	f De	liver	y		DD	/ <u>M</u>	<u>/</u> //	YYY	<u> </u>	ii. G	Gravi	da S	Status	3											
l)	Status at time of disc	harge	Dis	scharg	je to	hom	ie		Disc	char	ge to	ano	ther	hosp	ital		Dec	ease	ed										
m)	n) Total Claimed Amount																												
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->						DE	IAIL					וט ו	AGN	105	בט ( 	(PR	IIVIA	KT)											
a)										) Co	des	T	T	I							Jesc	riptic	on 						
	i. Primary Diagnosis										-																		
	ii. Additional Diagnosis																										-		
	iii. Co-morbidities															_											_		
	iv. Co-morbidities																												
b)								ICD 10 Codes								Description													
	i. Procedure 1																												
	ii. Procedure 2																												
	iii. Procedure 3																												
	iv. Details of Proce	dure																											
c)	c) Present ailment is a complication of PED?								es		ı	No				spec	ify												
d)	d) Pre-authorization obtained								Yes No details)																				
e)	e) Pre-authorization Number																												
f)	f) If authorization by network hospital not obtained give reason																												
g)	Hospitalization due	to Inju	ıry		Y	'es		١	10		i. I	If Yes, give cause Self-inflicted Road Traffic Accident							t										
	Substance abuse/a consumption	lcohol											stanc Cond					his	Y	es		١	No			Yes,		h	
iii. If Medico legal Yes							١	10		iv.	Repo	orted	to Po	olice		Y	es		No		v. F	IR N	lo.						
vi. If not reported to police give reason																								1					

CLAIM DOCUMENTS SUBMITTED - CHECK LIST												
Claim Form duly signed	Operation Theatre notes		Doctor's reference slip for investigation									
Original Pre-authorization request	Hospital main bill		ECG									
Copy of the Pre-authorization approval letter	Hospital break-up bill		Pharmacy bills									
Copy of photo ID card of patient verified by hospital	Investigation reports		MLC report & Police FIR									
Hospital Discharge summary	CT/MR/USG/HPE investigation reports		Original death summary from hospital where applicable									
Any other, please specify												

	ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL (Only fill in case of non-network hospital)																											
a)	Address	of the I	Hospit	al																								
	City																											
	State																				Pin C	ode	;					
b)	Phone No	0.										c)	Reg	istrat	tion N	No.												
	Date of Registration DD / MM / YYYY Expiry date of Registration DD / MM /										/ <u>Y</u>	YYY	_															
	Name of	the Re	gister	ing A	utho	rity																						
d)	PAN													e) 1	Numb	er o	f Inp	atier	t be	ds								
f)	f) Facilities available in the hospital i. OT Yes No ii. ICU Yes										N	o																
	iii. Others	s																										

#### **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. The signature of the insured is taken on this form after Claim Form B is fully filled up by us.

Hospital have required infrastructure to fulfill the hospital definition as per IRDA guideline, which is reproduced below:

- Has at least 10 inpatient beds, in those towns having a population of less than 10,00,000 and 15 inpatient beds in all other places
- Has fully qualified nursing staff under its employment round the clock
- Has fully qualified doctor(s) in charge round the clock
- Has a fully equipped operation theatre of its own where surgical procedures are carried out.
- Maintains daily Medical records of patients and will make these accessible to the Company's authorized personnel.

Place:	Date: DD/MM/YYYY	Signature of	Signature and Seal of
		Insured/Claimant	the Hospital Authority