98414 03382

CLAIM FORM FOR HEALTH INSURANCE POLICIES OF THE NEW INDIA ASSURANCE CO LTD - 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)

DETAILS OF PRIMARY INSURED: — SECTION A

a) Policy No: 7207003428 0400000021 b) Sl. No/ Certificate No:
c) Company / TPA ID No:
d) Name: CHITHAMBARATHANU T
e) Address: 67 10TH CROSS STREET HINDU COLONY
NANGANALLUR
City: CHENNAI State: TAMILNADU
Pin Code: 600061 Phone No: 9841403382 Email ID: chithambarathanu.t@tspl.com

DETAILS OF INSURANCE HISTORY — SECTION B

a) Currently covered by any other Mediclaim / Health Insurance: [ ] Yes [✓] No b) Date of commencement of first Insurance without break: 07 07 16
c) If yes, company name: Policy No:
Sum Insured (Rs.): d) Have you been hospitalized in the last four years since inception of the contract? [ ] Yes [✓] No Date:
Diagnosis: e) Previously covered by any other Mediclaim / Health insurance [ ] Yes [ ] No
f) If yes, Company Name:

DETAILS OF INSURED PERSON HOSPITALIZED — SECTION C

a) Name: THIRUNELVELY PERUMAL
b) Gender: Male [✓] Female [ ] c) Age: years 69 months 04 d) Date of Birth: 02 03 52
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: E-mail ID:

DETAILS OF HOSPITALIZATION — SECTION D

a) Name of hospital where Admitted: SUBAM SPECIALITY HOSPITAL
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: 25 05 21
e) Date of Admission: 04 06 21 f) Time: 11 00 g) Date of Discharge: 09 06 21 h) Time: 10 00
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:

DETAILS OF CLAIM — SECTION E

a) Details of the treatment expenses claimed

i. Pre-hospitalization Expenses	Rs.	ii. Hospitalization Expenses	Rs. 100524
iii. Post-hospitalization Expenses	Rs.	iv. Health Check up Cost	Rs.
v. Ambulance Charges	Rs.	vi. Others (code)	Rs.
		Total	Rs. 100524
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, if any
- [ ] 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 BILLS ENCLOSED — SECTION F

Sl. No	Bill No	Date	Issued by	Towards	Amount (Rs)
1				Hospital Main Bill	100524
2				Pre-hospitalization Bills: ___ Nos	
3				Post-hospitalization Bills: ___ Nos	
4				Pharmacy Bills	13524
5					
6					
7					
8					
9					
10					

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT — SECTION G

A/C 000701518051
c) Bank Name and Branch: ICICI BANK CENOTAPH ROAD CHENNAI
d) Cheque/ DD Payable details: e) IFSC Code: ICIC0000001

(IMPORTANT: PLEASE TURN OVER)

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 / receipts for the purpose of this claim & that I will not be making any supplementary claim except the proposed hospitalization claim, if any.

Date 17/07/21 Place NAGERCOIL Signature of the Insured

SECTION H

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 serial number of 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 four years since inception of the contract?	Indicate whether hospitalized in the last four 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.		

CLAIM FORM FOR THE NEW INDIA ASSURANCE CO LTD– 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 | SECTION B | SECTION C | SECTION D | SECTION E | SECTION F

DETAILS OF HOSPITAL

a) Name of the hospital: SUBAM SPECIALITY HOSPITAL
b) Hospital ID:
c) Type of Hospital: Network ☐ Non Network ☐ (If non network fill section E)
d) Name of the treating doctor: V.S MUTHU RAMALINGAM
e) Qualification: MS ORTHO D.ORTHO
f) Registration No. with State Code: 49676
g) Phone No: 9994BD5103

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient: MR THIRUNELVELI PERUMAL
b) IP Registration Number: 213B20
c) Gender: Male ☑ Female ☐
d) Age: Years 65 Months 4/12 e) Date of birth:
f) Date of Admission: 04 06 21
g) Time: 05 (51) PM h) Date of Discharge: 09 06 21 i) Time: 12 (15) PM
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:

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a)	ICD 10 Codes	Description	b)	ICD 10 PCS	Description
i. Primary Diagnosis:		DM/HT/ COVID PNEUMONIA 30% HYPOTHYROIDISM	i. Procedure 1:		CONSERVATIVE TREATMENT WITH LIFE SAVING DRUGS
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 e) Pre-authorization Number:
f) If authorization by network hospital not obtained, give reason:
g) 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:

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

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

a) Address of the Hospital: SUBAM SPECIALITY HOSPITAL
215 ASARI BU ROAD SMRV SCHOOL OPP
City: NAGERCOIL State: TAMIL NADU
Pin Code: 629001 b) Phone No: 9994BD5103 c) Registration No. with State Code: TN 22 04
d) Hospital PAN: AHUPM4686R e) Number of Inpatient beds: 50 f) Facilities available in the hospital: i. OT ☑ Yes ☐ No ii. ICU ☑ Yes ☐ No
iii. Others: CATH LAB.

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: 14 07 21
Place: NAGERCOIL
Signature and Seal of the Hospital Authority

SUBAM SPECIALITY HOSPITAL VADASERY

Dr. V.S. MUTHU RAMALINGAM, D.Ortho, M.S.Ortho.
Reg. No: 49676
SUBAM SPECIALITY HOSPITAL
215, Opp. S.M.R.V. SCHOOL,
VADASERY, NAGERCOIL.