**{iname}**

**Health Claim of : {pname} Claim Number : {claimno}**

**ID Proof details ;**

***Questionnaire for the insured. To be filled in with a black or blue ball point pen.***

1. What were the complaints presented by you during admission in {hname}, {hplace} on {doa}?
2. Since when are you suffering from the above mentioned problem, Please specify?
3. Where were you consulting for the same problem before this admission? Kindly provide a copy of all the previous consultation papers. **Mandatory.**
4. How did you sustain injury? Please narrate the accident/incident in detail with date and time?
5. Did you have a valid Driving License? Please provide a copy of your driving license.
6. Where were you going during the time of accident/incident and who was with you during the time of accident/incident?
7. Were you taken to any hospital immediately after the accident? If so, kindly mention the Hospital details?

1. Hospital Name and Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of the treating Doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What kind of treatment was given to you in the above mentioned hospital? Kindly provide a copy of all treatment records.

*Insured Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**{iname}**

**Health Claim of : {pname} Claim Number : {claimno}**

1. Did they take any X-ray in the hospital immediately after injury? If so, please provide a copy of the X-ray report?
2. Have you registered any police complaint? If so, please provide the details. If FIR done, provide a copy of FIR.
3. Is there any kind of media news available for this accident? If so, please provide the details.
4. Please fill in the following:-

|  |  |  |
| --- | --- | --- |
| **Habits** | **Units Per Day** | **Since When** |
| Smoking |  |  |
| Alcohol |  |  |
| Tobacco chewing |  |  |

1. What was the final diagnosis arrived?
2. How many days were you admitted in the hospital?
3. What was the explanation given by your doctor for getting admitted in the hospital?
4. What is the exact date & time of admission and discharge? Please mention.

Date of admission \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of discharge \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please mention about the class of accommodation and Room rent/day.

Class of accommodation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Room rent /day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What was the final bill amount paid by you during discharge? Please provide a copy of final bill payment receipt along with payment proof if payment done other than cash.

*Insured Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**{iname}**

**Health Claim of : {pname} Claim Number : {claimno}**

1. Have you been advised with out patient medications before getting admitted in the hospital? If so please provide the copy of same.
2. How much had you paid for the hospitalization, lab and pharmacy?
3. How were you purchasing your medicnes during the admission ? By cash then and there or by credit Please clarify
4. Are you suffering from any of this below mentioned disease? Kindly mention the duration.

High Blood Pressure since \_\_\_\_\_\_\_\_years, on regular treatment since diagnosis.

High Blood Sugar since \_\_\_\_\_\_\_\_years, on regular treatment since diagnosis.

Heart disease since \_\_\_\_\_\_\_\_years, on regular treatment since diagnosis.

Kidney problem since \_\_\_\_\_\_\_\_\_ years, on regular treatment .Since diagnosis

Cholesterol problem since \_\_\_\_\_\_\_\_\_ years, on regular treatment .Since diagnosis

Arthritis since \_\_\_\_\_\_\_\_\_ years, on regular treatment .Since diagnosis.

Seizures since \_\_\_\_\_\_\_\_\_ years, on regular treatment .Since diagnosis.

Bronchial Asthma since \_\_\_\_\_\_\_\_\_ years, on regular treatment .Since diagnosis.

1. Have you underwent any operations/admission ever before, if so please provide the details?

1. Are you taking any medicines for any other illness not mentioned above? If so please provide the details.

*Insured's Signature :*

**{iname}**

**Health Claim of : {pname} Claim Number : {claimno}**

1. How much did you paid as advance at the time of admission by cash/cheque? How much did you paid at the time of discharge by cash/cheque?

At the time admission\_\_\_\_\_\_\_\_\_by At the time of discharge \_\_\_\_\_\_\_\_\_by

***Please provide the details of your employment / School / College:( If applicable)***

Name of the Organisation/Institution :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

Working since : \_\_\_\_\_\_\_\_\_\_ Designation : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*I declare that the above mentioned details are true to the best of my knowledge*

***I do hereby authorize the representative of {iname} and give my full consent to collect the necessary details regarding my treatment, photocopies of relevant documents and previous consultation and OPD papers from the hospital where I have been treated, for claim processing***

***I do hereby give my full consent for {iname} to take a photograph of my face in case if do not have any valid photo ID proof for submiting to the company's representative during his visit for documentation***

Date : Place :

Insured's Signature :

Insured's Name : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Note: Please provide us a copy of all the OPD and previous consultation papers, Discharge summaries , Investigation reports and other relevant documents to process the claim at the earliest.***

To

The Insurance Desk / Medical records department

{hname}

{hplace}

***Consent Letter***

***I do hereby authorize the representative of {iname} and give my full consent to collect the necessary details regarding my treatment, photocopies of relevant documents and previous consultation and OPD papers from the hospital where I have been treated, for claim processing .***

Date : Place :

Insured's Signature :

Insured's Name : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of admission : {doa}

Date of discharge : {dod}

UHID / MRD number : {opno} / {ipno}

***Note : Please provide us a copy of all the OPD and previous consultation papers , Discharge summaries , Investigation reports and other relevant documents to process the claim at the earliest.***

Customer Feedback Form

|  |  |
| --- | --- |
| Customer Name: | {pname} |
| Address: |  |
| Email/Phone |  |
| Vendor Name | {vname} |
| Name of Verification Officer |  |

1. Did verification officer explain you the purpose of visit?
2. Did he take consent for verification process ?
3. Did he present you authority letter/ Identity card ?
4. Was there any misbehavior/rude/arrogant behavior from verification officer during verification?
5. Did he take photographs of all the related documents, prescription, reports, and films with willful consent
6. Was the information shared without any force, fear, influence or pressure and without giving money or gift to the representative

Here by you are allowing us to take your Google locations as a part of claim verification

Date Date

Signature of insured Signature of verification officer

Contact No :