***{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 presenting complaints presented by you during first consultation / admission at {hname}, {hplace}?
2. Since when are you suffering from this above mentioned complaints? Please specify.
3. Where were you consulting for the same problem before this admission? Kindly provide the copies of relevant past medical records (OPD/IPD Documents). **Mandatory.**
4. What was final diagnosis or the Problem as explained by the doctor to you?
5. Since when are you married? Have you got any children, please mention the details if any.

1. Since when are you visiting and consulting at {hname}, {hplace} for this problem? Kindly provide a copy of the all consultation paper and treatment records prior to this admission. **Mandatory.**
2. What was the reason/explanation given to you by the doctor for doing a Hystero-Laproscopy now?
3. What was the possible outcome expected by doing this surgery as explained by your Doctor (benefits of doing this surgery).

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

***{iname}***

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

1. Had you ever got hospitalized for any other problem before this admission? If so, kindly provide the copy of the discharge summary.
2. Are you under any medical advice for conception (pregnancy)? If so, please provide the detail.
3. Kindly provide a copy of all consultation papers of {hname}, {hplace} from the first Visit.
4. Kindly provide the referral doctor details who referred you to {hname}, {hplace}.
5. Kindly provide a copy of first consultation papers, Investigation reports, Prescriptions and treatment records which is prior to admission. **Mandatory.**
6. What was the reason mentioned by the doctor to come for review during D1/D2 of mensus. Kindly clarify the purpose?
7. Did you undergone Hystero-Salphingo-Gram test? If so, please provide the copy of the test. Who advised you for HSG?

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

***{iname}***

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

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

Name of the Organization/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 submitting 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.***

**TATA AIG General Insurance Co. Ltd.**

**Customer Feedback Form**

|  |  |  |  |
| --- | --- | --- | --- |
| **Claim Details** | | | |
| **Claim No.** |  | **Policy No.** |  |
| **Insured Name** |  | **Patient Name** |  |
| **Date of Visit** |  | **Place of Visit** |  |
| **Field Officer Name & Contact No.** |  | | |

Thank you for taking the time to provide feedback. Your Opinion is important to us and will help us improve our processes. Please take a moment to answer the following questions honestly.

1. **Please rate the Field officer’s behavior during the interaction.**

**Excellent Good Average Poor**

Please specify (if Average or Poor selected)

1. **Did the field officer ask for any favor or special treatment during the interaction?**

**Yes No**

1. **Did the investigator hint at or suggest receiving a bribe?**

**Yes No**

1. **Did the field officer take permission from you to check your personal information such as Google timelines, WhatsApp details, money transaction details, Photographs, etc.?**

**Yes No**

1. **How satisfied are you with the overall approach of the Field Officer?**

**Satisfied Dissatisfied**

Please specify (If Dissatisfied)

Thank you for your feedback. We appreciate your time and honesty.

**Signature Witness Signature**

**Insured Name / Patient Name Name**

**Contact No. Contact No.**