**{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. When did you consulted at {hname}, {hplace} for the first time for the above said complaints?
4. Did you treated under OPD basis before this admission? If so please provide a copy of previous consultation paper.
5. Who referred to {hname}, {hplace}? If no referral, how do you know about this hospital? Please clarify.
6. Kindly allow our field officer to verify and collect google time line.
7. 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?

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

**{iname}**

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

1. Are you taking any medicines for any other illness not mentioned above? If so please provide the details.
2. What is the exact date of admission and date of discharge, Please mention

Date of admission \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Time\_\_\_\_\_\_\_\_\_\_\_

Date of discharge \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Time\_\_\_\_\_\_\_\_\_\_\_\_

1. How many days were you in the hospital as In- Patient, please mention?
2. What was the explanation given by your doctor for getting admitted in the hospital?
3. Kindly provide the Room No, Class of Accommodation and room rent / day.

Room No \_\_\_\_\_\_\_\_\_\_ Class of Accommodation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rent / day \_\_\_\_\_\_\_\_\_\_

No. of Days Accommodated \_\_\_\_\_\_\_ From To

1. What was the final diagnosis made in the hospital? Please clarify.
2. What are all the lab investigation performed, please mention in detail.
3. What was the treatment given during hospitalization period?
4. How were you purchasing your medicines during the admission? By cash or by credit? Please clarify

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

**{iname}**

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

1. What was the final bill amount paid by you during discharge? Please provide a copy of final bill payment receipt.
2. How much had you paid for the hospitalization, lab and pharmacy?
3. 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 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.**