**ID Proof details ;**

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

1. What are the complaints presented by you during the admission at {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 the previous consultation paper. MANDATORY
4. Are you suffering from Heart disease ? If so kindly mention the exact duration.

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

1. Are you suffering from Dyslipidemia ? If so kindly mention the exact duration and provide the 1st consultation paper and all follow-up treatment records for the same.

Dyslipidemia since \_\_\_\_\_\_\_\_years, on regular treatment since diagnosis.

1. Kindly mention the exact duration and past history of Diabetics (High Blood Sugar) . kindly mention the exact duration and provide the 1st consultation paper and all follow-up treatment records for the same**.**

Diabetics Mellitus since \_\_\_\_\_\_\_years, on regular treatment since diagnosis.

Name of the drugs with dosage:

|  |  |
| --- | --- |
| 1. | 3. |
| 2. | 4. |

Insured's signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Kindly mention the exact duration and past history of HTN (High Blood Pressure) . Kindly provide the 1st consultation paper and all past treatment records**.**

HTN since \_\_\_\_\_\_\_years, on regular treatment since diagnosis.

Name of the drugs with dosage:

|  |  |
| --- | --- |
| 1. | 3. |
| 2. | 4. |

1. Please provide the Contact details of the Physician/ Doctor who is treating you for HTN (High Blood Pressure) and Diabetics (High Blood Sugar) before this admission, Also provide a copy of the prescription paper?

HTN (High Blood Pressure)

Name of the Doctor : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinic/Hospital Name Address : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Phone no/ Mobile no : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetics (High Blood Sugar)

Name of the Doctor : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinic/Hospital Name Address : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Phone no/ Mobile no : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you suffering from any of this below mentioned disease? Kindly mention the duration.

Kidney 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.

Insured's signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you underwent any operations/admission ever before, if so please provide the details?
2. Are you taking any medicines for any other illness not mentioned above? If so please provide the details.
3. Please mention the family doctor name who is treating you regularly with his contact number?
4. 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. What kind of room was given for you to accommodate, What was the room rent per day as mentioned by the hospital admin?

Class of Accommodation :

Room rent per day : Rs. / day

1. What was the final bill amount paid by you during discharge?
2. What was the final diagnosis made in the hospital ? Please clarify

Insured's signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What were the investigations done ? Please clarify and provide copies of investigation

reports

1. What was the treatment given to you during the time of hospitalization ? Did they give any IV glucose / drips/ IV injections during admission? If so please mention the details .
2. Were you kept in the ICU in any time of your admission in the hospital, if so please mention the details as how many days ?
3. Did they mention any package amount for this admission, if so please explain what was the package amount.
4. Please provide a copy of final bill payment receipt.
5. Were you admitted for doing all the lab investigations?
6. Did you consulted in {hname}, {hplace} for any other illness before this admission? If yes, please provide all the previous consultation records (Mandatory).

Insured's signature*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***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.**