**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 ? Kindly mention the duration.

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

1. Are you suffering from Diabetes (High Blood Sugar)?

Diabetes since \_\_\_\_\_\_\_\_\_ years on regular treatment. Since diagnosis.

Name of the drugs with dosage:

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

1. Are you suffering from HTN (High Blood Pressure)?

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

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.

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

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

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

reports

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

1. 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 ?
2. Did they mention any package amount for this admission, if so please explain what was the package amount.
3. Please provide a copy of final bill payment receipt.
4. How were you purchasing your medicnes during the admission ? By cash then and there or by credit Please clarify.
5. How much did you paid as advance by cash/cheque

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

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 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 : {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: |  |
| 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 :