***{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.***

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 :