Claim form for health insurance policies other than travel and personal accident - PART A

TO BE FILLED IN BY THE INSURED

(TO BE FILLED IN BLOCK LETTERS)

The issue of this Form is not to be taken as an admission of liability

DETAILS OF PRIMARY INSURED

SECTION A

a) Policy No: b) Sl. No/Certificate No

c) Company/TPA ID No:

d) Name: SURNAME FIRST NAME MIDDLE NAME

e) Address:

City State:

Pin Code Phone No: Email ID:

DETAILS OF INSURANCE HISTORY:

SECTION B

a) Currently covered by any other Mediclaim / Health Insurance: ◯ YES ◯ NO

b) Date of commencement of first Insurance without break: DD MM YYYY

c) If yes, company name: Policy No.

Sum Insured (Rs.)

d) Have you been hospitalized in the last four years since inception of the contract? ◯ YES ◯ NO Date DD MM YY

Diagnosis:

e) Previously covered by any other Mediclaim / Health insurance : ◯ YES ◯ NO

f) If yes, Company Name

DETAILS OF INSURED PERSON HOSPITALIZED:

SECTION C

a) Name: SURNAME FIRST NAME MIDDLE NAME

b) Gender: Male ◯ Female ◯ Third Gender ◯ c) Age: Years YY Month MM d) Date of Birth: DD MM YY

e) Relationship to Primary insured: Self ◯ Spouse ◯ Child ◯ Father ◯ Mother ◯ Other ◯

(Please Specify)

f) Occupation: Service ◯ Self Employed ◯ Homemaker ◯ Student ◯ Retired ◯ Other ◯

(Please Specify)

g) Address (if different from above):

City State:

Pin Code: Phone No: Email ID:

DETAILS OF HOSPITALIZATION:

SECTION D

a) Name of Hospital where Admitted:

b) Room Category occupied: Day Care ☐ Single occupancy ☐ Twin sharing ☐ 3 or more beds per room ☐

c) Hospitalization due to: Injury ☐ Illness ☐ Maternity ☐

d) Date of Injury / Date Disease first detected /Date of Delivery: DD MM YY e) Date of Admission: DD MM YY

f) Time: HH MM g) Date of Discharge: DD MM YY h) Time: HH MM i) If Injury give cause: Self inflicted ☐

Road Traffic Accident ☐ Substance Abuse / Alcohol Consumption ☐ i. If Medico legal: ◯ YES ◯ NO

ii. Reported to police: ◯ YES ◯ NO iii. MLC Report & Police FIR attached: ◯ YES ◯ NO j) System of Medicine:

MAX Bupa HEALTH INSURANCE

DETAILS OF CLAIM:

SECTION E

a) Details of the treatment expenses claimed

i. Pre-hospitalization Expenses: Rs.

ii. Hospitalization Expenses: Rs.

iii. Post-hospitalization Expenses: Rs.

iv. Health-Check up Cost: Rs.

v. Ambulance Charges: Rs.

vi. Others (code): Rs.

Total **Rs.**

vii. Pre-hospitalization period: Days

viii. Post-hospitalization period: Days

b) Claim for Domiciliary Hospitalization: ◯ YES ◯ NO (If yes, provide details in annexure)

c) Details of Lump sum / cash benefit claimed:

i. Hospital Daily Cash: Rs.

ii. Surgical Cash: Rs.

iii. Critical Illness Benefit: Rs.

iv. Convalescence: Rs.

v. Pre/Post hospitalization Lump sum benefit: Rs.

vi. Others Rs.

Total **Rs.**

Claim Documents Submitted- Check List:

- Claim Form Duly signed
- Copy of the Claim intimation if any
- Hospital Main Bill
- Hospital Break-up Bill
- Hospital Bill Payment Receipt
- Hospital Discharge Summary
- Pharmacy Bill
- Operation Theatre Notes
- ECG
- Doctor's request for investigation
- Investigation Reports (Including CT/ MRI / USG / HPE)
- Doctor's Prescriptions
- Others

DETAILS OF BILLS ENCLOSED:

SECTION F

Sl. No.	Bill No.	Date	Issued by	Towards	Amount (Rs)
1		D D M M Y Y		Hospital Main Bill	
2		D D M M Y Y		Pre-hospitalization Bills: Nos	
3		D D M M Y Y		Post-hospitalization Bills: Nos	
4		D D M M Y Y		Pharmacy Bills	
5		D D M M Y Y			
6		D D M M Y Y			
7		D D M M Y Y			
8		D D M M Y Y			
9		D D M M Y Y			
10		D D M M Y Y			

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT:

SECTION G

a) PAN

b) Account Number:

c) Bank Name and Branch:

d) Cheque/ DD Payable details:

e) IFSC Code:

DECLARATION BY THE INSURED:

SECTION H

I hereby declare that the information furnished in this claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent & authorize TPA / insurance company, to seek necessary medical information / documents from any hospital / Medical Practitioner who has attended on the person against whom this claim is made. I hereby declare that I have included all the bills / receipts for the purpose of this claim & that I will not be making any supplementary claim except the pre/post-hospitalization claim, if any.

Date D D M M Y Y

Place

Signature of the Insured

MAX Bupa HEALTH INSURANCE

GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled in by the insured)		
DATA ELEMENT	**DESCRIPTION**	**FORMAT**
SECTION A - DETAILS OF PRIMARY INSURED		
a) Policy No.	Enter the policy number	As allotted by the insurance company
b) SI. No/ Certificate No.	Enter the social insurance number or the certificate number of social health insurance scheme	As allotted by the organization
c) Company TPA ID No.	Enter the TPA ID No	License number as allotted by IRDAI and printed in TPA documents.
d) Name	Enter the full name of the policyholder	Surname, First name, Middle name
e) Address	Enter the full postal address	Include Street, City and Pin Code

SECTION B - DETAILS OF INSURANCE HISTORY		
a) Currently covered by any other Mediclaim / Health Insurance?	Indicate whether currently covered by another Mediclaim / Health Insurance	Tick Yes or No
b) Date of Commencement of first Insurance without break	Enter the date of commencement of first insurance	Use dd-mm-yy format
c) Company Name	Enter the full name of the insurance company	Name of the organization in full
Policy No.	Enter the policy number	As allotted by the insurance company
Sum Insured	Enter the total sum insured as per the policy	In rupees
d) Have you been Hospitalized in the last four years since inception of the contract?	Indicate whether hospitalized in the last four years	Tick Yes or No
Date	Enter the date of hospitalization	Use mm-yy format
Diagnosis	Enter the diagnosis details	Open Text
e) Previously Covered by any other Mediclaim/ Health Insurance?	Indicate whether previously covered by another Mediclaim / Health Insurance	Tick Yes or No
f) Company Name	Enter the full name of the insurance company	Name of the organization in full

SECTION C - DETAILS OF INSURED PERSON HOSPITALIZED		
a) Name	Enter the full name of the patient	Surname, First name, Middle name
b) Gender	Indicate Gender of the patient	Tick Male, Female or Third Gender
c) Age	Enter age of the patient	Number of years and months
d) Date of Birth	Enter Date of Birth of patient	Use dd-mm-yy format
e) Relationship to primary Insured	Indicate relationship of patient with policyholder	Tick the right option. If others, please specify.
f) Occupation	Indicate occupation of patient	Tick the right option. If others, please specify.
g) Address	Enter the full postal address	Include Street, City and Pin Code
h) Phone No	Enter the phone number of patient	Include STD code with telephone number
i) E-mail ID	Enter e-mail address of patient	Complete e-mail address

SECTION D - DETAILS OF HOSPITALIZATION		
a) Name of Hospital where admitted	Enter the name of hospital	Name of hospital in full
b) Room category occupied	Indicate the room category occupied	Tick the right option
c) Hospitalization due to	Indicate reason of hospitalization	Tick the right option
d) Date of Injury/Date Disease first detected/ Date of Delivery	Enter the relevant date	Use dd-mm-yy format
e) Date of admission	Enter date of admission	Use dd-mm-yy format
f) Time	Enter time of admission	Use hh:mm format
g) Date of discharge	Enter date of discharge	Use dd-mm-yy format
h) Time	Enter time of discharge	Use hh:mm format
i) If Injury give cause	Indicate cause of injury	Tick the right option
If Medico legal	Indicate whether injury is medico legal	Tick Yes or No
Reported to Police	Indicate whether police report was filed	Tick Yes or No
MLC Report & Police FIR attached	Indicate whether MLC report and Police FIR attached	Tick Yes or No
j) System of Medicine	Enter the system of medicine followed in treating the patient	Open Text

SECTION E - DETAILS OF CLAIM		
a) Details of Treatment Expenses	Enter the amount claimed as treatment expenses	In rupees (Do not enter paise values)
b) Claim for Domiciliary Hospitalization	Indicate whether claim is for domiciliary hospitalization	Tick Yes or No
c) Details of Lump sum/ cash benefit claimed	Enter the amount claimed as lump sum/ cash benefit	In rupees (Do not enter paise values)
d) Claim Documents Submitted Check List	Indicate which supporting documents are submitted	Tick the right option

SECTION F - DETAILS OF BILLS ENCLOSED
Indicate which bills are enclosed with the amounts in rupees

SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT		
a) PAN	Enter the permanent account number	As allotted by the Income Tax department
b) Account Number	Enter the bank account number	As allotted by the bank
c) Bank Name and Branch	Enter the bank name along with the branch	Name of the Bank in full
d) Cheque/ DD payable details	Enter the name of the beneficiary the cheque/ DD should be made out to	Name of the individual/ organization in full
e) IFSC Code	Enter the IFSC code of the bank branch	IFSC code of the bank branch in full

SECTION H - DECLARATION BY THE INSURED
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.

MAX Bupa HEALTH INSURANCE

CLAIM FORM - PART B

TO BE FILLED IN BY THE HOSPITAL

(TO BE FILLED IN BLOCK LETTERS)

The issue of this Form is not to be taken as an admission of liability
Please include the original preauthorization request form in lieu of PART A

SECTION A

DETAILS OF HOSPITAL

a) Name of the hospital:

b) Hospital ID: c) Type of Hospital: Network ◯ Non Network ◯ (If non network fill section E)

d) Name of the treating doctor: SURNAME FIRST NAME MIDDLE NAME

e) Qualification: f) Registration No. with State Code:

g) Phone No.

SECTION B

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient: SURNAME FIRST NAME MIDDLE NAME

b) IP Registration Number: c) Gender: Male ◯ Female ◯ Third Gender ◯

d) Age: Years YY Months MM e) Date of birth: DD MM YYYY

f) Date of Admission: DD MM YYYY g) Time: HH MM h) Date of Discharge: 21 01 18 YYYY

i) Time: HH MM j) Type of Admission: Emergency Planned Day Care Maternity

k) If Maternity i. Date of Delivery: DD MM YYYY ii. Gravida Status:

l) Status at time of discharge: Discharge to home ◯ Discharge to another hospital ◯ Deceased ◯

m)Total claimed amount

SECTION C

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a)	ICD 10 Codes	Description	b)	ICD 10 PCS	Description
i. Primary Diagnosis:			i. Procedure 1:		
ii. Additional Diagnosis:			ii. Procedure 2:		
iii. Co-morbidities:			iii. Procedure 3:		
iv. Co-morbidities:			iv. Details of Procedure:		

c) Pre-authorization obtained: ◯ YES ◯ NO d) Pre-authorization Number:

e) If authorization by network hospital not obtained, give reason:

f) Hospitalization due to Injury: ◯ YES ◯ NO I. If Yes, give cause Self-inflicted Road Traffic Accident Substance abuse / alcohol consumption

ii. If Injury due to Substance abuse / alcohol consumption, Test Conducted to establish this: ◯ YES ◯ NO (If Yes, attach reports)

iii. If Medico legal: ◯ YES ◯ NO iv. Reported to Police: ◯ YES ◯ NO v. FIR no.

vi. If not reported to police give reason:

HEALTH INSURANCE

CLAIM DOCUMENTS SUBMITTED - CHECK LIST

SECTION D

- ☐ Claim Form duly signed
- ☐ Original Pre-authorization request
- ☐ Copy of the Pre-authorization approval letter
- ☐ Copy of photo ID card of patient verified by hospital
- ☐ Hospital Discharge summary
- ☐ Operation Theatre notes
- ☐ Hospital main bill
- ☐ Hospital break-up bill
- ☐ Investigation reports
- ☐ CT/MR/USG/HPE investigation reports
- ☐ Doctor's reference slip for investigation
- ☐ ECG
- ☐ Pharmacy bills
- ☐ MLC report & Police FIR
- ☐ Original death summary from hospital where applicable
- ☐ Any other, please specify

ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)

SECTION E

a) Address of the Hospital:

City State:

Pin Code: b) Phone No: d) Hospital PAN:

c) Registration No. with State Code: e) Number of Inpatient beds

f) Facilities available in the hospital: i. OT : ◯ YES ◯ NO ii. ICU : ◯ YES ◯ NO

iii. Others :

DECLARATION BY THE HOSPITAL

(PLEASE READ VERY CAREFULLY)

SECTION F

We hereby declare that the information furnished in this Claim Form is true & correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited.

Date: D D M M Y Y Y Y

Place:

Signature and Seal of the Hospital Authority:

MAX Bupa HEALTH INSURANCE

GUIDANCE FOR FILLING CLAIM FORM - PART B (To be filled in by the hospital)		
DATA ELEMENT	**DESCRIPTION**	**FORMAT**
SECTION A - DETAILS OF HOSPITAL		
a) Name of Hospital	Enter the name of hospital	Name of hospital in full
b) Hospital ID	Enter ID number of hospital	As allocated by the TPA
c) Type of Hospital	Indicate whether In network or non network hospital	Tick the right option
d) Name of treating doctor	Enter the name of the treating doctor	Name of doctor in full
e) Qualification	Enter the qualifications of the treating doctor	Abbreviations of educational qualifications
f) Registration No. with State Code	Enter the registration number of the doctor along with the state code	As allocated by the Medical Council of India
g) Phone No.	Enter the phone number of doctor	Include STD code with telephone number
SECTION B - DETAILS OF THE PATIENT ADMITTED		
a) Name of Patient	Enter the name of hospital	Name of hospital in full
b) IP Registration Number	Enter insurance provider registration number	As allotted by the insurance provider
c) Gender	Indicate Gender of the patient	Tick Male, Female or Third Gender
d) Age	Enter age of the patient	Number of years and months
e) Date of Birth	Enter date of admission	Use dd-mm-yy format
f) Date of Admission	Enter date of admission	Use dd-mm-yy format
g) Time	Enter time of admission	Use hh:mm format
h) Date of Discharge	Enter date of discharge	Use dd-mm-yy format
I) Time	Enter time of discharge	Use hh:mm format
j) Type of Admission	Indicate type of admission of patient	Tick the right option
k) If Maternity		
Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format
Gravida Status	Enter Gravida status if maternity	Use standard format
l) Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
m) Total claimed amount	Indicate the total claimed amount	In rupees (Do not enter paise values)
SECTION C - DETAILS OF AILMENT DIAGNOSED (PRIMARY)		
a) ICD 10 Code		
Primary Diagnosis	Enter the ICD 10 Code and description of the primary diagnosis	Standard Format and Open text
Additional Diagnosis	Enter the ICD 10 Code and description of the additional diagnosis	Standard Format and Open text
Co-morbidities	Enter the ICD 10 Code and description of the co-morbidities	Standard Format and Open text
b) ICD 10 PCS		
Procedure 1	Enter the ICD 10 PCS and description of the first procedure	Standard Format and Open text

Procedure 2	Enter the ICD 10 PCS and description of the second procedure	Standard Format and Open text
Procedure 3	Enter the ICD 10 PCS and description of the third procedure	Standard Format and Open text
Details of Procedure	Enter the details of the procedure	Open text
c) Pre-authorization obtained	Indicate whether pre-authorization obtained	Tick Yes or No
d) Pre-authorization Number	Enter pre-authorization number	As allotted by TPA
e) If authorization by network hospital not obtained, give reason	Enter reason for not obtaining pre authorization number	Open text
f) Hospitalization due to injury	Indicate if hospitalization is due to injury	Tick Yes or No
Cause	Indicate cause of injury	Tick the right option
If injury due to substance abuse/ alcohol consumption, test conducted to establish this	Indicate whether test conducted	Tick Yes or No
Medico Legal	Indicate whether injury is medico legal	Tick Yes or No
Reported To Police	Indicate whether police report was filed	Tick Yes or No
FIR No.	Enter first information report number	As issued by police authorities
If not reported to police, give reason	Enter reason for not reporting to police	Open Text

SECTION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST
Indicate which supporting documents are submitted

SECTION E - DETAILS IN CASE OF NON NETWORK HOSPITAL		
a) Address	Enter the full postal address	Include Street, City and Pin Code
b) Phone No.	Enter the phone number of hospital	Include STD code with telephone number
c) Registration No. with State Code	Enter the registration number of the doctor along with the state code	As allocated by the Medical Council of India
d) Hospital PAN	Enter the permanent account number	As allotted by the Income Tax department
e) Number of Inpatient beds	Enter the number of inpatient beds	Digits
f) Facilities available in the hospital	Indicate facilities available in the hospital	Tick the right option. If others, please specify

SECTION F - DECLARATION BY THE HOSPITAL
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign and stamp

Annexure - Claim Form for reimbursement

Do You Know?

- Non-submission of original bills and receipts is the main reason for delay in claim settlements. Please provide the originals
- Provide your bank details for direct/ Electronic Fund Transfer (EFT) for faster claim settlement.
- To receive updates on your claim status, please provide your mobile no. & E-mail ID
- You can check your claim status at: www.maxbupa.com → Claims → Claims status → Login to check status.

Dear Policyholder,

Please fill the following information along with the reimbursement claim form for your medical insurance policy.

Policy No.

Membership No.

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

Name of Accountholder:

Bank Name:

Branch:

City:

IFSC Code:

Payment option: Cheque ◯ DD ◯ NEFT ◯

***Note:** Please submit a cancelled cheque leaf or a copy of latest bank statement or passbook with accountholder's name, account no., and IFSC code mentioned on it.

CUSTOMER IDENTIFICATION PROCEDURE (AS PER KYC NORMS OF IRDAI)

Please submit clear and legible copy of one document (valid and effective as on date of claim submission) each from Part A and Part B and your recent passport size photograph (not more than 6 months old) incase claim amount exceeds Rs 100,000

Part A **Proof of legal name and any other names used**	i. Pan Card ii. If Pan Card is not available please submit any of the documents mentioned below stating reason for not having Pan Card. a) Passport b) Voter's Identity Card c) Driving License d) Personal Identification and Certification of the employees for your identity. e) Letter issued by Unique identification Authority of India containing details of name address and Aadhar Number f) Job Card issued by NREGA duly signed by an officer of the State Government

Part B **Proof of Residence**	i. Electricity Bill not older than 6 months from the date of claim submission ii. Telephone Bill pertaining to any kind of telephone connection like mobile, landline, wireless etc. Provided it is not older than 6 months from the date of claim submission iii. Ration Card iv. Valid lease agreement along with rent receipts which is not more than 3 months old as a residence proof v. Saving Bank Passbook with details of permanent/ present residence address (updated upto 1 month prior to claim submission document) vi. Statement of saving bank account with details of permanent/ present address (updated upto 1 month prior to claim submission document)

I hereby declare that I have submitted above mentioned documents and recent photograph (not more than 6 months old) for the purpose of claim and the said documents are valid and effective.

Date D D M M Y Y Y Y

Signature of Policyholder:

(Please attach copy of a cancelled cheque of your bank for ensuring accuracy of name of the bank, branch name, Account number and IFSC code. If name of the payee is not printed on the cheque leaf please attach copy of the first page of the bank passbook also)

Consent Letter

To,

Date D D M M Y Y

Medical Superintendent

_____

_____

_____

I, Mr./Ms _____ Age _____ Resident

of _____ State _____ Hereby

give my willful consent to Mr/ Dr _____ of Max Bupa Health

Insurance Company Limited to verify and collect necessary documents/ statements including but not limited to certified copies of medical records from your esteemed hospital for the purpose of settlement of my Insurance claim.

My other relevant details are provided below;

Detail of Insured:-

DOA:-

DOD:-

MRD/ Indoor/ IP No:-

Policy No:-

I request you to provide all the information/ documents as required by Max Bupa Health Insurance Company Ltd.

Name:-

Signature/ Thumb Impression

Witness Name & Signature

Request for Cashless Hospitalisation for Health Insurance Policy Part - C

Details of the Third Party Administrator/ Insurer/ hospital: (To be filled in block letters)

a) Name of Insurance company: MAX BUPA HEALTH INSURANCE

b) Customer helpline number: 1860 500 8888

c) Fax no./email Id:

d) Name of Hospital:

i. Address

ii. ROHINI ID

iii. E-mail Id

TO BE FILLED BY INSURED/PATIENT

A. Name of the Patient:

B. Gender: Male ☐ Female ☐ Third Gender ☐ C. Age: Year (YY) Month (MM)

D. Date of Birth: (DD MM YYYY) E. Contact number:

F. Contact number & name of attending relative:

G. Insured Card ID number:

H. Current Address of Insured Patient

I. Occupation of Insured Patient

J. Policy number/Name of Corporate:

K. Employee ID:

L. Currently do you have any other mediclaim /health insurance: ☐ Yes ☐ No

Company Name:

Give Details:

M. Do you have a family Physician: ☐ Yes ☐ No

N. Name of the Family Physician:

O. Contact number, if any: (Please complete declaration of this form)

TO BE FILLED BY TREATING DOCTOR/HOSPITAL

A. Name of the treating Doctor:

B. Contact number:

C. Nature of Illness/Disease with presenting complaint:

D. Relevant critical findings:

E. Duration of the present ailment ☐☐☐ Days (i) Date of first consultation: (DD MM YYYY)

(ii) Past history of present ailment, if any

F. Provisional diagnosis:

(i) ICD 10 code:

G. Proposed line of treatment: ☐ Medical Management ☐ Surgical Management ☐ Intensive care ☐ Investigation ☐ Non-allopathic treatment

H. If investigation &/or Medical Management, provide details

(i) Route of Drug Administration

I. If Surgical, name of surgery

(i) ICD 10 code:

J. If other treatment, provide details

K. How did injury occur

L. In case of accident (i) Is it RTA: Yes NO (ii) Date of Injury: D D M M Y Y Y Y

(iii) Report to Police Yes NO (iv) FIR No.

(v) Injury /Disease caused due to substance abuse/alcohol consumption Yes NO

(vi) Test conducted to establish this Yes NO (if yes, attach report)

M. In case of Maternity G P L A (i) Expected date of Delivery D D M M Y Y Y Y

Details of patient admitted

A. Date of admission D D M M Y Y Y Y

B. Time of admission H H M M

C. Is this an emergency/planned hospitalization event: Emergency Planned

D. Mandatory Past History of any chronic illness
If yes (Since month/year)

Diabetes	M M Y Y Y Y
Heart disease	M M Y Y Y Y
Hypertension	M M Y Y Y Y
Hyperlipidemias	M M Y Y Y Y
Osteoarthritis	M M Y Y Y Y
Asthma/COPD/Bronchitis	M M Y Y Y Y
Cancer	M M Y Y Y Y
Alcohol/Drug abuse	M M Y Y Y Y
Any HIV/ or STD Related ailment	M M Y Y Y Y

Any other ailment, give details

E. Expected number of days stay in hospital: (Days)

F. Days in ICU

G. Room Type

H. Per Day Room Rent + Nursing and Service Charges + Patients Diet: (INR)

I. Expected cost of investigation + diagnostic: (INR)

J. ICU Charges (INR)

K. OT charges (INR)

L. Professional fees Surgeon + Anesthetist Fees + Consultation Charges: (INR)

M. Medicines+ Consumables+ Cost of Implants (if applicable please specify)

N. Other hospital expenses if any

O. All-inclusive package charges if any applicable

P. Sum Total expected cost of hospitalization

DECLARATION

We confirm having read understood and agreed to the Declarations of this form

a. Name of the treating Doctor S U R N A M E F I R S T N A M E M I D D L E N A M E

b. Qualification: c. Registration number with State code

Hospital Seal
(Must include Hospital ID)

Patient/Insured Name and Sign

DECLARATION BY THE PATIENT/REPRESENTATIVE

a. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Insurer/ T.P.A after the discharge. I agree to sign on the Final Bill & the Discharge Summary, before my discharge.
b. Payment to hospital is governed by the terms and conditions of the policy. In case the Insurer/ TPA is not liable to settle the hospital bill, I undertake to settle the bill as per the terms and conditions of the policy.
c. All non-medical expenses and expenses not relevant to current hospitalization and the amounts over & above the limit authorized by the Insurer/ T.P.A not governed by the terms and conditions of the policy will be paid by me.
d. I hereby declare to abide by the terms and conditions of the policy and if at any time the facts disclosed by me are found to be false or incorrect I forfeit my claim and agree to indemnify the Insurer/ T.P.A
e. I agree and understand that T.P.A is in no way warranting the service of the hospital & that the Insurer/ TPA is in no way guaranteeing that the services provided by the hospital will be of a particular quality or standard.
f. I hereby warrant the truth of the forgoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppression or concealment with respect to the claim, my right to claim reimbursement of the said expenses shall be absolutely forfeited.
g. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer/TPA.
h. "I/We authorize Insurance Company TPA to contact me/us through mobile/email for any update on this claim".

1. Patient's/Insured's Name:
2. Contact number:
3. e-mail Id (optional)
4. Patient's / Insured's Signature:

Date D D M M Y Y Y Y Time H H M M

HOSPITAL DECLARATION

a. We have no objection to any authorized TPA / Insurance Company official verifying documents pertaining to hospitalization.
b. All valid original documents duly countersigned by the insured/patient as per the checklist below will be sent to TPA / Insurance Company within 7 days of the patient's discharge.
c. We agree that TPA / Insurance Company will not be liable to make the payment in the event of any discrepancy between the facts in this form and discharge summary or other documents.
d. The patient declaration has been signed by the patient or by his representative in our presence.
e. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole respons1b1hty for any delay in offering clarifications.
f. We will abide by the terms and conditions agreed in the MOU.
g. We confirm that no additional amount would be collected from the insured in excess of Agreed Package Rates except costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility/choosing separate line of treatment which is not envisaged/considered in package).
h. We confirm that no recoveries would be made from the deposit amount collected from the Insured except for costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility/choosing separate line of treatment which is not envisaged/considered in package).
i. In the event of unauthorized recovery of any additional amount from the Insured in excess of Agreed Package Rates, the authorized TPA/ Insurance Company reserves the right to recover the same from us (the Network Provider) and/or take necessary action, as provided under the MoU or applicable laws.

Hospital Seal

Doctor's Signature

Date D D M M Y Y Y Y Time H H M M

ANNEXURE FOR PREAUTH CLAIMS

Dear Policyholder,

Please fill the following information along with the cashless form for your medical insurance policy.

Policy No.

Membership Number

Hospital Id
(To be filled by hospital)

DOCUMENT CHECKLIST:

I. Copy of Photo ID, address proof and recent photo of patient. (for Valid proof of documents kindly refer KYC documents list) KYC documents list includes PAN Card/Driving License/Voter Id. Card/ Aadhar Card
II. Past illness records (With duration of symptoms) if any
III. First and subsequent consultation paper along with admission note.
IV. Complete medical history along with supporting investigation reports.
V. In case of accident, MLC/FIR copy (if applicable)
VI. Claim consent letter

All documents mentioned above to be submitted along with the completed filled cashless form. Insurer may require further documents to process the request.

Name of the Proposer/insured SURNAME FIRST NAME MIDDLE NAME

Contact No.

Signature

Name of the TPA coordinator SURNAME FIRST NAME MIDDLE NAME

Date: DDMMYYYY

Place:

Signature

Consent Letter

To,

Date___/___/____

Medical Superintendent

_____

_____

_____

I, Mr./Ms _____ Age _____ Resident

of _____ State _____ Hereby

give my willful consent to Mr/ Dr _____ of Max Bupa Health

Insurance Company Limited to verify and collect necessary documents/ statements including but not limited to certified copies of medical records from your esteemed hospital for the purpose of settlement of my Insurance claim.

My other relevant details are provided below;

Detail of Insured:-

DOA:-

DOD:-

MRD/ Indoor/ IP No:-

Policy No:-

I request you to provide all the information/documents as required by Max Bupa Health Insurance Company Ltd.

Name

Signature/ Thumb Impression

Witness Name & Signature