

# CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT - PART A TO BE FILLED IN BY THE INSURED The issue of this Form is not to be taken as an admission of liability

DETAILS OF PRIMARY INSURED: (To be filled in block let	.ers)
a) Policy No: b) SI. No./Certificate No:	
c) Company/TPA ID No:	· · ·
d) Name: SURNAME FIRST NAME MIDDLE NAME	┰┐ឰ
e) Address:	SECTION A
	<u>††</u>
City: State:	⇈▮
Pin Code : Phone No : Email ID :	
DETAILS OF INSURANCE HISTORY:	_
a) Currently covered by any other Mediclaim/Health insurance: Yes No b) Date of commencement of first insurance without break: D D M N	
c) If yes, company name : Policy No.	<del>   </del>
Sum Insured (Rs.)	SECTION NO.
Diagnosis:  e) Previously covered by any other Mediclaim/Health Insurance:  Yes	<del></del> ₩ ë
f) If yes, Company Name :	
DETAILS OF INSURED PERSON HOSPITALIZED:	
a. Name:   S	☴▮
b) Gender: Male Female c) Age: Years Y // Months M N d) Date of Birth: D D	
e) Relationship to Primary Insured: Self Spouse Child Father Mother Other (Please Specify)	ro.
f) Occupation: Service   Self Employed   Homemaker   Student   Retired   Other   (Please Specify)	— <u>ii</u>
g) Address (if different from above):	<b>┼</b> ॑
	┿
City: State: Pin Code: Phone No: Email ID:	┿
DETAILS OF HOSPITALIZATION:	<b>= 1</b>
a) Name of Hospital where Admitted :	
b) Room Category occupied: Day care Single occupancy Twin sharing 3 or more beds per room	
c) Hospitatization due to: Injury Illness Maternity d) Date of injury/Date Disease first detected/Date of Delivery	# 8
e) Date of Addmission: DD MMM YY f) Time: HHMMM g) Date of Discharge: DD MMM YY h) Time: HHMM	SECTION SECTION
i) If injury give cause: Self inflicted Road Traffic Accident Substance Abude /Alcohol Consumption i) If Medico legal: Yes No	Z D
ii) Reported to police : Yes No iii) MLC Report & Police FIR attached Yes No j) System of Medicine	
DETAILS OF CLAIM	
a) Dataile of the treatment expenses glaimed:	
a) Details of the treatment expenses claimed:  Claim Documents Submitted - Check List  Claim Expenses: Re Claim France -	:
i. Pre-Hospitalization Expenses: Rs. III Claim Form Duly signed	:
ii. Pre-Hospitalization Expenses: Rs. iii. Hospitalization Expenses: Rs. Claim Form Duly signed iv. Health-Check up Cost: Rs. Copy of the claim intimation, if any	
ii. Pre-Hospitalization Expenses: Rs.	
ii. Pre-Hospitalization Expenses: Rs.	
ii. Pre-Hospitalization Expenses: Rs. III. Hospitalization Expenses: Rs. III. Hospitalization, if any vi. Ambulance Charges: Rs. III. Hospitalization, if any vi. Others (code): III. Rs. III. Hospital Main Bill Hospital Break-up Bill Payment Receipt	SECTION E
ii. Pre-Hospitalization Expenses: Rs.	
ii. Pre-Hospitalization Expenses: Rs.   III. Hospitalization Expenses: Rs.   Claim Form Duly signed   iv. Health-Check up Cost: Rs.   Copy of the claim intimation, if any v. Ambulance Charges: Rs.   Vi. Others (code): Rs.   Hospital Main Bill   Hospital Break-up Bill   Hospital Break-up Bill   Hospital Break-up Bill   Hospital Discharge Summary   Days   No (If yes, provide details in annexure)   Pharmacy Bill	
ii. Pre-Hospitalization Expenses: Rs.	
ii. Pre-Hospitalization Expenses: Rs.	
ii. Pre-Hospitalization Expenses: Rs.	SECTION E
ii. Pre-Hospitalization Expenses: Rs.	SECTION E
ii. Pre-Hospitalization Expenses: Rs. ii. Hospitalization Expenses: Rs. iii. Hospitalization period: Rs. iii. Surgical Cash: Rs. iii. Surgical Cash: Rs. iii. Surgical Cash: Rs. iii. Critical illness Benefit: Rs. iii. Hospitalization Expenses: Rs. iii. Hospitali	SECTION E
ii. Pre-Hospitalization Expenses: Rs.	SECTION E
ii. Pre-Hospitalization Expenses: Rs. iii. Hospitalization Expenses: Rs. iii. Hospital	SECTION E
ii. Pre-Hospitalization Expenses: Rs.	SECTION E
ii. Pre-Hospitalization Expenses: Rs.	SECTION E
ii. Hospitalization Expenses: Rs.	SECTION E
ii. Pre-Hospitalization Expenses: Rs.	SECTION E
ii. Pre-Hospitalization Expenses: Rs.	SECTION E
ii. Pre-Hospitalization Expenses: Rs.	SECTION E
ii. Hospitalization Expenses: Rs.	SECTION E
ii. Pre-Hospitalization Expenses: Rs.	SECTION E SECTION
ii. Pre-Hospitalization Expenses: Rs.	SECTION E SECTION
ii. Pre-Hospitalization Expenses : Rs. ii. Hospitalization period : Copy of the claim intimation, if any v. Ambulance Charges : Rs. iii. Hospital Main Bill Hospital Main Bill Hospital Main Bill Hospital Break-up Bill Hospital Dispersery Bill Operation Theatre Notes ECG  Details of Lump sum / cash benefit claimed:  ii. Hospital Dispersery Bill Operation Theatre Notes  ECG  Doctor's request for investigation iii. Critical Illness Benefit: Rs. iii. Surgical Cash: Rs. iii. Surgical Cash: Rs. iii. Surgical Cash: Rs. iii. Others: Rs. iii. Dispersery Bill Bill Dispersery Bill Dispersery Bill Bill Bill Dispersery Bill Bill Bill Bill Bill Bill Bill Bil	SECTION E SECTION
ii. Hospitalization Expenses: Rs.   ii. Hospitalization Expenses: Rs.   Claim Form Duly signed   Copy of the claim infimation, if any v. Ambulance Charges: Rs.   vi. Others (code): Rs.   Hospital Main Bill   Hospital Bill Payment Receipt   Hospital Discharge Summary   Pharmacy Bill   Operation Theatre Notes   ECG   Doctor's request for investigation   Investigation Reports (including CTMRIUSG v. Pre/Post Hospitalization   Vi. Others: Rs.   Vi. Others	SECTION E SECTION F
ii. Hospitalization Expenses: Rs. ii. Hospitalization Expenses: Rs. ii. Hospitalization Expenses: Rs. ii. Hospitalization Expenses: Rs. iii. Others (code): Rs. iii. Hospitalization Expenses: Rs. iii. Hospitalization Expenses: Rs. iii. Hospitalization Expenses: Rs. iii. Others (code): Rs. iii. Hospitalization Expenses: Rs. iii. Others (code): Rs. iii. Surgical Cash: Rs. iii. Others: Rs. iii.	SECTION E SECTION F
ii. Hospitalization Expenses: Rs.   ii. Hospitalization Expenses: Rs.   Claim Form Duly signed   Copy of the claim infimation, if any v. Ambulance Charges: Rs.   vi. Others (code): Rs.   Hospital Main Bill   Hospital Bill Payment Receipt   Hospital Discharge Summary   Pharmacy Bill   Operation Theatre Notes   ECG   Doctor's request for investigation   Investigation Reports (including CTMRIUSG v. Pre/Post Hospitalization   Vi. Others: Rs.   Vi. Others	SECTION E SECTION

DECLARATION BY THE INSURED		

Thereby 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 & authorise 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 DD MM YY Date: Place Signature of the Insured GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled in by the insured) **DATA ELEMENT** DESCRIPTION **FORMAT** SECTION A - DETAILS OF PRIMARY INSURED Enter the policy number Enter the social insurance number of the certificate number of social health insurance scheme b) SI. No./Certificate No. As allotted by the organization Enter the TPA.ID No. c) Company TPA ID No. License number as allofted by IRDA and printed in TPA documents d) Name Enter the full name of the policyholder Surname, First name, Middle name Enter the full postal address Include street, City and Pin Code e) Address SECTION B - DETAILS OF INSURANCE HISTORY a) Currently covered by any other Indicate whether currently covered by another Tick Yes or No Mediclaim / Health Insurance? Medicliam / Health Insurance b) Date of Commencement of first insurance without break Enter the date of commencement of first insurance Use dd-mm-yy format ç) Company Name Enter the full name of the insurance company Name of the organization in full Enter the policy number-As allotted by the insurance company Policy No. Sum Insured Enter the total sum insured as per the policy In rupees d) Have you been Hospitalized in the last four years since Indicate whether hospitalized in the last four years Tick Yes or No inception of the contract?

inception of the contract.						
Date	Enter the date of hospitalization	User 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 or Female				
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 formát				
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 formát				
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 formát				
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 légal	Indicate whether injury in 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 daim 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 bank name along with the branch	Name of the bank in full					
d) Cheque/DD payable details	Enter the name of 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



## <u>CLAIM FORM - PART B</u> TO BE FILLED IN BY THE HOSPITAL

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

(To be filled in block letters)

DETAILS OF HOSPITAL																						
a) Name of the Hospital :																				Ш		
b) Hospital ID :						]	c)	Туре	of Hos	spital :	Net	work [	No	n Netw	vork		(if n	on net	work fil	ll sectio	on E)	SEC
d) Name of the treating doctor	: 🗆	SU	图 处	X M	E.			E	1 8			t A.	M IE		A H	D -	) L	E	N A	Μī		SECTION A
e) Qualification :				f)	Registra	ation No	. with	State	Code:			П		g) P	hone l	No.				П		<u>בֿ</u> כ
DETAILS OF THE PATIENT A	DMITT	ED																				_
a) Name of the patient :		8 U	P 14	A M	<b>C</b>			7	1 8	9	Υ Î	A	à Ĕ		n i	0 1	0 1	Ē.	5.3 A	84 E		
b) IP Registration Number :					c) Ge	nder : N	/lale	F	emale	d)	Age: Y	ears	Y M	onths	M M	9)	Date of	Birth:	(J) (J)	Mi	ž V	<u> </u>
f) Date of Admission :	D D	ММ	Y. 3	( g)	Time:	HH	M	M	h) D	ate of	Discha	ge:	D 1	14	Y V		i)	Time	Н	$\mathbb{H}$	M	M g
j) Type of Admission :	Emergen	ıcy	Plannec	<b>.</b>	Day Car	ne	Mater	nity	k)	if Mate	mity i) D	ate of D	elivery:	p o	âñ	rife.	ΥΥ	ii) Gra	vida Sta	ıtus:		SECTION
l) Status at time of discharge :	Disc	harge t	to home	•	Disch	arge to	anot	her ho	ospital		Dec	eased		m)	Total	clain	ned arr	ount				×
DETAILS OF AILMENT DIAG	NOSED	(PRIM	ARY)																			_
a) ICD	10 Cod	<b>es</b>		De	scriptio	n			b)				ICD 1	0 PCS				Descr	ption			_
i. Primary Diagnosis									i.	Proce	dure 1 :											
ii. Additional Diagnosis									ii.	Proce	dure 2 :											
iii. Co-morbidities									ii.	Proce	dure 3											
iv. Co-morbidities									iv.	Detai	ls of Pro	cedure										
c) Pre-authorization obtained :		Yes	 ∏No	_		d) Pre	-auth	orizai	i i Jon Nu	mber :	П	1 1		TT					T			SECTION
e) If authorization by network h	ш		_	ive rea:	son:	-,																$\dashv$ $\delta$
f) Hospitalization due to injury :		Yes	No		Yes, giv	ve caus	e :	Self-ir	nflicted		Road	Traffic	Accide	nt	Subs	stanc	e abus	e / alc	ohol co	nsumi	otion [	
ii. If Injury due to Substance ab	ш	_	_						_	Ye			f Yes, a				ii. If Me		_	Yes		No No
iv. Reported to Police :		Yes	No	,	. Fir no	. : [	П	Т		<u> </u>	П	<u>`</u>		П					<u> </u>	์ โ	ш	
vi. If not reported to police give	reason																		<u> </u>			
CLAIM DOCUMENTS SUBMI	TTED - (	CHECK	< LIST																			
Claim Form duly s	laned								1 [		nvestiga	tion re	norts									
Original Pre-autho	•	reques	it							_	_		PE inve	stigatio	n repo	orts						
Copy of the Pre-au	uthorizaí	tion app	proval le	etter					[	<u> </u>	octor's	referer	nce slip i	for inve	stigati	ion						SE
Copy of photo ID o	card of p	atient v	verified	by hos	pital					E	CG											SECTION D
Hospital Discharge	e Summ	ary							[	F	harmad	y bills										D
Operation Theatre	notes									=	•		Police F									
Hospital main bill										_	_		umman		nospita	al wh	өгө ар	olicable	•			
Hospital break-up	DIII								1 [	<b>」</b> ′	uny otne	r, piea	se speci	Ty								
ADDITIONAL DETAILS IN CA	SE OF	NON-N	IETWO	RK HO	SPITAL	L (ONL	<b>fi</b> Ll	L IN C	CASE	OF NO	N-NET	WORK	HOSPI	TAL)								_
a) Address of the Hospital :																				Ш		
										Щ										Щ		
City:						Щ				Щ	State	: 🔲								Щ		
Pin Code :	Щ	$\coprod$	Щ	b) Ph	one No	;:LLL							istration	No. wi	th Stat	te Co	de:			Ш		k
d) Hospital PAN :		Щ.	. <b>о</b> т :			] No	-		_	¬ ·	ont beds											SECTION E
f) Facilities available in the hos iii) Others :	pitali.		. OI : [	Ye	8	NU		ICU :		Yes												¬ ≝
, 0210.0																						
DECLARATION BY THE HOS	PITAL														(PLEA	ASE I	READ	VERY	CARE	FULLY	<u>()</u>	_
We hereby declare that the info												edge &	belief. I	f we ha	ive ma	ade a	ny fals	e or un	true st	ateme	nt,	
SEPPINGUISH OF GOTIGERING IL OF	any ma	IUI 10	.5., 041	g. ii. W	- STATE OF	uoi III	oid	311	J., DC	J. 11313	-											SE
Date:	Υ.																					SECTION F
				_																		
Place :				╛	Sig	nature :	and S	eal of	fthe H	ospital	Authori	ty:										

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 patient	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 or Female					
d) Age	Enter age of the patient	Number of years and months					
e) Date of Birth	Enter date of birth	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					
i) 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	User 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)					
•	CTION C - DETAILS OF THE AILMENT DIAGNOSED (PRIMARY)	in raped (50 flot effet pales values)					
		T					
a) ICD 10 Code		Standard Format and Open text					
Primary Diagnosis	primary diagnosis						
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-morbidites	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					
) 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					
	BECTION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST						
Indicate which supporting documents are submitted							
<del>-</del>	ECTION E - DETAILS IN CASE OF NON NETWORK HOSPITAL						
	T .	Include Street, City and Pin Code					
a) Address	•						
b) Phone No. c) Registration No. with State Code	Enter the phone number of hospital  Enter the registration number of the doctor along with	Include STD code with telephone number  As allocated by the Medical Council of India					
· ·	the state code	As allotted by the Income Tax department					
d) Hospital PAN e) Number of Inpatient beds	Enter the permanent account number	• '					
e) Number of Inpatient beds f) Facilities available in the hospital	Enter the number of inpatient beds Indicate facilities available in the hospital	Digits  Tick the right antion. If others, please specific					
1) I dollides avaliable III the hospital	indicate racinges available in the hospital	Tick the right option, If others, please specify					
	SECTION F - DECLARATION BY THE HOSPITAL						