

## CLAIM FORM - 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:		
a) Policy No:	b) SI. No/ Certificate No:	
c) Company / TPA ID No: UN NAMENTED		
e)Address:		
Pin Code:	Email ID:	
DETAILS OF INSURANCE HISTORY:		
a) Currently covered by any other Mediclaim / Health Insurance: <b>Yes</b>	No b) Date of commencement of first Insurance with	nout break : DD MM YY
c) If yes, company name	Policy No :	
Sum Insured (Rs.)	<del></del> •	Yes No Date: MM YY
Diagnosis:	e) Previously covered by any other Mediclain	
f) If yes, Company Name		
DETAILS OF INSURED PERSON HOSPITALIZED:		
a) Name:	RST NAME MIC	D L E N A M E .
b) Gender: Male Female c)Age: years Y	Months M M Date of Birth:	
e) Relationship to Primary insured: Self Spouse Child Fa	ther Mother Other (Please Specify)	
f) Occupation: Service Self Employed Homemaker	Student Retired Other (Please Spec	eify)
e)Address(if different from above)		
City:	State:	
Pin Code: Phone No:	Email ID:	
DETAILS OF HOSPITALIZATION:		
a) Name of Hospital where Admitted:		
b) Room Category occupied: Day care Single occupancy	Twin sharing 3 or more beds per	room Delivery DD MM YY
	Date of Injury / Date Disease first detected /Date of	Delivery: DD MM YY
e) Dated Admission:	g) Date of Discharge:	h) Time: H H : M M
, — — — — ,	g) Date of Discharge: D M M Y Y  Substance Abuse/Alcohol Consumption i. If I	
i) If Injury give cause: Self inflicted Road Traffic Accident		Medico legal: Yes No
i) If Injury give cause: Self inflicted Road Traffic Accident ii. Reported to police: Yes No iii. MLC Report & Police DETAILS OF CLAIM:	Substance Abuse/Alcohol Consumption i. If I	Medico legal: Yes No
i) If Injury give cause: Self inflicted Road Traffic Accident ii. Reported to police: Yes No iii. MLC Report & Police  DETAILS OF CLAIM:  a) Details of the treatment expenses claimed	Substance Abuse/Alcohol Consumption i. If I	Medico legal: Yes No
i) If Injury give cause: Self inflicted Road Traffic Accident ii. Reported to police: Yes No iii. MLC Report & Police  DETAILS OF CLAIM: a) Details of the treatment expenses claimed i. Pre-hospitalization Expenses: Rs.	Substance Abuse/Alcohol Consumption i. If I FIR attached: Yes No j) System of Medicine  Despitalization Expenses: Rs.	Medico legal: Yes No  Claim Documents Submitted- Check List: Claim Form Duly signed
i) If Injury give cause: Self inflicted Road Traffic Accident ii. Reported to police: Yes No iii. MLC Report & Police  DETAILS OF CLAIM:  a) Details of the treatment expenses claimed i. Pre-hospitalization Expenses: Rs. iii. Host-hospitalization Expenses: Rs. iv. H	Substance Abuse/Alcohol Consumption i. If I FIR attached: Yes No j) System of Medicine Dispitalization Expenses: Rs. Do	h) Time: HHH: MM  Medico legal: Yes No  Claim Documents Submitted- Check List:
i) If Injury give cause: Self inflicted Road Traffic Accident ii. Reported to police: Yes No iii. MLC Report & Police  DETAILS OF CLAIM:  a) Details of the treatment expenses claimed i. Pre-hospitalization Expenses: Rs. iii. H  iii. Post-hospitalization Expenses: Rs. iv. H	Substance Abuse/Alcohol Consumption i. If I FIR attached: Yes No j) System of Medicine ospitalization Expenses: Rs.	h) Time: H H : M M  Medico legal: Yes No  Claim Documents Submitted- Check List: Claim Form Duly signed Copy of the claim intimation, if any Hospital Main Bill Hospital Break-up Bill
i) If Injury give cause: Self inflicted Road Traffic Accident ii. Reported to police: Yes No iii. MLC Report & Police DETAILS OF CLAIM:  a) Details of the treatment expenses claimed  i. Pre-hospitalization Expenses: Rs. iii. H  iii. Post-hospitalization Expenses: Rs. iv. H  v. Ambulance Charges: Rs. vi.O	Substance Abuse/Alcohol Consumption i. If I FIR attached: Yes No j) System of Medicine cospitalization Expenses: Rs. Spitalization Expenses: R	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
i) If Injury give cause: Self inflicted Road Traffic Accident ii. Reported to police: Yes No iii. MLC Report & Police  DETAILS OF CLAIM:  a) Details of the treatment expenses claimed i. Pre-hospitalization Expenses: Rs. IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	Substance Abuse/Alcohol Consumption i. If I FIR attached: Yes No j) System of Medicine Despitalization Expenses: Rs. Do pospitalization Expenses: Rs. Do pospitalizat	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
i) If Injury give cause: Self inflicted Road Traffic Accident ii. Reported to police: Yes No iii. MLC Report & Police  DETAILS OF CLAIM:  a) Details of the treatment expenses claimed i. Pre-hospitalization Expenses: Rs. In Indian ii. H iii. Post-hospitalization Expenses: Rs. In Indian iv. H v. Ambulance Charges: Rs. In Indian iv. H v. Ambulance Charges: Rs. In Indian iv. H viii. Pre-hospitalization period: days Indian iv. H viii. Pre-hospitalization period: days Indian iv. H viii. Pre-hospitalization period: Indian iv. Ind	Substance Abuse/Alcohol Consumption i. If I FIR attached: Yes No j) System of Medicine cospitalization Expenses: Rs. Spitalization Expenses: R	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
i) If Injury give cause: Self inflicted Road Traffic Accident ii. Reported to police: Yes No iii. MLC Report & Police  DETAILS OF CLAIM:  a) Details of the treatment expenses claimed  i. Pre-hospitalization Expenses: Rs. IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	Substance Abuse/Alcohol Consumption i. If II  FIR attached: Yes No j) System of Medicine  ospitalization Expenses: Rs.              calth-Check up Cost: Rs.          thers (code): Rs.        Total Rs.        Post-hospitalization period: days      f yes, provide details in annexure)	h) Time: H H : M M  Medico legal: Yes No  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
i) If Injury give cause: Self inflicted Road Traffic Accident ii. Reported to police: Yes No iii. MLC Report & Police  DETAILS OF CLAIM:  a) Details of the treatment expenses claimed i. Pre-hospitalization Expenses: Rs. No iii. H iii. Post-hospitalization Expenses: Rs. No iv. H v. Ambulance Charges: Rs. No iv. O  vii. Pre-hospitalization period: days viii. b) Claim for Domiciliary Hospitalization: Yes No (I c) Details of Lump sum / cash benefit claimed: i. Hospital Daily Cash:	Substance Abuse/Alcohol Consumption i. If I FIR attached: Yes No j) System of Medicine pospitalization Expenses: Rs. Spitalization Expenses: R	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
i) If Injury give cause: Self inflicted Road Traffic Accident ii. Reported to police: Yes No iii. MLC Report & Police  DETAILS OF CLAIM:  a) Details of the treatment expenses claimed  i. Pre-hospitalization Expenses: Rs. In Indian iii. Host-hospitalization Expenses: Rs. Indian iii. Host-hospitalization period: Indian iii. Hospitalization period: Indian iii. Hospitalization iii. Hospitalization iii. Hospitalization iii. Hospitalization iiii. Indian iiii. Indian iiii. Indian iiii. Indian iiiiii. Indian iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	Substance Abuse/Alcohol Consumption i. If I FIR attached: Yes No j) System of Medicine cospitalization Expenses: Rs. Code in the code in t	Claim Documents Submitted- Check List:  Claim Form Duly signed Copy of the claim intimation, if any Hospital Main Bill Hospital Break-up Bill Hospital Discharge Summary Pharmacy Bill Operation Theatre Notes ECG Doctor's request for investigation Investigation Reports (Including CT MR1/USG/HPE) Doctor's Prescriptions
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i) If Injury give cause: Self inflicted  Road Traffic Accident ii. Reported to police: Yes No iii. MLC Report & Police DETAILS OF CLAIM:  a) Details of the treatment expenses claimed  i. Pre-hospitalization Expenses: Rs.  ii. H  iii. Post-hospitalization Expenses: Rs.  iv. H  v. Ambulance Charges: Rs.  vi.O  vii. Pre-hospitalization period: days  viii. b) Claim for Domiciliary Hospitalization: Yes No (III) c) Details of Lump sum / cash benefit claimed: i. Hospital Daily Cash: Rs.  iii. Critical Illness Benefit: Rs.  iiii. Critical Illness Benefit: v. Pre/Post hospitalization Lump sum benefit: Rs.  iiii. Critical Illness Benefit: V. Pre/Post hospitalization Lump sum benefit: Rs.  iiii. Critical Illness Benefit: Rs.  iiii. Details of Bill No Date Issued by  1.  iiii. MLC Report & Police  Veal Tall Sof Bill No III.  iii. MLC Report & Police  Road Traffic Accident III. MLC Report & Police  III.  iii. MLC Report & Police  III.  iii. H  V. Herchospitalization Expenses: Rs.  iii. H  III.  iii. H	Substance Abuse/Alcohol Consumption i. If I FIR attached: Yes No j) System of Medicine pospitalization Expenses: Rs. Spitalization Post-hospitalization period: days Spitalization Post-hospitalization Expenses: Rs. Spitalization Expenses: Rs. Spitalizatio	h) Time: H H : M M  Medico legal: Ves No  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



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 project hospitalization plain if any

Date: D D M M Y Y Place: Signature of the Insured	

DATA ELEMENT	DR FILLING CLAIM FORM - PART A (To be filled in by the insure  DESCRIPTION	FORMAT
DATA ELEMENT		FORMAI
	SECTION A - DETAILS OF PRIMARY INSURED	
) Policy No.	Enter the policy number  Enter the social insurance number or the certificate number of	As allotted by the insurance company
o) SI. No/ Certificate No.	social health insurance scheme	As allotted by the organization
c) Company TPA ID No.	Enter the TPA ID No	License number as allotted by IRDA and printed in TPA documents.
i) 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	
n)Currently covered by any other Mediclaim / Health Insurance?	Indicate whether currently covered by another Mediclaim / Health Insurance	Tick Yes or No
) Date of Commencement of first Insurance without break	Enter the date of commencement of first insurance	Use dd-mm-yy format
) 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
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 Health Insurance?	Indicate whether previously covered by another Mediclaim /	Tick Yes or No
) Company Name	Enter the full name of the insurance company	Name of the organization in full
	SECTION C - DETAILS OF INSURED PERSON HOSPITALI	ZED
i) Name	Enter the full name of the patient	Surname, First name, Middle name
) Gender	Indicate Gender of the patient	Tick Male or Female
e) Age	Enter age of the patient	Number of years and months
l) Date of Birth	Enter Date of Birth of patient	Use dd-mm-yy format
) Relationship to primary Insured	Indicate relationship of patient with policyholder	Tick the right option. If others, please specify.
) Occupation	Indicate occupation of patient	Tick the right option. If others, please specify.
) Address	Enter the full postal address	Include Street, City and Pin Code
i) Phone No	Enter the phone number of patient	Include STD code with telephone number
) E-mail ID	Enter e-mail address of patient	Complete e-mail address
	SECTION D - DETAILS OF HOSPITALIZATION	
) Name of Hospital where admitted	Enter the name of hospital	Name of hospital in full
o) Room category occupied	Indicate the room category occupied	Tick the right option
e) Hospitalization due to	Indicate reason of hospitalization	Tick the right option
l) Date of Injury/Date Disease first detected/ Date of	Enter the relevant date	Use dd-mm-yy format
Delivery		
e) Date of admission	Enter date of admission	Use dd-mm-yy format
) Time	Enter time of admission	Use hh:mm format
Date of discharge	Enter date of discharge	Use dd-mm-yy format
n)Time	Enter time of discharge	Use hh:mm format
) 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
) 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)
) Details of Treatment Expenses		
<u> </u>	Indicate whether claim is for domiciliary hospitalization	l lick Yes or No
o) Claim for Domiciliary Hospitalization		Tick Yes or No In rupees (Do not enter paise values)
c) Claim for Domiciliary Hospitalization c) Details of Lump sum/ cash benefit claimed	Enter the amount claimed as lump sum/ cash benefit	In rupees (Do not enter paise values)
c) Claim for Domiciliary Hospitalization c) Details of Lump sum/ cash benefit claimed	Enter the amount claimed as lump sum/ cash benefit  Indicate which supporting documents are submitted	
O) Claim for Domiciliary Hospitalization  Details of Lump sum/ cash benefit claimed  Claim Documents Submitted-Check List	Enter the amount claimed as lump sum/ cash benefit	In rupees (Do not enter paise values)
c) Claim for Domiciliary Hospitalization  Details of Lump sum/ cash benefit claimed  Claim Documents Submitted-Check List  Indicate which bills are enclosed with the amounts in rupees	Enter the amount claimed as lump sum/ cash benefit  Indicate which supporting documents are submitted  SECTION F - DETAILS OF BILLS ENCLOSED	In rupees (Do not enter paise values)
D) Claim for Domiciliary Hospitalization D) Details of Lump sum/ cash benefit claimed D) Claim Documents Submitted-Check List Indicate which bills are enclosed with the amounts in rupees	Enter the amount claimed as lump sum/ cash benefit  Indicate which supporting documents are submitted	In rupees (Do not enter paise values)
c) Claim for Domiciliary Hospitalization  Details of Lump sum/ cash benefit claimed  Claim Documents Submitted-Check List  Indicate which bills are enclosed with the amounts in rupees	Enter the amount claimed as lump sum/ cash benefit  Indicate which supporting documents are submitted  SECTION F - DETAILS OF BILLS ENCLOSED	In rupees (Do not enter paise values)
D) Claim for Domiciliary Hospitalization  D) Details of Lump sum/ cash benefit claimed  D) Claim Documents Submitted-Check List  Indicate which bills are enclosed with the amounts in rupees  SECTION  D) PAN	Enter the amount claimed as lump sum/ cash benefit  Indicate which supporting documents are submitted  SECTION F - DETAILS OF BILLS ENCLOSED  ON G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT	In rupces (Do not enter paise values)  Tick the right option
p) Claim for Domiciliary Hospitalization p) Details of Lump sum/ cash benefit claimed d) Claim Documents Submitted-Check List Indicate which bills are enclosed with the amounts in rupees	Enter the amount claimed as lump sum/ cash benefit  Indicate which supporting documents are submitted  SECTION F - DETAILS OF BILLS ENCLOSED  ON G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT  Enter the permanent account number  Enter the bank account number  Enter the bank name along with the branch	In rupces (Do not enter paise values)  Tick the right option  As allotted by the Income Tax department
D) Claim for Domiciliary Hospitalization  D) Details of Lump sum/ cash benefit claimed  D) Claim Documents Submitted-Check List  Indicate which bills are enclosed with the amounts in rupees  SECTION  D) PAN  D) Account Number  D) Bank Name and Branch	Enter the amount claimed as lump sum/ cash benefit  Indicate which supporting documents are submitted  SECTION F - DETAILS OF BILLS ENCLOSED  ON G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT  Enter the permanent account number  Enter the bank account number	In rupces (Do not enter paise values)  Tick the right option  As allotted by the Income Tax department As allotted by the bank
D) Claim for Domiciliary Hospitalization D) Details of Lump sum/ cash benefit claimed D) Claim Documents Submitted-Check List D) Claim Documents Submitted-Check List D) PAN D) Account Number	Enter the amount claimed as lump sum/ cash benefit  Indicate which supporting documents are submitted  SECTION F - DETAILS OF BILLS ENCLOSED  ON G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT  Enter the permanent account number  Enter the bank account number  Enter the bank name along with the branch  Enter the name of the beneficiary the cheque/ DD should be	In rupees (Do not enter paise values)  Tick the right option  As allotted by the Income Tax department  As allotted by the bank  Name of the Bank in full