

CLAIM FORM - PART A

TO BE FILLED IN BY THE INSURED

(To be filled in block letter)

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

DETAILS OF PRIMARY INSURED

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

a) Currently covered by any other Mediclaim / Health Insurance : Yes No

b) Date of commencement of first insurance without break : (copy of policies to be attached)

c) If Company Name : Policy No :
Sum Insured (Rs.) :

d) Have you been hospitalized in the last 4 year? Yes No Date : Diagnosis :

e) Previously covered by any other Mediclaim / Health Insurance : Yes No f) If Yes, Company Name :

DETAILS OF INSURED PERSON HOSPITALIZED

a) Name : SURNAME FIRST NAME MIDDLE NAME

b) Gender : Male Female c) Age : Year Months d) Date of Birth

e) Relationship to Primary Insured : Self Spouse Child Father Mother Other (Please specify)

f) Occupation : Service Self Employed Homemaker Student Retired Other (Please specify)

e) Address (if different from Above) :

City : State :

Pin Code : Phone No : Email ID :

DETAIL OF HOSPITALIZATION

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 :

e) Date of Admission : f) Time : g) Date Of Discharge : h) Time :

i) If Injury Give Cause : Self Inflicted Road Traffic Accident Substance / 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 :

DETAIL OF CLAIM

a) Details of The Treatment Expenses Claimed

i. Pre-hospitalization Expenses : Rs.	<input type="text"/>	ii. Hospitalization Expenses : Rs.	<input type="text"/>
iii. Post-hospitalization Expenses : Rs.	<input type="text"/>	iv. Health-Check up Cost : Rs.	<input type="text"/>
v. Ambulance charges : Rs.	<input type="text"/>	vi. Other (code) : <input type="text"/>	Rs. <input type="text"/>
vii. Pre-hospitalisation period : days	<input type="text"/>	Total Rs.	<input type="text"/>
		viii. Post-hospitalization Period : days	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

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.	<input type="text"/>	ii. Surgical Cash : Rs.	<input type="text"/>
ii. Critical Illness Benefit : Rs.	<input type="text"/>	iv. Convalescence : Rs.	<input type="text"/>
v. Pre/Post Hospitalization Lump Sum Benefit : Rs.	<input type="text"/>	vi. Other : Rs.	<input type="text"/>
		Total Rs.	<input type="text"/>

Claim Documents Submitted - Check List

- | | |
|--|---|
| <input type="checkbox"/> Claim Form Duly Signed | <input type="checkbox"/> Operation Theater Notes |
| <input type="checkbox"/> Copy of the claim Intimation | <input type="checkbox"/> ECG |
| <input type="checkbox"/> Hospital Main Bill | <input type="checkbox"/> Doctor's Request For Investigation |
| <input type="checkbox"/> Hospital Break-up Bill | <input type="checkbox"/> Investigation Report (Including CT / MRI/ USG / HPE) |
| <input type="checkbox"/> Hospital Bill Payment Receipt | <input type="checkbox"/> Other |
| <input type="checkbox"/> Hospital Discharge Summary | |
| <input type="checkbox"/> Pharmacy Bill | |

DETAILS OF BILL ENCLOSED

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: _____Nos	
3.		d d m m y y		Pre-hospitalization: _____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 PRIMARY INSURED'S ACCOUNT

a) Pan : b) Account Number :

c) Bank Name and Branch :

d) Cheque/ DD Payable details : e) IFSC Code :

DECLARATION BY THE INSURED

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, 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 :

Place :

Signature of the insured

ANTI-MONEY LAUNDERING REQUIREMENT (For claim more than or equal to Rs. 1 Lakh - One Document each from (1) and (2))

- Proposer's Identification (a) Passport (b) PAN Card (c) Voter's ID Card (d) Driving License (e) AADHAR Card
- Proposer's Address (a) Current Telephone /Mobile Bill (b) Current Bank Passbook (c) Electricity Bill (d) Ration Card (e) Valid Rent Lease Agreement

CLAIM FORM - PART B

TO BE FILLED IN BY THE HOSPITAL

(To be filled in block letter)

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

DETAILS OF HOSPITAL

a) Name of Hospital :

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

d) 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*

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

g) Phone No :

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient: *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) IP Registration Number : c) Gender : Male Female d) Age : Year Months

e) Date of Birth : *d d m m y y* f) Date of Admission : *d d m m y y* g) Time : *h h m m*

h) Date of Discharge : *d d m m y y* i) Time : *h h m m* j) Type of Admission : Emergency Planned Day Care Maternity

k) If Maternity : i. Date of Delivery : *d d m m y y* ii. Grade of status :

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

DETAIL OF AILMENT DIAGNOSED (PRIMARY)

a)	ICD 10Codes	Description	b)	ICD 10Codes	Description
i) Primary Diagnosis :	<input type="text"/>	<input type="text"/>	i) Procedure 1 :	<input type="text"/>	<input type="text"/>
ii) Additional Diagnosis :	<input type="text"/>	<input type="text"/>	ii) Procedure 2 :	<input type="text"/>	<input type="text"/>
iii) Co-morbidities :	<input type="text"/>	<input type="text"/>	iii) Procedure 3 :	<input type="text"/>	<input type="text"/>
iv) Co-morbidities :	<input type="text"/>	<input type="text"/>	iv) Details of Procedure :	<input type="text"/>	

c) Present ailment is a complication of PED? Yes No i) (If Yes, Specify Details) : _____

d) Pre-authorization obtained : Yes No e) Pre-authorization Number :

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

g) 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 Report) iii) If Medico Legal : Yes No

v) FIR no : vi) If not reported to police give reason: _____

CLAIM DOCUMENTS SUBMITTED - CHECK LIST

<input type="checkbox"/> Claim From DulySinged <input type="checkbox"/> Original Pre-authorization request <input type="checkbox"/> Copy of Pre-authorization Approval latter <input type="checkbox"/> Copy of photo ID card of patient verified by hospital <input type="checkbox"/> Hospital Dischargesummary <input type="checkbox"/> Operation Theaternotes <input type="checkbox"/> Hospital main bill <input type="checkbox"/> Hospital break-up bill	<input type="checkbox"/> Investigation report <input type="checkbox"/> CT/MR/USG/HPE investigation report <input type="checkbox"/> Doctor's reference slip for investigation <input type="checkbox"/> ECG <input type="checkbox"/> Pharmacy bills <input type="checkbox"/> MLC report & Police FIR <input type="checkbox"/> Original death summary from hospital where applicable <input type="checkbox"/> Any other, please specify
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(IMPORTANT : PLEASE TURN OVER)

SECTION A

SECTION B

SECTION C

SECTION D

DETAILS IN CASE OF NON NETWORK HOSPITAL

a) Address of Hospital:

 City: State:
 Pin Code: b) Phone No: c) Registration No:
 d) PAN e) Number of Inpatient beds: f) Facilities available in the hospital :i) OT : Yes No ii) ICU : Yes No
 iii) Other :

DECLARATION BY THE INSURED

(PLEASE READ VERY CAREFULLY)

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, 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 :

Place :

Signature of the insured

DECLARATION BY THE HOSPITAL

(PLEASE READ VERY CAREFULLY)

We hereby declare that the information furnished in this Claim Form is true & correct to the best of our my 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. The signature of the insured is taken on this form after Claim Form B is fully filled up by us.

Date :

Place :

Signature and Seal of the hospital Authority