

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

IRDAI License No. 008

DETAILS OF PRIMARY INSURED:	(To be filled in block letters)
a) Policy No: b) Sl. No./Certificate No:	
c) Company/TPA ID No:	<u>ω</u>
d) Name: SURNAME FIRST NAME M	
e) Address :	
	
City: State: 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	
c) If yes, company name : Policy No. Policy No.	tract ? Yes No Date: M M Y Y Sher Mediclaim/Health Insurance: Yes No
Sum Insured (Rs.) d) Have you been hospitalized in the last four years since inception of the con	ntract ? Yes No Date: MM Y Y G
Diagnosis : e) Previously covered by any oth	her Mediclaim/Health Insurance: Yes No 🗵
f) If yes, Company Name :	
DETAILS OF INSURED PERSON HOSPITALIZED:	
a. Name: SURNAME FIRST NAME M	I D D L E N A M E
b) Gender: Male Female c) Age: Years Y Y Months M M d) Date of Bir	rth : D D M M Y Y
e) Relationship to Primary Insured: Self Spouse Child Father Mother Other (Please Spe	
f) Occupation: Service Self Employed Homemaker Student Retired Other (Please Spe	ecify)
g) Address (if different from above) :	cify)
g) Address (ii dilierent nom above).	
City: State: State:	
Pin Code : Phone No : 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	er room
c) Hospitatization due to : Injury Illness Maternity d) Date of injury/Date Disease first de	etected/Date of Delivery
e) Date of Addmission : DDMMYY Thine: HHMM g) Date of Discharge : D	D M M Y Y h) Time : H H M M 9
i) If injury give cause : Self inflicted Road Traffic Accident Substance Abude /Alcohol Consumption	i) If Medico legal: Yes No
ii) Reported to police : Yes No iii) MLC Report & Police FIR attached Yes No j) Sys	stem of Medicine
DETAILS OF CLAIM	
a) Details of the treatment expenses claimed :	Claim Documents Submitted - Check List :
	Claim Documents Submitted - Check List :
a) Details of the treatment expenses claimed :	
a) Details of the treatment expenses claimed : i. Pre-Hospitalization Expenses : Rs. ii. Hospitalization Expenses : Rs. iii. Hospitalization Expenses : Rs. iv. Health-Check up Cost : Rs. iv. Health-Check up Cost : Rs. iii.	Claim Form Duly signed Copy of the claim intimation, if any
a) Details of the treatment expenses claimed : i. Pre-Hospitalization Expenses : Rs. ii. Hospitalization Expenses : Rs. iv. Health-Check up Cost : Rs. v. Ambulance Charges : Rs. vi. Others (code) : Rs.	Claim Form Duly signed Copy of the claim intimation, if any
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a) Details of the treatment expenses claimed : i. Pre-Hospitalization Expenses : Rs.	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
a) Details of the treatment expenses claimed : i. Pre-Hospitalization Expenses : Rs.	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
a) Details of the treatment expenses claimed: i. Pre-Hospitalization Expenses: Rs.	Claim Form Duly signed Copy of the claim intimation, if any Hospital Main Bill Hospital Bill Payment Receipt Hospital Discharge Summary Pharmacy Bill Operation Theatre Notes
a) Details of the treatment expenses claimed: i. Pre-Hospitalization Expenses: Rs. ii. Hospitalization Expenses: Rs. iv. Health-Check up Cost: Rs. v. Ambulance Charges: Rs. vi. Others (code): Rs. vi. Others (code): Rs. viii. Pre-Hospitalization period: Days viii. Post-Hospitalization	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
a) Details of the treatment expenses claimed: i. Pre-Hospitalization Expenses: Rs. ii. Hospitalization Expenses: Rs. iv. Health-Check up Cost: Rs. v. Ambulance Charges: Rs. vi. Others (code): Rs. vi. Others (code): Rs. viii. Post-Hospitalization period: Days viii. Post-Hospitalization	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
a) Details of the treatment expenses claimed: i. Pre-Hospitalization Expenses: Rs.	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)
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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 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

Claim, it arry				I
Date :	D D M M Y Y	Place	Signature of the Insured	

GUIDANCE FOI	R FILLING CLAIM FORM - PART A (To be filled in by the ins	sured)
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 of 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 IRDA 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 Medicliam / 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	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
		Name of the organization in full
	TION C - DETAILS OF INSURED PERSON HOSPITALIZED	Commanda First serve Middle serve
a) Name	Enter the full name of the patient	Surname, First name, Middle name Tick Male or Female
b) Gender	Indicate Gender of the patient	
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 f) Occupation	Indicate relationship of patient with policyholder Indicate occupation of patient	Tick the right option, if others, please specify 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
7 - 114111 - 2	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 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 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		
SECTIO	ON 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/	Name of the individual/organization in full
	DD should be made out to	<u> </u>
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 for	mat), 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

IRDAI License No. 008

(To be filled in block letters)

DETAILS OF HOSPITAL	
a) Name of the Hospital :	╗┖
b) Hospital ID : c) Type of Hospital : Network Non Network (if non network fill section E)	SEC
d) Name of the treating doctor : SURNAME FIRST NAME MIDDLE NAME	SECTION
e) Qualification : f) Registration No. with State Code: g) Phone No.	<u> </u>
DETAILS OF THE PATIENT ADMITTED	
a) Name of the patient : SURNAME FIRST NAME MIDDLE NAME	7
b) IP Registration Number : C) Gender : Male Female d) Age: Years Y Y Months M M e) Date of Birth: D D M M Y	Y
f) Date of Admission : DDMMYYY g) Time: HHMM h) Date of Discharge: DDMMYYY i) Time HHMM	M o
j) Type of Admission : Emergency Planned Day Care Maternity k) if Maternity i) Date of Delivery: DD MM YY Y ii) Gravida Status:	
I) Status at time of discharge : Discharge to home Discharge to another hospital Deceased m) Total claimed amount	SECTION B
DETAILS OF AILMENT DIAGNOSED (PRIMARY)	
a) ICD 10 Codes Description b) ICD 10 PCS Description	-
i. Primary Diagnosis i. Procedure 1 :	$\neg \blacksquare$
I. Filliary Diagnosis	$\dashv \blacksquare$
ii. Additional Diagnosis ii. Procedure 2 :	
iii. Co-morbidities iii. Procedure 3 :	
iv. Co-morbidities iv. Details of Procedure	
	SECTION
c) Pre-authorization obtained : Yes No d) Pre-authorization Number :	
e) If authorization by network hospital not obtained, give reason:] <u> </u>
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	┙
CLAIM DOCUMENTS SUBMITTED - CHECK LIST	_
Claim Form duly signed Investigation reports	
Original Pre-authorization request CT/MRI/USG/HPE investigation reports	
Copy of the Pre-authorization approval letter Doctor's reference slip for investigation	SEC
Copy of photo ID card of patient verified by hospital ECG	SECTION D
Hospital Discharge Summary Pharmacy bills	Z D
Operation Theatre notes MLC reports & Police FIR	
Hospital main bill Original death summary from hospital where applicable	
Hospital break-up bill Any other, please specify	
ADDITIONAL DETAILS IN CASE OF NON-NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)	_
a) Address of the Hospital :	
City: State:	
Pin Code : b) Phone No.: c) Registration No. with State Code:	
d) Hospital PAN : e) Number of Inpatient beds:	SECTION
f) Facilities available in the hospital: i. OT: Yes No ii. ICU: Yes No	_ NE
iii) Others :	┚
DECLARATION BY THE HOSPITAL (PLEASE READ VERY CAREFULLY)	
We hereby declare that the information furnished this Claim Form is true & correct to the best of our knowledge & 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 forfieted	
	SECT
Date: DDDMMMYYY	SECTION F
Place : Signature and Seal of the Hospital Authority :	

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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
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	User dd-mm-yy format
Gravida Status	Enter Gravida status if maternity	Use standard format
I) 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)
SE	CTION C - DETAILS OF THE 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-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
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	1	
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	ECTION E - DETAILS IN CASE OF NON NETWORK HOSPITAL	T
a) Address	Enter the full postal address	Include Street, City and Pin Code
b) Phone No. c) Registration No. with State Code	Enter the phone number of hospital Enter the registration number of the doctor along with the state code	Include STD code with telephone number 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
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	SECTION F - DECLARATION BY THE HOSPITAL	