

CLAIM FORM – PART A

TO BE FILLED BY THE INSURED (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 : _____
	e) Address : _____
	City : _____ State : _____
	Pin Code : _____ Email ID : _____

DETAILS OF INSURANCE HISTORY	
SECTION B	a) Currently covered by any other Mediclaim/Health Insurance : <input type="checkbox"/> Yes <input type="checkbox"/> No
	b) Date of commencement of first Insurance without break : <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>
	c) If yes, Company Name : _____
	Policy No. : _____ Sum Insured (₹) : _____
	Have you been hospitalised in the last four years since inception of the contract? <input type="checkbox"/> Yes <input type="checkbox"/> No Date : <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>
	d) Diagnosis : _____
	e) Previously covered by any other Mediclaim/Health Insurance : _____
f) If Yes, Company Name : _____	

DETAILS OF INSURED PERSON HOSPITALISED	
SECTION C	a) Name : _____ b) Gender : Male <input type="checkbox"/> Female <input type="checkbox"/>
	c) Age : Years <input type="text" value="Y"/> <input type="text" value="Y"/> Months <input type="text" value="M"/> <input type="text" value="M"/> d) Date of Birth: <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>
	e) Relation with Primary Insured : Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Other <input type="checkbox"/> (Please Specify) _____
	f) Occupation : Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Other <input type="checkbox"/> (Please Specify) _____
	g) Address : _____
	City : _____ State : _____
	Pin Code : _____ Email ID : _____

DETAILS OF HOSPITALISATION	
SECTION D	a) Name of Hospital where admitted : _____
	b) Room Category Occupied: Day care <input type="checkbox"/> Single Occupancy <input type="checkbox"/> Twin Sharing <input type="checkbox"/> 3 or more beds per room
	c) Hospitalisation due to : Injury <input type="checkbox"/> Illness <input type="checkbox"/> Maternity <input type="checkbox"/>
	d) Date of injury/Date of disease first detected/Date of Delivery : <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>
	e) Date of Admission: <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> f) Time: <input type="text" value="H"/> <input type="text" value="H"/> : <input type="text" value="M"/> <input type="text" value="M"/>
	g) Date of Discharge: <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> h) Time: <input type="text" value="H"/> <input type="text" value="H"/> : <input type="text" value="M"/> <input type="text" value="M"/>
	i) If injury, give cause: Self-inflicted <input type="checkbox"/> Road Traffic Accident <input type="checkbox"/> Substance Abuse/Alcohol Consumption <input type="checkbox"/>
	i) If medico legal: <input type="checkbox"/> Yes <input type="checkbox"/> No ii) Reported to Police: <input type="checkbox"/> Yes <input type="checkbox"/> No
	iii) MLC Report & Police FIR attached <input type="checkbox"/> Yes <input type="checkbox"/> No
	j) System of Medicine : _____

SECTION E DETAILS OF CLAIM	
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	a) Details of Treatment expenses claimed (in Rupees) :	
i)	Pre-hospitalisation Expenses : ₹ _____	ii) Hospitalisation Expenses : ₹ _____
iii)	Post-hospitalisation Expenses : ₹ _____	iv) Health-Check up cost : ₹ _____
v)	Ambulance Charges : ₹ _____	vi) Others (code): _____ ₹ _____
		Total : ₹ _____
vii)	Pre-hospitalisation Period: days _____	viii) Post-hospitalisation Period: days _____
b)	Claim for domiciliary hospitalisation : <input type="checkbox"/> Yes <input type="checkbox"/> No	(If yes, provide details in annexure)
c) Details of Lump sum / cash benefit claimed (in Rupees) :		
i)	Hospital Daily Cash : ₹ _____	ii) Surgical Cash : ₹ _____
iii)	Critical Illness Benefit : ₹ _____	iv) Convalescence : ₹ _____
v)	Pre/Post hospitalisation Lump sum benefit : ₹ _____	vi) Others: _____ ₹ _____
		Total : ₹ _____
Claims Documents Submitted – Check List		
<input type="checkbox"/>	Claim form duly signed	<input type="checkbox"/> Operation Theatre Notes
<input type="checkbox"/>	Copy of the claim intimation, if any	<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 Reports (Including CT/MRI/UCG/HPE
<input type="checkbox"/>	Hospital Bill Payment Receipt	<input type="checkbox"/> Doctor's Prescriptions
<input type="checkbox"/>	Hospital Discharge Summary	<input type="checkbox"/> Others
<input type="checkbox"/>	Pharmacy Bill	

DETAILS OF BILLS ENCLOSED										
Sl. No.	Bill No.	Date						Issued by	Towards	Amount (₹)
		D	D	M	M	Y	Y			
1		D	D	M	M	Y	Y		Hospital main bill	
2		D	D	M	M	Y	Y		Pre-hospitalisation bills	
3		D	D	M	M	Y	Y		Post-hospitalisation bills	
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			

SECTION G		DETAILS OF PRIMARY INSURED'S BANK ACCOUNT	
a)	PAN	:	_____
b)	Account Number	:	_____
c)	Bank Name and Branch	:	_____
d)	Cheque/DD Payable details	:	_____
e)	IFSC Code	:	_____

SECTION H		DECLARATION BY THE INSURED	
<p>I hereby declare that the information furnished in the claim form is true and 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 and 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 and I will not be making any supplementary claim except the pre/post-hospitalisation claim, if any.</p>			
Date:	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	Place:	_____
		Signature of 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			
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 organisation
c)	Company TPA ID No.	Enter the TPA ID No.	License number as allocated 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 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 Organisation 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 hospitalised in the last four years since inception of the contract?	Indicate whether hospitalised in the last four years	Tick Yes or No
	Date	Enter the date of hospitalisation	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 Organisation in full
SECTION C – DETAILS OF INSURED PERSON HOSPITALISED			
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 format

e)	Relation with Primary Insured	Indicate relation 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 the patient	Include STD code with telephone number
i)	E-mail ID	Enter e-mail address of the patient	Complete e-mail address
SECTION D – DETAILS OF HOSPITALISATION			
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)	Hospitalisation due to	Indicate reason of hospitalisation	Tick the right option
d)	Date of injury/Date of 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 Hospitalisation	Indicate whether claim is for domiciliary hospitalisation	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 amount in rupees			
SECTION I – DETAILS OF PRIMARY INSURED'S BANK ACCOUNT			
a)	PAN	Enter the Permanent Account Number	As allocated 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 /organisation in full
e)	IFSC Code	Enter the IFSC Code of the Bank Branch	IFSC code of the bank branch in full
SECTION J – DECLARATION BY THE INSURED			
Read declaration carefully and mention date (in dd-mm-yy format), place (open text) and sign.			

CLAIM FORM – PART B
TO BE FILLED IN BY THE HOSPITAL (in block letters)
The issue of this Form is not to be taken as an admission of liability
Please include the original pre-authorisation 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: <input type="checkbox"/> Non Network: <input type="checkbox"/> (If non network, fill section E)

d) Name of the treating doctor : _____

e) Qualification : _____

f) Registration No. with state code : _____ g) Phone No. : _____

SECTION B

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient : _____

b) IP Registration Number : _____ c) Gender Male Female

d) Age : Years Months

e) Date of Birth :

f) Date of Admission : g) Time: :

h) Date of Discharge : i) Time: :

j) Type of Admission : Emergency Planned Day Care Maternity

k) If Maternity : Date of Delivery :

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

c) Pre-authorization obtained Yes No d) Pre-authorization number _____

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

f) Hospitalisation 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 : _____

SECTION D		CLAIM DOCUMENTS SUBMITTED – CHECK LIST	
<input type="checkbox"/>	Claim form duly signed	<input type="checkbox"/>	Investigation reports
<input type="checkbox"/>	Original Pre-authorization request	<input type="checkbox"/>	CT/MRI/USG/HPE investigation reports
<input type="checkbox"/>	Copy of the Pre-authorization approval letter	<input type="checkbox"/>	Doctor's reference slip for investigation
<input type="checkbox"/>	Hospital Discharge Summary	<input type="checkbox"/>	ECG
<input type="checkbox"/>	Operation Theatre Notes	<input type="checkbox"/>	Pharmacy Bills
<input type="checkbox"/>	Hospital main bill	<input type="checkbox"/>	MLC reports and Police FIR
<input type="checkbox"/>	Copy of the photo ID card of the patient verified by Hospital	<input type="checkbox"/>	Original death summary from hospital where applicable
<input type="checkbox"/>	Hospital break-up bill	<input type="checkbox"/>	Any other, please specify

SECTION E		ADDITIONAL DETAILS IN CASE OF NON NETWORK HOPITAL (ONLY FILL IN CASE OF NON NETWORK HOSPITAL)	
a)	Address :	_____	
	City :	State :	_____
	Pin Code :	b) Phone No. :	_____
c)	Registration No. with state code :	d) Hospital PAN :	_____
e)	Number of inpatient beds :	_____	
f)	Facilities available in the Hospital :	i. OT: <input type="checkbox"/> Yes <input type="checkbox"/> No	ii. ICU: <input type="checkbox"/> Yes <input type="checkbox"/> No
iii.	Others :	_____	

SECTION F		DECLARATION BY THE HOSPITAL	
We hereby declare that the information furnished in the claim form is true and correct to the best of 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.			
Date:	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	Place :	_____
Treating Doctor's Signature and Seal		:	_____
of the Hospital Authority		:	_____

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 the hospital	Enter the name of hospital	Name of the hospital in full
b)	Hospital ID	Enter ID number of the 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 qualification 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 the doctor	Include STD code with telephone number
SECTION B – DETAILS OF THE PATIENT ADMITTED			
a)	Name of the Patient	Enter the name of patient	Name of patient 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		
	i. Date of Delivery	Enter date of delivery if maternity	Use dd-mm-yy format
	ii. Gravida	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 INSURED PERSON HOSPITALISED			
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 Code and description of the first procedure	Standard Format and Open text
	Procedure 2	Enter the ICD 10 Code and description of the second procedure	Standard Format and Open text
	Procedure 3	Enter the ICD 10 Code 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)	Hospitalisation due to injury	Indicate if hospitalisation 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 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 Hospital obtained from local body like City Corporation/Municipality	As allocated by the City Corporation / Municipality
d)	Hospital PAN	Enter the Permanent Account Number	As allocated 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 J – DECLARATION BY THE HOSPITAL			
Read declaration carefully and mention date (in dd-mm-yy format), place (open text) and sign with stamp.			