CLAIM FORM - A

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

(To be filled in BLOCK letters)

SECTION A					
DETAILS OF PRIMARY INSURED					
a) Policy No.:		b) Sl. No./Certificate No.:			
c) Company/TPA ID No.:					
d) Name:					
e) Address:					
City:		State:		Pin Code:	
Phone Number:		Email ID:			

SECTION B		
DETAILS OF INSURANCE HISTORY		
a) Currently covered by any other Mediclaim / Health Insurance: Yes / No b) Date of commencement of first Insurance without break: DD/MM/YYYY		
c) If yes, company name:	Policy No.:	Sum Insured (Rs.):
d) Have you been hospitalized in the last four years since inception of the contract? Yes / No		Date: DD/MM/YYYY
Diagnosis:		
e) Previously covered by any other Mediclaim / Health insurance: Yes / No		
f) If yes, Company Name:		

SECTION C				
DETAILS OF INSURED PERSON HOSPITALISED				
a) Name:				
b) Gender: Male / Female / Third Gender	c) Age: Years YY Months MM		d) Date of birth: (DD/MM/YYYY)	
e) Relationship with Primary Insured: Self / Spouse / Child / Father / Mother,			Others (Please Specify):	
f) Occupation: Service / Self-employed / Homemaker / Student / Retired			Others (Please Specify):	
g) Address (if different from above):				
City:		State:		Pin Code:
Phone No.:		Email ID:		

SECTION D		
DETAILS OF HOSPITALISATION		
a) Name of Hospital where admitted:		
b) Room category occupied:		
c) Hospitalization due to: Injury / Illness / Maternity		
d) Date of injury / Date disease first detected / Date of delivery: DD/MM/YYYY		
e) Date of Admission: (DD/MM/YYYY)	f) Time: HH : MM	
g) Date of Discharge: (DD/MM/YYYY)	h) Time: HH : MM	
i) If injury, give cause: Self-inflicted Road Traffic Accident / Substance Abuse / Alcohol Consumption		
If Medico Legal: Yes / No (ii) Reported to Police: Yes / No	(iii) MLC Report & Police FIR attached: Yes / No	
j) System of medicine:		

SECTION E

DETAILS OF CLAIM

a) Details of the Treatment Expenses claimed:

(i) Pre-hospitalization expenses: Rs.	(ii) Hospitalization expenses: Rs.
(iii) Post-hospitalization expenses: Rs.	(iv) Health Check-up cost: Rs.
(v) Ambulance charges: Rs.	(vi) Others(code):_____: Rs.
	Total: Rs.
(vii) Pre-hospitalization period: __days	(viii) Post-hospitalization period: _____days

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.	(ii) Surgical cash: Rs.
(iii) Critical illness benefit: Rs.	(iv) Convalescence: Rs.
Pre/Post hospitalization lump sum benefit Rs.	(vi) Others(code):_____: Rs.
	Total: Rs.

Claim Documents Submitted Checklist:

(i) Claim form Duly signed (Yes/No)	(viii) Operation Theatre Notes (Yes/No)
(ii) Copy of the claim intimation, if any (Yes/No	(ix) ECG (Yes/No)
(iii) Hospital Main bill (Yes/No)	(x) Doctor's request for investigation (Yes/No)
(iv) Hospital Break-up bill(Yes/No)	(xi) Investigation on reports (including CT/MRI/USG/HPE (Yes/No)
(v) Hospital Bill Payment Receipt(Yes/No)	(xii) Doctor's prescription (Yes/No)
(vi) Hospital Discharge Summary (Yes/No))	(xiii) Others
(vii) Pharmacy bill (Yes/No)	

SECTION F

DETAILS OF BILLS ENCLOSED

Sr.No.	Bill No.	Date	Issued by	Towards	Amount (Rs.)
1		(DD/MM/YYYY)		Hospital main bill	
2		(DD/MM/YYYY)		Pre-hospitalization bills:_____Nos.	
3		(DD/MM/YYYY)		Post-hospitalization bills:_____Nos.	
4		(DD/MM/YYYY)		Pharmacy bills	
5		(DD/MM/YYYY)			
6		(DD/MM/YYYY)			
7		(DD/MM/YYYY)			
8		(DD/MM/YYYY)			
9		(DD/MM/YYYY)			
10		(DD/MM/YYYY)			

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 PERSON

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 TAP / 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/pos-hospitalization claim, if any.

Date:
Place:

Signature of the Insured

GUIDANCE FOR FILING CLAIM FORMPART 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 organization
c) Company TPA ID No.	Enter the TPA ID No	License number as allotted by IRDAand printed in TPAdocuments.
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 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) i. CompanyName	Enter the full name ofthe insurance company	Name of the organization in full
ii. Policy No.	Enter the policy number	As allotted by the insurance company
iii. Sum Assured:	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
i. Date	Enter the date of hospitalization	Use mm-yy format
ii. 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 format
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 FOR CLAIM BEING FILED		
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
j) If Injury give cause	Indicate cause of injury	Tick the right option
i. If Medico legal	Indicate whether injury is medico legal	Tick Yes or No
ii. Reported to Police	Indicate whether police report was filed	Tick Yes or No
iii. MLC Report & Police FIRattached	Indicate whether MLC report and Police FIRattached	Tick Yes or No
k) 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		
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 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/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.		

CLAIM FORM B

CLAIM FOR PART - B
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 pre-authorization request form in lieu of PART - A

(To be filled in BLOCK letters)

SECTION A		
DETAILS OF HOSPITAL		
a) Name of Hospital:		
b) Hospital ID:		
c) Type of Hospital: Network / Non Network	(If non network, fill Section E)	
d) Name of 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 / Third Gender	d) Age: Years YY Months MM	
e) Date of Birth:(DD/MM/YYYY)			
f) Date of Admission:(DD/MM/YYYY)	g) Time: HH: MM	h) Date of Discharge: DD/MM/YYYY)	i) Time: HH: MM
j) Type of Admission: Emergency / Planned / Day Care / Maternity			
k) If Maternity,	(i) Date of Delivery:(DD/MM/YYYY)	(ii) 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)	(i)	Primary Diagnosis:	ICD 10 Code:	Description:
	(ii)	Additional Diagnosis:	ICD 10 Code:	Description:
	(iii)	Co-morbidities:	ICD 10 Code:	Description:
	(iv)	Co-morbidities:	ICD 10 Code:	Description:
b)	(i)	Procedure 1:	ICD 10 PCS:	Description:
	(ii)	Procedure 2:	ICD 10 PCS:	Description:
	(iii)	Procedure 3:	ICD 10 PCS:	Description:
	(iv)	Details of Procedure:		
c) Pre-authorization obtained: Yes / No		d) Pre-authorization Number:		
e) If authorization by network hospital not obtained, give reason:				
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:		

SECTION D					
CLAIM DOCUMENTS SUBMITTED CHECKLIST					
(i)	Claim Form duly signed	(Yes/No)	(ix)	Investigation Report	(Yes/No)
(ii)	Original Pre-authorization request	(Yes/No)	(x)	CT / MRI / USG / HPE investigation reports	(Yes/No)
(iii)	Copy of Pre-authorization approval letter	(Yes/No)	(xi)	Doctor's reference slip for investigation	(Yes/No)
(iv)	Copy of photo ID card of patient verified by hospital	(Yes/No)	(xii)	ECG	(Yes/No)

(v)	Hospital Discharge Summary	(Yes/No)	(xiii)	Pharmacy Bills	(Yes/No)
(vi)	Operation Theatre notes	(Yes/No)	(xiv)	MLC Report & Police FIR	(Yes/No)
(vii)	Hospital Mail Bill	(Yes/No)	(xv)	Original death summary from hospital, where applicable	(Yes/No)
(viii)	Hospital Break-up Bill	(Yes/No)	(xvi)	Any other, please specify _	(Yes/No)

SECTION E		
DETAILS IN CASE OF NONETWORK HOSPITAL (ONLY FILL IN CASE OF 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:	
f) Facilities available in the hospital: (i) OT: Yes / No	(ii) ICU: Yes / No	
(iii) Others:		

SECTION F
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 knowledge and belief 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: (DD/MM/YYYY)
Place: Signature & Seal of the Hospital Authority

GUIDANCE FOR FILING CLAIM FORMPART B (To be filled in by the hospital)		
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 hospitals	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 qualification
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(s)	Include STD code with telephone number
SECTION B DETAILS OF THE PATIENT		
a) Name of Patient	Enter the name of hospital	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 of patient	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	Use 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)
SECTION C DETAILS OF AILMENT DIAGNOSED (PRIMARY)		
a) ICD 10 Code		
Primary Diagnosis	Enter the ICD 10 Code and description of the primary diagnosis	Standard Format and OpenText
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 c-o morbidities	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: CHECKLIST		
Indicate which supporting documents are submitted.		
SECTION E DETAILS IN CASE OF NO-NETWORK HOSPITAL		
a) Address	Enter the full postal address	Include Street, City and Pin Code
b) Phone No.	Enter the phone number of hospitals	Include STD code with telephone number
c) 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
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
SECTION F DECLARATION BY THE HOSPITAL		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign and stamp		