zuno

Need to claim?
We won't play the claim game!

Zuno Health Insurance

Claim form - A

Instructions:
1. This form has to be filled in BLOCK letters by the Insured / Policy Holder.
2. The filling up and submission of this Form does not make us liable to accept the Claim.

Section A – Details of the primary insured / policyholder

a) Policy No.: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ b) Sl. No ./ Certificate No: ☐☐☐☐☐☐☐☐☐☐☐☐

c) Company/ TPA ID No.: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

d) Name: _____ e) Address: _____

City: _____ State: _____ Pin code: ☐☐☐☐☐☐

Phone No.: ☐☐☐☐☐☐☐☐☐☐ Email ID: _____

Section B – Some details of your other/past insurance

a) Are you currently covered by any other mediclaim/ health insurance: Yes ☐ No ☐

b) Date of start of the first insurance without break:

c) If yes, company name: _____ Policy number: ☐☐☐☐☐☐☐☐☐☐ Sum insured (INR): _____

d) Have you been hospitalized in the last four years since the beginning of the policy? Yes ☐ no ☐

Date: D D M M Y Y Y Y Diagnosis: _____

e) Were you previously covered by any other mediclaim / health insurance? Yes ☐ No ☐

f) If yes, company name: _____

Section C – Details of hospitalized insured person / policy holder

a) Name: _____

b) Gender: Male ☐ Female ☐ Third gender ☐ c) Age: Years ☐☐ Months ☐☐ d) Date of birth: D D M M Y Y Y Y

e) Relationship with primarily insured: Self ☐ Spouse ☐ Child ☐ Father ☐ Mother ☐ Other (Please Specify)

f) Occupation: Service ☐ Self-employed ☐ Homemaker ☐ Student ☐ Retired ☐ Other (Please Specify)

g) Address (if different from above): _____ City: _____ State: _____

Pin code: ☐☐☐☐☐☐ h) Phone No.: ☐☐☐☐☐☐☐☐☐☐ i) Email ID: _____

Section D – 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 ☐

c) Hospitalization due to: Injury ☐ Illness ☐ Maternity ☐

d) Date of Injury / date disease first detected /date of delivery: D D M M Y Y Y Y

e) Date of admission: D D M M Y Y Y Y Time: H H M M

f) Date of discharged: D D M M Y Y Y Y Time: H H M M

g) If injury, give cause: Self inflicted ☐ Road traffic accident ☐ Substance abuse /alcohol consumption ☐

h) If medico legal: (i)Yes ☐ No ☐ (ii) Reported to Police: Yes ☐ No ☐ iii) MLC report & police FIR attached: Yes ☐ No ☐

i) System of medicine: _____

Section E – details of claim

a) Details of the treatment expenses claimed

(i) Pre-hospitalization expenses: ₹_____ (ii) Hospitalization expenses: ₹_____

(iii) Post-hospitalization expenses: ₹_____ (iv) Health-check-up cost: ₹_____

(v) Ambulance charges: ₹_____ (vi) Others (code):_____: ₹_____

Total: ₹_____

(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: ₹_____ (ii) Surgical cash: Rs. ₹_____

(iii) Critical illness benefit: ₹_____ (iv) Convalescence: ₹_____

(v) Pre/Post hospitalization lump sum benefit: ₹_____ (vi) Others: ₹_____

Total: ₹_____

Claim documents submitted – checklist

- ☐ Duly signed claim Form
- ☐ Copy of the claim intimation, if any
- ☐ Hospital main bill
- ☐ Hospital break-up bill
- ☐ Hospital discharge summary
- ☐ Hospital bill payment receipt
- ☐ Pharmacy bill
- ☐ Operation theatre notes
- ☐ ECG
- ☐ Doctor's request for investigation
- ☐ Investigation reports (Including CT/MRI / USG / HPE)
- ☐ Doctor's prescriptions
- ☐ Others

Section F – details of bills enclosed

Sl.No.	Bill No.	Date	Issued by	Towards	Amount (₹)
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 primarily insured's bank account

a) PAN: ☐☐☐☐☐☐☐☐☐☐ b) Account No.: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

c) Bank name and branch: _____

d) Cheque/DD payable details: ☐☐☐☐☐☐☐☐☐☐ e) IFSC: ☐☐☐☐☐☐☐☐☐☐☐

Section H – 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 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 pre/post hospitalization claim, if any.

Date: D D M M Y Y Y Y
Place: _____

Signature of the Insured

Guidance for filling claim form – part A (to be filled 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 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 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) 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	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 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		

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
e) Date of injury/date disease first detected/ date of delivery	Enter the relevant date	Use dd-mm-yy format
d) 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 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 in case of non-network hospital		
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.		

Zuno Health Insurance

Claim form - B

Instructions:
1. To be filled in BLOCK letters by the Insured.
2. The issue of this form is not to be taken as an admission of liability.

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 No.: ☐☐☐☐☐☐☐☐☐☐☐☐

c) Gender: Male ☐ Female ☐ Third Gender ☐ d) Age: Y Y M M e) Date of birth: D D M M Y Y Y Y

f) Date of admission: D D M M Y Y Y Y g) Time: H H M M h) Date of discharge: D D M M Y Y 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 Y Y 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)	ICD 10 codes	Description
(i) Primary diagnosis:		
(ii) Additional diagnosis:		
(iii) Co-morbidities:		
(iv) Co-morbidities:		
b)	**ICD 10 codes**	**Description**
(i) Procedure 1:		
(ii) Procedure 2:		
(iii) Procedure 3:		
(iv) Details of procedure:		

c) Pre-authorization obtained: Yes ☐ No ☐ d) Pre-authorization No.: ☐☐☐☐☐☐☐☐☐☐☐☐

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, give reason: _____

Section D – claim documents submitted – checklist

- ☐ Claim form duly signed
- ☐ Original pre-authorization request
- ☐ Copy of the Pre-authorization approval letter
- ☐ Copy of photo ID card of patient verified by hospital
- ☐ Hospital discharge summary
- ☐ Operation theatre notes
- ☐ Hospital main bill
- ☐ Hospital break-up bill
- ☐ Investigation reports
- ☐ CT/MR/USG/HPE investigation reports
- ☐ Doctor's reference slip for investigation
- ☐ ECG
- ☐ Pharmacy bills
- ☐ MLC report & police FIR
- ☐ Original death summary from hospital where applicable
- ☐ Any other, please specify:

Section E – additional details in case of non-network hospital (only fill in case of non-network hospital)

a) Address of 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 ☐

Other: _____

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. 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: ☐D☐D☐M☐M☐Y☐Y☐Y☐Y

Place: _____

Signature & Seal of the Hospital Authority

Guidance for filling claim form – part B (to be filled by the insured)

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 enter the TPA ID No	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 hospital	Name of hospital in full
b) IP Registration No.	Enter insurance provider registration number	As allotted by the insurance provider
c) Gender	Indicate gender of the patient	Tick male or female or third gender
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	Use dd-mm-yy format
Gravida status	Enter Gravida status if maternity	Use standard format
l) Baby's date of admission	Enter date of admission	Use dd-mm-yy format
m) Baby's date of discharge	Enter date of discharge	Use dd-mm-yy format
n) Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
o) 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 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 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 No.	Enter pre-authorization number	As allotted by TPA
e) If authorization by network hospital not obtained, 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
If reported, 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 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		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.		

Zuno General Insurance Limited, (Formerly known as Edelweiss General Insurance Company Limited) Registered Office: 2nd Floor, Tower 3, Wing B, Kohinoor City Mall, Kohinoor City, Kirol Road, Kurla (West), Mumbai - 400 070, IRDAI Regn. No.: 159, CIN: U66000MH2016PLC273758, Reach us on: 1800 12000 (Toll-Free), 022 42312000 (Call charges applicable) Email: support@hizuno.com, Website: www.hizuno.com, Issuing/Corporate Office: +91 22 4272 2200, Grievance Redressal Officer: +91 22 4931 4422, Dedicated Toll-Free Number for Grievance: 1800 120 216216. Trade logo displayed above belongs to Zuno General Insurance Limited under license.