ZURICH kotak
General Insurance

ZK - 26-27/v1

Health Insurance Policy Claim Form
Part - A

TO BE FILLED BY THE INSURED
The issue of this Form is not to be taken as an admission of liability

(To be filled in block letters)

DETAILS OF PRIMARY INSURED

a) Policy Number ____ b) Sl. No./Certificate No ____
c) Company / TPA ID No. ____
d) Name FIRST NAME MIDDLE NAME LAST NAME
e) Address ____
City ____ State ____ Pin Code ____
f) Phone No ____ g) 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 DDMMYYYY
c) If Yes, Company Name ____ Policy No. ____ Sum Insured (₹) ____
d) Have you been hospitalised in the last four years since inception of the contract? ☐ Yes ☐ No Date DDMMYYYY
Diagnosis ____
e) Previously covered by any other Mediclaim / Health Insurance ☐ Yes ☐ No
f) If Yes, Company Name ____

DETAILS OF INSURED PERSON HOSPITALISED

a) Name FIRST NAME MIDDLE NAME LAST NAME
b) Gender ☐ Male ☐ Female ☐ Others c) Age (YEARS) / (MONTHS) d) Date of birth DDMMYYYY
e) Relationship to Primary 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 ____

DETAILS OF HOSPITALISATION

a) Name of the Hospital where Admitted ____
b) Room Category occupied Day care ☐ Single occupancy ☐ Twin sharing ☐ 3 or more beds per room ☐ ICU ☐
c) Hospitalisation due to Injury ☐ Illness ☐ Maternity ☐
d) Date of Injury/ Date Disease first detected / Date of Delivery DDMMYYYY e) Date of Admission DDMMYYYY f) Time HH:MM
g) Date of Discharge DDMMYYYY h) Time HH:MM
i) If Injury give cause Self Inflicted ☐ Road Traffic Accident ☐ Substance Abuse/ 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 ____

DETAILS OF CLAIM

a) Details of Treatment Expenses Claimed

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 ☐ Yes ☐ No (if yes, provide details in Annexure)

c) Details of Lump Sum / Cash Benefit Claimed

i) Hospital Daily Cash ₹ ____ ii) Surgical Cash ₹ ____

iii) Critical Illness Benefit ₹ ____ iv) Convalescence ₹ ____

v) Pre / Post Hospitalisation Lumpsum benefit ₹ ____ vi) Others ₹ ____

Total: ₹ ____

Claim Documents Submitted Check List:

- ☐ 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)
- ☐ Doctor's Prescriptions
- ☐ Others

DETAILS OF BILLS ENCLOSED

Sl No	Bill No	Date	Issued by	Towards	Amount (₹)
1.		D D M M Y Y Y Y		Hospital Main Bill	
2.		D D M M Y Y Y Y		Pre-hospitalisation Bills:_____Nos	
3.		D D M M Y Y Y Y		Post-hospitalisation Bills:_____Nos	
4.		D D M M Y Y Y Y		Pharmacy Bills	
5.		D D M M Y Y Y Y			
6.		D D M M Y Y Y Y			
7.		D D M M Y Y Y Y			
8.		D D M M Y Y Y Y			
9.		D D M M Y Y Y Y			
10.		D D M M Y Y Y Y			

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 ____

DECLARATION BY 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 & 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-hospitalisation claim, if any.

Date D D M M Y Y Y Y Place ____ Signature of Insured ____

GUIDANCE FOR FILLING CLAIM FORM – PART A (To be filled in by the insured)		
SECTION A - DETAILS OF PRIMARY INSURED		
DATA ELEMENT	**DESCRIPTION**	**FORMAT**
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 number	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 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 Hospitalised 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 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 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 the Patient	Use dd-mm-yy format
e) Relationship to Primary Insured	Indicate Relationship of Patient with Policy holder	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 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 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) Total Days spent in ICU	Enter number of days	Use numerical format

j) 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
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 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 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.		

ZURICH kotak
General Insurance

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Health Insurance Policy Claim Form
Part - B

TO BE FILLED 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

(To be filled in block letters)

DETAILS OF HOSPITAL

a) Name of the Hospital

b) Hospital ID

c) Type of Hospital Network ☐ Network ☐ Non Network (If non network fill section E)

d) Name of the Treating Doctor FIRST NAME MIDDLE NAME LAST NAME

e) Qualification f) Registration No. with State Code

g) Phone Number

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient FIRST NAME MIDDLE NAME LAST NAME

b) IP Registration Number c) Gender ☐ Male ☐ Female ☐ Others

d) Age (YEARS) / (MONTHS) e) Date of birth DDMMYYYY

f) Date of Admission DDMMYYYY g) Time HH:MM h) Date of Discharge DDMMYYYY i) Time HH:MM

j) Type of Admission ☐ Emergency ☐ Planned ☐ Day Care ☐ Maternity ☐ ICU

k) If Maternity i) Date of Delivery DDMMYYYY ii) Gravida Status

l) Status at time of discharge ☐ Discharge to home ☐ Discharge to another hospital ☐ Deceased

m) Total claimed amount

DETAILS OF AILMENT DIAGNOSED (Primary)

		Description
a) ICD 10 Codes		
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 Authorization 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

CLAIM DOCUMENTS SUBMITTED - CHECK LIST

- ☐ 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

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

f) Facilities available in the hospital i) OT ☐ Yes ☐ No ii) ICU ☐ Yes ☐ No iii) Others

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 DDMMYYYY

Place

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 Hospital	Enter the name of hospital	Name of hospital in full
b) Hospital ID	Enter ID number of hospital	As allocated by theTPA
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 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 admission	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 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		
Procedure1	Enter the ICD 10 PCS and description of the first procedure	Standard Format and Open text
Procedure2	Enter the ICD 10 PCS and description of the second procedure	Standard Format and Open text
Procedure3	Enter the ICD 10 PS 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 obtain in 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 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		
SECTION E - ADDITIONAL 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	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		