

CLAIM FORM - PART A TO 8E FILLED IN 8Y 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 No: b) SI. Nol Certificate No:	
c) Companyl TPA ID No:	
d) Name: SURNAME FIRST NAME MIDDL	
e) Address :	
City: State: State:	
Pin Code:	
DETAILS OF INSURANCE HISTORY:	
a) Currently covered by any other Mediclaim I Health Insurance: Yes No b) Date of commencement of first Insurance without break: D D M M	Y (Copies of Policies to be attached)
c) If yes, company name: Policy No. Policy No.	
Sum Insured (Rs.) d) Have you been hospitalized in the last 4 years? Yes No Date: M M Y Y Diagnosis:	
e) Previously covered by any other Mediclaim I Health insurance : Yes No f) If yes, Company Name	
DETAILS OF INSURED PERSON HOSPITALIZED:	
a) Name: SURNAME FIRST NAME MIDDL	E NAME
b) Gender: Male Female C) Age: years Y Y months M M d) Date of Birth: D D M M Y Y	
e) Relationship to Primary insured: Self Spouse Spouse Mother Other (Please Specify)	U
f) Occupation: Service Self Employed Homemaker Student Other (Please Specify)	П
g) Address (if different from above):	
City: State: State:	
Pin Code:	
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	Ų
c) Hospitalization due to: Injury Illness Maternity d) Date of Injury I Date Disease first detected IDate of Delivery:	M M Y Y
e) Date of Admission: \square	M M Y Y C C C C C C C C C C C C C C C C
i) If Injury give cause: Self inflicted Road Traffic Accident Substance Abuse I Alcohol Consumption i. If Medico legal:	Yes No
	jiesiNo
ii. Reported to police: Yes No iii. MLC Report & Police FIR attached: Yes No j) System of Medicine:	
ii. Reported to police: Yes No iii. MLC Report & Police FIR attached: Yes No j) System of Medicine: DETAILS OF CLAIM:	Jies No
DETAILS OF CLAIM: a) Details of the treatment expenses claimed	n Documents Submitted· Check List:
DETAILS OF CLAIM: a) Details of the treatment expenses claimed i. Pre-hospitalization Expenses: Rs.	n Documents Submitted· Check List: Claim Form Duly signed
DETAILS OF CLAIM: a) Details of the treatment expenses claimed i. Pre-hospitalization Expenses: Rs. Claim iii. Post-hospitalization Expenses: Rs. Claim iii. Po	n Documents Submitted Check List: Claim Form Duly signed Copy of the claim intimation
DETAILS OF CLAIM: a) Details of the treatment expenses claimed i. Pre-hospitalization Expenses: Rs.	n Documents Submitted Check List: Claim Form Duly signed Copy of the claim intimation Hospital Main Bill
DETAILS OF CLAIM: a) Details of the treatment expenses claimed i. Pre-hospitalization Expenses: iii. Post-hospitalization Expenses: Rs	n Documents Submitted Check List: Claim Form Duly signed Copy of the claim intimation Hospital Main Bill Hospital Break-up Bill
DETAILS OF CLAIM: a) Details of the treatment expenses claimed i. Pre-hospitalization Expenses: Rs.	n Documents Submitted Check List: Claim Form Duly signed Copy of the claim intimation Hospital Main Bill Hospital Break-up Bill
DETAILS OF CLAIM: a) Details of the treatment expenses claimed i. Pre-hospitalization Expenses: iii. Post-hospitalization Expenses: v. Ambulance Charges: Rs	n Documents Submitted · Check List: Claim Form Duly signed Copy of the claim intimation Hospital Main Bill Hospital Break-up Bill Hospital Bill Payment Receipt Hospital Discharge Summary Pharmacy Bill
DETAILS OF CLAIM: a) Details of the treatment expenses claimed i. Pre-hospitalization Expenses: Rs.	n Documents Submitted Check List: Claim Form Duly signed Copy of the claim intimation Hospital Main Bill Hospital Break-up Bill Hospital Bill Payment Receipt Hospital Discharge Summary Pharmacy Bill Operation Theatre Notes
DETAILS OF CLAIM: a) Details of the treatment expenses claimed i. Pre-hospitalization Expenses: Rs.	n Documents Submitted Check List: Claim Form Duly signed Copy of the claim intimation Hospital Main Bill Hospital Break-up Bill Hospital Bill Payment Receipt Hospital Discharge Summary Pharmacy Bill Operation Theatre Notes ECG
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DETAILS OF CLAIM: 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-Ch	n Documents Submitted Check List: Claim Form Duly signed Copy of the claim intimation 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
DETAILS OF CLAIM: a) Details of the treatment expenses claimed i. Pre-hospitalization Expenses: Rs.	n Documents Submitted Check List: Claim Form Duly signed Copy of the claim intimation 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 IMRI (LUSG I HPE)
DETAILS OF CLAIM: a) Details of the treatment expenses claimed i. Pre-hospitalization Expenses: iii. Post-hospitalization Expenses: Rs.	n Documents Submitted Check List: Claim Form Duly signed Copy of the claim intimation 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 IMRI I USG I HPE) Doctor's Prescriptions Others
DETAILS OF CLAIM: a) Details of the treatment expenses claimed i. Pre-hospitalization Expenses: Rs.	n Documents Submitted Check List: Claim Form Duly signed Copy of the claim intimation 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 I MRI I USG I HPE) Doctor's Prescriptions
DETAILS OF CLAIM: 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. Cothers (code): Rs. iv.	n Documents Submitted Check List: Claim Form Duly signed Copy of the claim intimation 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 IMRI I USG I HPE) Doctor's Prescriptions Others Amount (Rs)
DETAILS OF CLAIM: a) Details of the treatment expenses claimed i. Pre-hospitalization Expenses: Rs. ii. Hospitalization Expenses: Rs. iii. Hospitalizatio	n Documents Submitted Check List: Claim Form Duly signed Copy of the claim intimation 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 IMRI I USG I HPE) Doctor's Prescriptions Others Amount (Rs)
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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, 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	Y Place:	Signature of the Insured	

		FILLING CLAIM FORM - PART A (To be filled in by the insured	·
	DATA ELEMENT	DESCRIPTION	FORMAT
-1	DelianNe	SECTION A - DETAILS OF PRIMARY INSURED	A H - 44 1 h - 1
a)	Policy No.	Enter the policy number Enter the social insurance number or the certificate number of	As allotted by the insurance company
b)	SI. No/ Certificate No.	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	<u>, </u>
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 4 years	Indicate whether hospitalized in the last 4 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	ON 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
	N (11 % 1 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1	SECTION D - DETAILS OF HOSPITALIZATION	I No. 10 to 10 to 10
a)	Name of Hospital where admitted	Enter the name of hospital	Name of hospital in full
b)	Room category occupied Hospitalization due to	Indicate the room category occupied Indicate reason of hospitalization	Tick the right option Tick the right option
c) 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 Reported to Police	Indicate whether injury is medico legal Indicate whether police report was filed	Tick Yes or No 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	1 -1
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	
Indio	cate 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
	IFSC Code	Enter the IFSC code of the bank branch	IFSC code of the bank branch in full
e)	ii 3C Code		

CLAIMFORM-PART8
TO 8E FILLED IN 8Y 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:	
) Hospital ID: c) Type of Hospi	tal: Network
Name of the treating doctor: SURNAME FIRS	
Qualification: f) Registration No. with State Code:	g) Phone No.
ETAILS OF THE PATIENT ADMITTED	
Name of the Patient: SURNAME CFTRS	TONAMESOMMODUESCOMMESO
) 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
) Date of Admission: DD MM M YY Y g) Time: HH H: MM	h) Date of Discharge: DD MM M YY i) Time: HH : MM
Type of Admission: Emergency Planned Day Care Maternity k) If Status at time of discharge: Discharge to home Discharge to another	Maternity i. Date of Delivery: DD MM M YY ii. Gravida Status: Deceased
ETAILS OF AILMENT DIAGNOSED (PRIMARY)	поэрна
) ICD 10 Codes Description	b) ICD 10 PCS Description
i. Primary Diagnosis:	i. Procedure 1:
ii. Additional Diagnosis:	ii. Procedure 2:
iii. Co-morbidities:	iii. Procedure 3:
iv. Co-morbidities:	iv. Details of Procedure:
Present ailment is a complication of PED? Yes No (If Yes, specify details)	
Pre-authorization obtained: Yes No e) Pre-authorization	ation Number:
If authorization by network hospital not obtained, give reason:	
Hospitalization due to Injury: Yes No i. If Yes, give cause Self-inflicted	Road Traffic Accident Substance abuse I alcohol consumption
FIR no	ın:
LAIM DOCUMENTS SUBMITTED • CHECK LIST	
Claim Form duly signed Original Pre-authorization request	☐ Investigation reports ☐ CTIMRIUSGIHPE investigation reports
Copy of the Pre-authorization approval letter	Doctor's reference slip for investigation
Copy of photo ID card of patient verified by hospital	□ ECG □ Pharmagy hills
Hospital Discharge summary Operation Theatre notes	Pharmacy bills MLC report & Police FIR
Hospital main bill	Original death summary from hospital where applicable
Hospital break-up bill	Any other, please specify
ETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSP	
Address of the Hospital:	DADAGUGUGUGUGUGUGD
ا بایان از	ddddddddddddddddddddd
City:	
PAN: Pin Code: b)Phone No. e) Number of Inpatient beds	c) Registration No.: Yes No ii. ICU: Yes No II. CU: Seguistration No.:
Others:	I) Tacinites available in the hospital
ECLARATION BY THE INSURED	(PLEASE READ VERY CAREFULLY)
claim reimbursement shall be forfeited. I also consent & authorize TPA I insurance company, to seek nec	and belief. If I have made any false or untrue statement, suppression or concealment of any material fact, my righ essary medical information I documents from any hospital I Medical Practitioner who has attended on the persor his claim & that I will not be making any supplementary claim except the prelpost hospitalization claim, if any.
ite: DD MM M YY Place:	
	Signature of the Insured:
FCL ARATION BY THE HOSPITAL	
	(PLEASE READ VERY CAREFULLY)
e hereby declare that the information furnished in this Claim Form is true & correct to the best of our knowle	(PLEASE READ VERY CAREFULLY) edge and belief. If we have made any false or untrue statement, suppression or concealment of any material fact,
le hereby declare that the information furnished in this Claim Form is true & correct to the best of our knowle ur right to claim under this claim shall be forfeited. The signature of the insured is taken on this form after Clai	(PLEASE READ VERY CAREFULLY) edge and belief. If we have made any false or untrue statement, suppression or concealment of any material fact,
Ve hereby declare that the information furnished in this Claim Form is true & correct to the best of our knowled urright to claim under this claim shall be forfeited. The signature of the insured is taken on this form after Claim after:	(PLEASE READ VERY CAREFULLY) edge and belief. If we have made any false or untrue statement, suppression or concealment of any material fact,

	DATA ELEMENT	DESCRIPTION	FORMAT
		SECTION A - DETAILS OF HOSPITAL	
a)	Name of Hospital	Enter the name of hospital	Name of hospital in full
))	Hospital ID	Enter ID number of hospital	As allocated by the TPA
<u>, </u>	Type of Hospital	Indicate whether In network or non network nospital	Tick the right option
<u>/</u> l)	Name of treating doctor	Enter the name of the treating doctor	Name of doctor in full
)	Qualification	Enter the qualifications of the treating doctor	Abbreviations of educational qualifications
,	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
)	Phone No.	Enter the phone number of doctor	Include STD code with telephone number
	S	ECTION B – DETAILS OF THE PATIENT ADMITTED	,
	Name of Patient	Enter the name of hospital	Name of hospital in full
)	IP Registration Number	Enter insurance provider registration number	As allotted by the insurance provider
)	Gender	Indicate Gender of the patient	Tick Male or Female
)	Age	Enter age of the patient	Number of years and months
)	Date of Admission	Enter date of admission	Use dd-mm-yy format
	Time	Enter time of admission	Use hh:mm format
	Date of Discharge	Enter date of discharge	Use dd-mm-yy format
)	Time	Enter time of discharge	Use hh:mm format
	Type of Admission	Indicate type of admission of patient	Tick the right option
	If Maternity	yp	
	Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format
	Gravida Status	Enter Date of Delivery if maternity Enter Gravida status if maternity	Use standard format
	Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
	-	ION C – DETAILS OF AILMENT DIAGNOSED (PRIMARY)	rick the light option
	ICD 10 Code	ON C - DETAILS OF AILMENT DIAGNOSED (FRIMART)	I
		Enter the ICD 10 Code and description of the primary	
	Primary Diagnosis	diagnosis Enter the ICD 10 Code and description of the additional	Standard Format and Open text
	Additional Diagnosis Co-morbidities	diagnosis Enter the ICD 10 Code and description of the co-morbidities	Standard Format and Open text Standard Format and Open text
	ICD 10 PCS	Effici the ICD To Code and description of the co-morbidities	Standard Format and Open text
	Procedure 1	Enter the ICD 10 BCS and description of the first precedure	Standard Format and Open text
		Enter the ICD 10 PCS and description of the first procedure	'
	Procedure 2 Procedure 3	Enter the ICD 10 PCS and description of the second procedure	Standard Format and Open text
		Enter the ICD 10 PCS and description of the third procedure	Standard Format and Open text
	Details of Procedure Present Ailment is a Complication of PED	Enter the details of the procedure Indicate whether present ailment is a complication of some pre-	Open text Tick Yes or No
	Pre-authorization obtained	existing disease Indicate whether pre-authorization obtained	Tick Yes or No
	Pre-authorization Number	Enter pre-authorization number	As allotted by TPA
	If authorization by network hospital not obtained, give	Enter pre-authorization number	Open text
	reason 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
	SECT	ION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST	
dic	cate which supporting documents are submitted		
	SECTION	ON E – DETAILS IN CASE OF NON NETWORK HOSPITAL	
	Address	Enter the full postal address	Include Street, City and Pin Code
	Phone No.	Enter the phone number of hospital	Include STD code with telephone number
	Registration No.	Enter the registration number of patient	As allocated by the Hospital
	PAN	Enter the permanent account number	As allotted by the Income Tax department
	Number of Inpatient Beds	Enter the number of inpatient beds	Digits
	Facilities available in the hospital	Indicate facilities available in the hospital	Tick the right option. If others, please spec
	· ·	SECTION F - DECLARATION BY THE INSURED	
	d declaration carefully and mention date (in dd:mm:yy form		
za	a accidiation carcially and inclition date (in ad.iiiii.vv ioin		