AROGYA SANJEEVANI POLICY, LGI LTD.
CLAIMS MANUAL
INDEX

Liberty General Insurance Limited
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IRDA registration number: 150 ● CIN: U66000MH2010PLC209656

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1. Objectives

This manual is written with the following purpose:

- To outline process in handling and processing of claims
- To outline process and roles of Third Party Administrators

2. Scope

This manual enumerates activities related to:

- Claim Intimation
- Claim Submission
- Claim Registration
- Claim Processing
- Claim Settlement

3. Philosophy

It would be our mission to promptly and fairly handle, resolve all claims in a professional, efficient and courteous manner.

Effective response when a claim is made adds value to our product. We will achieve fair, reasonable, equitable disposition with utmost integrity in every respect and by providing superior service to our customers.

4. Service Providers

When a claim is reported, making immediate contact is of vital importance. Details would be obtained at the time of reporting as to when and how the policy holders may be reached.

In order to provide quality service to the customers and to provide for speedy disposal of claims the company would empanel reputed, experienced TPAs

5. Mode of claim intimation and Notification

Treatment may be taken in a network provider and is subject to pre authorization by the Company or its authorized TPA. (ii) Cashless request form available with the network provider and TPA shall be completed and sent to the Company/TPA for authorization. (iii) The Company/ TPA upon getting cashless request form and related medical information from the insured person/ network provider will issue pre-authorization letter to the hospital after verification. (iv) At the time of discharge, the insured person has to verify and sign the discharge papers, pay for non-medical and inadmissible expenses. (v) The Company / TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details. (vi)In case of denial of cashless access, the insured person may obtain the treatment as per treating doctor's advice and submit the claim documents to the Company / TPA for reimbursement.

Procedure for reimbursement of claims:
For reimbursement of claims the insured person may submit the necessary documents to TPA(if applicable)/Company within the prescribed time limit as specified hereunder.

Sl. No.	Type of Claim	Prescribed Time limit
1.	Reimbursement of hospitalization, day care and pre hospitalization expenses	Within thirty days of date of discharge from hospital
2.	Reimbursement of post hospitalization expenses	Within fifteen days from completion of post hospitalization treatment

Notification of Claim

Notice with full particulars shall be sent to the Company as under:

i. Within24hours from the date of emergency hospitalization required or before the Insured Person's discharge from Hospital, whichever is earlier.
ii. At least 48 hours prior to admission in Hospital in case of a planned Hospitalization.

1.1 Documents to be submitted:
The reimbursement claim is to be supported with the following documents and submitted within the prescribed time limit.

i. Duly Completed claim form
ii. Photo Identity proof of the patient
iii. Medical practitioner's prescription advising admission
iv. Original bills with itemized break-up
v. Payment receipts
vi. Discharge summary including complete medical history of the patient along with other details.
vii. Investigation/ Diagnostic test reports etc. supported by the prescription from attending medical practitioner
viii. OT notes or Surgeon's certificate giving details of the operation performed (for surgical cases).
ix. Sticker/Invoice of the Implants, wherever applicable.
x. MLR(Medico Legal Report copy if carried out and FIR (First information report) if registered, where ever applicable.
xi. NEFT Details (to enable direct credit of claim amount in bank account) and cancelled cheque
xii. KYC (Identity proof with Address) of the proposer, where claim liability is above Rs. 1 Lakh as per AML Guidelines
xiii. Legal heir/succession certificate , wherever applicable
xiv. Any other relevant document required by Company/TPA for assessment of the claim.

Note:
1. The company shall only accept bills/invoices/medical treatment related documents only in the Insured Person's name for whom the claim is submitted
2. In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer, the Company shall accept the copy of the documents and claim settlement advice, duly certified by the other insurer subject to satisfaction of the Company
3. Any delay in notification or submission may be condoned on merit where delay is proved to be for reasons beyond the control of the Insured Person

Applicable to all claims under the Policy:
In the event of the original documents being provided to any other Insurance Company or to a reimbursement provider, the Company shall accept verified photocopies of such documents attested by such other Insurance Company/ reimbursement provider.

6. Appointment of Investigators
On receipt of the claim intimation and other details, in case if required an Investigator would be appointed depending on the facts of claim and any other criteria that evolves from time to time.

7. Claim Assessment Report
Based on, relevant documents received by the insured / hospital, claim assessment would be made, which would include various findings and the final payable amount.

8.Claim settlement methodology
Claims settlement will be either by way of cashless or reimbursement method.

9.Tracking Pending Claims
Our systems will be capable of tracking the pending claims Branch wise and close them at the earliest.
These claims would be reviewed by Claims Head regularly and issues in respect of the pending claims would be discussed.

10. Claims Authorisation Matrix
There would be Claims Authorities at different level, based on cadre, experience etc. Initially the claims approval authority will be with the corporate claims manager and will be delegated in phased manner.

11. Legal and arbitration matters:
Legal issues as a matter of policy would be handled by the corporate office. Appointment of Arbitrators, experts and Legal Counsels will be done as per procedures laid down for the same by Corporate Office.

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(Standard Claim Form As prescribed by IRDA for Health Products)

AROGYA SANJEEVANI POLICY; LIBERTY GENERAL INSURANCE LTD.
CLAIM FORM - PART A

TO BE FILLED IN BY THE INSURED (To be filled in Block Letters)

(The issue of this form is not to be taken as an admission of liability)

SECTION A - DETAILS OF PRIMARY INSURED

a) Policy Number : b) SL No. / Certificate No./ Claim Number (If any) :

c) Company / TAP ID No. :

d) Name :

e) Address :

i) City : j) State :

k) Pin Code : l) Phone No :

m) Email ID :

n) ABHA Id :

'If ABHA ID is not available, we urge you to visit https://abdm.gov.in/ for creation of ABHA ID and inform the same to us once created.'

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 : d d m m y y

c) If Yes, Company Name :

Policy No : Sum Insured (Rs.) :

d) Have you been hospitalized in the last four years since the inception of the contract? ☐ Yes ☐ No Date : d d m m y y

Diagnosis :

e) Previously covered by any other Mediclaim / Health Insurance : ☐ Yes ☐ No

f) If Yes, Company Name :

SECTION C : DETAILS OF INSURED PERSON HOSPITALIZED

a) Name :

b) Gender : ☐ Male ☐ Female c) Age : Year y y Months m m d) Date of Brith d d y y m m

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 : Phone No :

Email ID :

ABHA Id :

'If ABHA ID is not available, we urge you to visit https://abdm.gov.in/ for creation of ABHA ID and inform the same to us once created.'

SECTION D : DETAIL OF HOSPITALIZATION

a) Name of Hospital where admitted :

b) Room Category Occupied : ☐ Day Care ☐ Single Occupancy ☐ Twin Sharing ☐ 3 or more

c) Hospitalization due to : ☐ Illness ☐ Injury ☐ Maternity d) Date of Injury / Date Disease First Detected / Date of Delivery : d d y y m m

e) Date of Admission : d d y y m m Time : h h m m f) Date of Discharge : d d y y m m Time : h h m m

h) If Injury give cause : ☐ Self Inflicted ☐ Road Traffic Accident ☐ Substance / Alcohol Consumption i) If Medico legal : ☐ Yes ☐ No

j) Reported to Police : ☐ Yes ☐ No k) MLC Report & Police FIR Attached : ☐ Yes ☐ No

l) System of Medicine : _____

SECTION E : DETAIL OF CLAIM

a) Details of Treatment Expenses Claimed

1. Pre Hospitalization Expenses : Rs.
2. Hospitalization Expenses : Rs.
3. Post Hospitalization Expenses : Rs.
4. Health Check Up Cost : Rs.

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5. Ambulance Charges : Rs.

6. Other (Code) : Rs.

Total **Rs.**

Pre Hospitalisation Period : Days d d y y m m

Post Hospitalization Period : Days d d y y m m

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 : Rs.

iv. Convalescence : Rs.

v. Pre/Post Lump Sum : Rs.

vi. Other : Rs.

Total **Rs.**

Claim Documents Submitted Check List

- ☐ Claim Form Duly Filled
- ☐ Copy of the Claim Intimation, if any
- ☐ Hospital Main Bill
- ☐ Hospital Break Up Bill
- ☐ Hospital Bill Payment Receipt
- ☐ Hospital Discharge Summary
- ☐ Pharmacy Bill
- ☐ Operation Theater Notes
- ☐ ECG
- ☐ Doctor's request for investigation
- ☐ Investigation Report (Including CT / MRI / USG / HPE)
- ☐ Doctor's Prescription
- ☐ Others

SECTION F : DETAILS OF BILL ENCLOSED

Sl. No.	Bill No.	Date	Issued by	Towards	Amount (Rs.)
		d d m m y y		Hospital Main Bill	
		d d m m y y		Pre Hospitalization Bills	
		d d m m y y		Pre Hospitalization	
		d d m m y y		Pharmacy Bills	
		d d m m y y			
		d d m m y y			
		d d m m y y			
		d d m m y y			
		d d m m y y			
		d d m m y y		**Total**	

Please attach separate sheet for additional bills / receipt details

SECTION G : DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

a) PAN No. : b) Account Number :

c) Bank Name / Branch :

d) Payable details : ☐ Cheque ☐ DD ☐ NEFT *Payable to _____

e) IFSC Code :

SECTION H : 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 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 Place : _____

_____

Signature of the 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) Sl. No. / Certificate No.	Enter the social insurance number or the certificate number of social health insurance scheme	As allotted by the organization
c) 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 policy holder	Surname, First name, Middle name
e) Address	Enter the full postal address	Include Street, City and Pin Code

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GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled in by the insured)		
DATA ELEMENT	**DESCRIPTION**	**FORMAT**
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 4 years Date Diagnosis	Indicate whether hospitalized in the last 4 years Enter the date of hospitalization Enter the diagnosis details	Tick Yes or No Use mm-yy for mat 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 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 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 reas on 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
I) If Injury give cause If Medico legal Reported to Police MLC Report & Police FIR attached	Indicate cause of injury Indicate whether injury is medicolegal Indicate whether police report was filed Indicate whether MLC report and Police FIR attached	Tick the right option Tick Yes or No Tick Yes or No Tick Yes or No
j) System of Medicine	Enter the system of medicine followed intreating 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 BILLSEN CLOSED		
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	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 - DETAILS OF THE INSURED		
Read declaration carefully and mention date (in dd : mm : yy format), place (open text) and sign.		

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CLAIM FORM - PART B

TO BE FILLED IN BY THE HOSPITAL (To be filled in Block Letters)

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

SECTION A - HOSPITAL DETAILS

a) Name of Hospital :

b) Hospital ID : c) Type of Hospital : ☐ Network ☐ Non Network (If Non Network fill Sec 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 : Year (y y) Months (m m)

e) Date of Brith : (d d m m y y) f) Date of Admission : (d d m m y y) g) Time of Admission : (h h m m)

h) Date of Discharge : (d d m m 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) ii. Gravida Status :

I) Status at time of Discharge : ☐ Discharge to Home ☐ Discharge to another Hospital ☐ Deceased

m) Total Claimed Amount :

SECTION C : DETAIL OF AILMENT DIAGNOSED

Ailment Diagnosed (Primary)	ICD 10 Codes	Description	Details of Procedure/s done	ICD 10 Codes	Description
i) Primary Diagnosis			i) Procedure 1		
ii) Codes Description			ii) Code & Description		
iii) Additional Diagnosis			iii) Procedure 2		
iv) Code Description			iii) Code & Description		
v) Co-morbidities			iii) Procedure 3		

Pre-authorization obtained : ☐ Yes ☐ No Pre-authorization Number :

Hospitalization due to Injury : ☐ Yes ☐ No (If Yes, give cause) ☐ Self-inflicted ☐ Road Traffic Accident ☐ Substance abuse/ alcohol consumption

Reported to Police : ☐ Yes ☐ No

Medico Legal : ☐ Yes ☐ No

FIR no : vi) If not reported to police give reason : _____

If injury due to Substance Abuse / Alcohol consumption test conducted to establish this? ☐ Yes ☐ No
If YES please attach Report

If authorization by network hospital not obtained, give reason _____

Note : For details of Claim Documents to be submitted, please refer checklist

SECTION D : CLAIM DOCUMENTS SUBMITTED - CHECKLIST

- ☐ Claim From Duly Singed
- ☐ Original Pre Authorization Request
- ☐ Copy of Pre Authorization Approval Letter
- ☐ Copy of photo ID card of patient verified by Hospital
- ☐ Hospital Discharge Summary
- ☐ Operation Theater 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

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CLAIM FORM - PART B

SECTION E : 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

iii) Other :

SECTION F : DECLARATION BY THE HOSPITAL

We hereby declare that the information furnished in this Claim Form is true and correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppressed or concealed any material fact, our right to claim under this Policy shall be forfeited.

Date : d d m m y y

Place :

Seal & Signature of the Hospital Authority

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