



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:

SECTION D. DETAILS OF HOSPITALIZATION

- a) Name of the 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 / Disease first detected / Date of Delivery: DD MM YYYY
- e) Date of Admission: DD MM YY Time : HH MM f) Date of Discharge: DD MM YY Time : HH MM
- h) If injury, give cause : Self Inflicted / Road Traffic Accident/ Substance Abuse or Alcohol Consumption
- i) If Medico legal : YES/ NO j) Reported to Police: YES/ NO k) MLC report or Police FIR attached: YES / NO
- l) System of medicine _____

SECTION E. DETAILS OF CLAIM

a Details of Treatment Expenses Claimed

Daily Hospital Cash (DHC)Benefit _____
 Daily Hospital Cash (DHC)- Only Accidents Benefit _____
 Double Accident Benefit (DAB)- _____
 Double ICU Benefit (DIB) –Sickness _____
 Double ICU Benefit (DIB) –Accident _____
 Double Critical Illness Benefit (DCI)-Listed Critical Illnesses _____
 Day care Procedure Cash- Listed Procedures _____
 Recovery Benefit _____
 Convalescence Benefit _____
 Special care on Minor Surgeries _____
 Special care on Major Surgeries _____
Total: Rs.....

Claim Documents Submitted Check List

- Original Claim Form Duly Filled
- Copy of the Claim Intimation, if any
- Attested copy of Hospital Main Bill with Break Up Bill



- Attested copy of Hospital Bill Payment Receipt
- Attested copy of Hospital Discharge Summary
- Attested copy of Operation Theater Notes
- Others

F.DETAILS OF BILLS ENCLOSED

Sl. No	Bill No	Date	Issued by	Towards	Amount
				Total	

Please attach separate sheet for additional bills / receipt details

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: _____

* Please share cancelled cheque copy for correct payment.

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:

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) SI. No/ Certificate No.	Enter the social insurance number or the certificate number of	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		
a) Currently covered by any other Mediclaim / Health	Indicate whether currently covered by another Mediclaim /	Tick Yes or No
b) Date of Commencement of first Insurance	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	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	Indicate whether previously covered by another Mediclaim /	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
f) Occupation	Indicate occupation of patient	Tick the right option. If others, please
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 reason of hospitalization	Tick the right option
d) Date of Injury/Date Disease first detected/ Date of	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	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	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
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 - DECLARATION BY THE INSURED		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.		

CLAIM FORM – 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 preauthorization request form in lieu of PART A (To be filled in Block Letters)

SECTION A. Hospital Details:

Name of the Hospital		Hospital ID	
Type of Hospital	Network	Non Network	
If Non Network fill sec E			
Name of the treating Doctor			
Qualification	Registration No with State Code:	Phone No:	

SECTION B. Details of the patient admitted:

Name of the patient		IP Registration Number	
Gender	Male/ Female	Age	Date of Birth: DD MM YYYY
Date of Admission		Time of Admission	
Date of Discharge		Time of Discharge	
Type of Admission	Emergency	Planned	Day-care Maternity
If Maternity Date of delivery		Gravida Status	
Status at the time of Discharge: Discharge to Home/ Discharge to another Hospital/ Deceased			
Total Claimed Amount:			

SECTION C. DETAILS OF AILMENT DIAGNOSED

Ailment Diagnosed (Primary)						
ICD 10 Code	Primary Diagnosis	Codes Description	Additional Diagnosis	Codes Description	Co-morbidities	Codes Description
Details of Procedure/s done						
ICD 10 PCS	Procedure 1	Code & Description	Procedure 2	Code & Description	Procedure 3	Code & Description
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		If not reported to police , give reasons				
If injury due to Substance Abuse/ Alcohol consumption test conducted to establish this? If YES please attach Report					YES/ NO	



If authorization by network hospital not obtained,
give reason

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

Details of Hospital

Address of the Hospital	
City	
State	
Pin Code	
Phone No	
Registration no with state code	
Hospital PAN	
No of Inpatient Beds	
Facilities in the Hospital	OT <input type="checkbox"/> Yes <input type="checkbox"/> No ICU <input type="checkbox"/> Yes <input type="checkbox"/> No
Others	

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.

SEAL & SIGNATURE OF THE HOSPITAL AUTHORITY

**Date
Place**