

REIMBURSEMENT CLAIM FORM

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

(To be Filled in block letters)

DETAILS OF PRIMARY INSURED:	,										
	Certificate no.										
c) Company / TPA ID (MA ID)No:											
d) Name: SURNAME FIRST NA											
e)Address:											
City: State:											
Pin Code Phone No:	Email ID:										
DETAILS OF INSURANCE HISTORY:											
a) Currently covered by any other Mediclaim / Health Insurance: Yes No b) Date of commencement of first Insuran	nce without break: D D M M Y Y Y Y										
c) If yes, company name: Policy No.											
Sum insured (Rs.) d) Have you been hospitalized in the last four years since inception of the	contract? Yes No Date: M M Y Y										
Diagnosis:	e) Previously covered by any other Mediclaim /Health insurance : Yes No										
f) If yes, company name:											
DETAILS OF INSURED PERSON HOSPITALIZED a) Name: SURNAME FIRST NA											
b) Gender Male Female c) Age years Y Y Months M M d) Date of Birth											
e) Relationship to Primary insured: Self Spouse Child Father Mother Othe	r (Please Specify)										
f) Occupation Service Self Employed Home Maker Student Retired Other	r (Please Specify)										
g) Address (if diffrent from above) :	r (Please Specify)										
City: State:											
Pin Code Phone No: Phone No:	Email ID:										
a) Name of Hospital where Admited:											
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 file											
e) Date of Admission: DDDMMM YY f) Time HHH MH g) Date of Dis	scharge: D D M M Y Y h) Time: H H : M H										
I) If injury give cause: Self inflicted Road Traffic Accident Substance Abuse / Alcohol Const	umption I) If Medico legal Yes No										
ii) Reported to Police iii. MLC Report & Police FIR attached Yes No j) System o	f Medicine:										
a) Details of the Treatment expenses claimed	Claim Documents Submitted - Check List:										
I. Pre -hospitalization expenses Rs. IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	Claim form duly signed										
iii. Post-hospitalization expenses Rs iv. Health-Check up cost: Rs	Copy of the claim intimation, if any Hospital Main Bill										
v. Ambulance Charges: Rs. vi. Others (code): Rs.	Hospital Break-up Bill										
Total Rs.	Hospital Bill Payment Receipt										
vii. Pre -hospitalization period: days viii. Post -hospitalization period: day	Hospital Discharge Summary Pharmacy Bill										
b) Claim for Domiciliary Hospitalization: Yes No (If yes, provide details in annexure) c) Details of Lump sum / cash benefit claimed:	Operation heater Notes										
i. Hospital Daily cash: Rs. ii. Surgical Cash: Rs.	ECG										
iii. Critical Illness benefit: Rs. iv. Convalescence: Rs.	Doctols request for investigation Investigation Reports (Including CT										
v. Pre/Post hospitalization Lump sum benefit: Rs.	/ MRI / USG / HPE) Doctols Prescriptions										
Total Rs.	Others										
SI. No. Bill No. Date Issued by Towards	Amount (Rs)										
1. D D M M Y Y Hospital main Bill											
2. D D M M Y Y Pre-hospitalization Bills: N	los										
3. D D M M Y Y Post-hospitalization Bills:	Nos										
4. D D M M Y Y Pharmacy Bills											
5. D D M M Y Y											
5. D D M M Y Y											
5. D D M M Y Y 6. D D M M Y Y											
5.											
5.											
5.	INT:										
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5.											
5. D D M M Y Y 6. D D M M Y Y 8. D D M M Y Y 9. D D M M Y Y 10. D D M M M Y Y 10.											
5.	INT: If I have made any false or untrue statement, suppression or concealent of any material ent & authorize TPA / insurance Company, to seek necessary medical information / ereby declare that I have included all the bills / receipts for the purpose of this claim &										
5. D D M M Y Y 6. D D M M Y Y 8. D D M M Y Y 9. D D M M Y Y 10. D D M M M Y Y 10.											

	DATA ELEMENT	DESCRIPTION	FORMAT
		SECTION A - DETAILS OF PRIMARY INSURED	
a)	Policy No.	Enter the policy number	As allotted by the Insurance Company
)	SI. No/ Certificate No.	Enter the social Insurance number or the certificate number of social health insurance scheme	As allotted by the oraganization
:)	Company TPA ID No.	Enter the TPA ID No.	Licence number as allotted by IRDA and printe in TPA documents.
)	Name	Enter the full name of the policyholder	Surname, First name, Middle name
<i>)</i>	Address	Enter the full postal address	Include Street, City and Pin code
		SECTION B -DETAILS OF INSURANCE HISTORY	1
)	Currently covered by any other Mediclaim / Health Insurance?	Indicate whether currently covered by another Mediclaim / Health Insurance	Tick Yes or No
)	Date of commencement of first Insurance without break	Enter the date of commencement of first Insurance	Use dd-mm-yy-forrmat
)	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
)	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
)	Previously covered by any other Mediclaim / Health Insurance?	Indicate whether previously covered by another mediclaim / Health Insurance	Tick Yes or No
	Company Name	Enter the full name of the Insurance Company	Name of the organization in full
	· · · ·	TION C -DETAILS OF INSURED PERSON HOSPITALIZED	Traine of the organization in rail
	Name	Enter the full name of the patient	Surname, First name, Middle name
))	Gender	Indicate Gender of the patient	Tick Male or Female
		Enter age of the patient	Number of years and months
))	Age Date of Birth	<u> </u>	,
<u>/</u>	Relationship to primary Insured	Enter Date of Birth of patient Indicate relationship of patient with policyholder	Use dd-mm-yy format Tick the right option, if others, please specify
_	Occupation	indicate occupation of patient	Tick the right option. If others, please specify.
	Address Phone No	Enter the full postal address	Include Street, City and Pin code
)		Enter the phone number of patient	Include STD code with telephone number
)	E-mail ID	Enter e-mail address of patient SECTION D - DETAILS OF HOSPITALIZATION	Complete e-mail address
	Name of Hospital where admited		Name of bookital in full
))	Room category occupied	Enter the name of hospital indicate the room category occupied	Name of hospital in full Tick the right option
, <u> </u>	Hospitalization due to	indicate reason of hospitalization	Tick the right option
<u>' </u>	Date of injury/Date Disease first detected / Date of	· ·	
_	Delivery	Enter the relevant date	Use dd-mm-yy format
1	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
1	Time	Enter time of discharge	Use hh-mm- format
	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
	System of Medicene	Enter the system of medicine followed in treating the patient	Open Text
		SECTION E - DETAILS OF CLAIM	
	Details of Treatment Expences	SECTION E - DETAILS OF CLAIM Enter the amount claimed as treatment expences	In rupees (Do not enter paise values)
)	Claim for Domiciliary Hospitalization	Enter the amount claimed as treatment expences indicate whether claim is for domiciliary hospitalization	Tick Yes or No
)	Claim for Domiciliary Hospitalization Details of Lump sum/ Cash benifit claimed	Enter the amount claimed as treatment expences	
	Claim for Domiciliary Hospitalization	Enter the amount claimed as treatment expences indicate whether claim is for domiciliary hospitalization Enter the amount claimed as lump sum / cash benefit indicate which supporting documents are submitted	Tick Yes or No
	Claim for Domiciliary Hospitalization Details of Lump sum/ Cash benifit claimed Claim documents Submitted-Check List	Enter the amount claimed as treatment expences indicate whether claim is for domiciliary hospitalization Enter the amount claimed as lump sum / cash benefit	Tick Yes or No In rupees (Do not enter paise values)
	Claim for Domiciliary Hospitalization Details of Lump sum/ Cash benifit claimed Claim documents Submitted-Check List ate which bills are enclosed with the amount in rupees	Enter the amount claimed as treatment expences indicate whether claim is for domiciliary hospitalization Enter the amount claimed as lump sum / cash benefit indicate which supporting documents are submitted SECTION F - DETAILS OF BILLS ENCLOSED	Tick Yes or No In rupees (Do not enter paise values)
)))	Claim for Domiciliary Hospitalization Details of Lump sum/ Cash benifit claimed Claim documents Submitted-Check List ate which bills are enclosed with the amount in rupees SECTION	Enter the amount claimed as treatment expences indicate whether claim is for domiciliary hospitalization Enter the amount claimed as lump sum / cash benefit indicate which supporting documents are submitted SECTION F - DETAILS OF BILLS ENCLOSED ON G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT	Tick Yes or No In rupees (Do not enter paise values) Tick the right option
))))	Claim for Domiciliary Hospitalization Details of Lump sum/ Cash benifit claimed Claim documents Submitted-Check List ate which bills are enclosed with the amount in rupees SECTION	Enter the amount claimed as treatment expences indicate whether claim is for domiciliary hospitalization Enter the amount claimed as lump sum / cash benefit indicate which supporting documents are submitted SECTION F - DETAILS OF BILLS ENCLOSED ON G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT Enter the permanent account number	Tick Yes or No In rupees (Do not enter paise values) Tick the right option As allotted by the Income Tax Department
)))) mdic	Claim for Domiciliary Hospitalization Details of Lump sum/ Cash benifit claimed Claim documents Submitted-Check List ate which bills are enclosed with the amount in rupees SECTION PAN Account Number	Enter the amount claimed as treatment expences indicate whether claim is for domiciliary hospitalization Enter the amount claimed as lump sum / cash benefit indicate which supporting documents are submitted SECTION F - DETAILS OF BILLS ENCLOSED ON G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT Enter the permanent account number Enter the Bank account number	Tick Yes or No In rupees (Do not enter paise values) Tick the right option As allotted by the Income Tax Department As allotted by the Bank
)))))))	Claim for Domiciliary Hospitalization Details of Lump sum/ Cash benifit claimed Claim documents Submitted-Check List ate which bills are enclosed with the amount in rupees SECTION	Enter the amount claimed as treatment expences indicate whether claim is for domiciliary hospitalization Enter the amount claimed as lump sum / cash benefit indicate which supporting documents are submitted SECTION F - DETAILS OF BILLS ENCLOSED ON G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT Enter the permanent account number Enter the Bank account number Enter the Bank name along with the branch	Tick Yes or No In rupees (Do not enter paise values) Tick the right option As allotted by the Income Tax Department
)))))	Claim for Domiciliary Hospitalization Details of Lump sum/ Cash benifit claimed Claim documents Submitted-Check List ate which bills are enclosed with the amount in rupees SECTION PAN Account Number	Enter the amount claimed as treatment expences indicate whether claim is for domiciliary hospitalization Enter the amount claimed as lump sum / cash benefit indicate which supporting documents are submitted SECTION F - DETAILS OF BILLS ENCLOSED ON G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT Enter the permanent account number Enter the Bank account number	Tick Yes or No In rupees (Do not enter paise values) Tick the right option As allotted by the Income Tax Department As allotted by the Bank



CLAIM FORM - PART B TO BE FILLED IN BY THE HOSPITAL

The issue of theis form is not to be taken as admission of liability

(To be filled in block letters)

DETAILS OF HOSPITAL																																							
a) Name of the Hospital:						\Box				Ι	\mathbf{L}															\Box		L	T	Ι	I	\perp	\Box						
c) Hospital ID:	oital ID: C) Type of Hospital: Network Non Network (if non network, fill Section E)																																						
d) Name of the treating of	doctor:	\Box	\Box			\Box			\Box	Γ																		Γ		Τ		Ι							
e) Qualification:																																							
DETAILS OF PATIENT	ETAILS OF PATIENT ADMITTED																																						
a) Name of Patient:					П	\Box			\Box	$\overline{\mathbb{L}}$	T															\Box		L	T	Τ	Τ	I	I	\Box		\Box	\Box	\Box	
b) IP Registration No.:			$oldsymbol{oldsymbol{oldsymbol{\square}}}$		\Box	\Box	\Box		c) G	ende	r:	Male] F	emale]	d)	Age:	years			r	nonths			e) Da	ate of	Birth:			Ι		[
f) Date of Admission:											\Box	Ⅎ																											
j) Type of Admission:	ype of Admission: Emergency Planned Day Care Maternity k) If Maternity: i. Date of Delivery: ii. Gravida Status:																																						
I) Status at time of discha	tatus at time of discharge: Discharged to home Discharged to another hospital Deceased m) Total claimed amount																																						
DETAILS OF AILMENT	DIAGNOSE	D (PRIMA	RY)		_									•				•																					
a)		IC	CD 10 Cc	odes							Desc	ription	n				b)							IC	D 10	PCS								Des	scriptio	n			
i. Primary Diagnosis :					П	\Box	.		_								i. F	Proced	dure 1	:				L						F									\Box
ii. Additional Diagnos	ii. Additional Diagnosis : ii. Procedure 2 :																																						
iii. Co-morbidities :	iii. Co-morbidities : iii. Procedure 3 :											ᅥ																											
i. Ca madeiditiaa																																							
iv. Co-morbidities : iv. Details of Procedure : iv. Details of Procedure :																																							
	c) Pre authorization obtained: Yes No d) Pre-authorization number:																																						
e) If authorization by net		I not obtain	ned, give	reaso	n:		I	Щ							_	1					_	1											_	_					Ш
f) Hospitalization due to i	njury:	Yes	Ш	No		i.	. If yes	, give	e cause	e			Self in	flicted	\sqsubseteq	ļ	Roa	d Traff	fic Acc	ident		l				Su	bstand	ce ab	use / a	lcoho	l cons	sump	tion				-		
ii. If injurydue to Substan	i. If injurydue 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.		Ш		\Box	Ш	\perp	\sqcup	ĺ		٧	i. If not	report	ted to p	olice,	give rea	ason:	\Box																						
CLAIM DOCUMENTS S	UBMITTED	- CHECKL	IST			_		_																															
Claim Fo	orm duly sigr	ied															느	In	vestiga	ation re	ports																		
Original	Pre-authoriz	ation reque	est														ᆫ	CT	T/ MRI	/ USG	HPE/	Inves	tigatio	n repo	orts														
Copy of	the Pre-auth	orization ap	pproval le	etter														Do	octor's	refera	nce sli	p																	
Copy of	photo ID car	d of patien	t verified	I by ho	spital													E	CG																				
Hospital	discharge si	ummary																Ph	narma	cy bills																			
Oparatio	n Theatre No	otes																М	LC rep	ort & I	Police	FIR																	
Hospital	main bill																	10	riginal	death	summ	ary fro	m ho	spital,	where	applic	able												
Hospital	break-up bil	I																Ar	ny othe	er, plea	ise spi	ecify																	
DETAILS IN CASE OF N	ION NETWO	ORK HOSE	ITAL (C)NLY F	ILL IN C	CASE	OF N	ON N	1ETW(ORK	HOSPIT	ΓAL)																											
a) Address of the hospital	al:	$\Box \Box$			\Box	╝	╝		匚	\Box																				Γ	\perp	\perp	\bot	\Box	\Box	\Box	\bot	\Box	╝
		$\Box \Box$			\Box	\Box			匚																					Γ	Ι	\perp	\Box	\Box			\Box	\Box	
	City:	口	\Box		\Box	\Box			匚	\Box	П								State:											Γ	Τ	Ι	\Box	\Box	\Box	\Box	\Box	\Box	╡
	Pin Code:	口	\prod		\Box	⊒	<u> </u>	ŀ	b) Pho	one N	0:														c) R	egistra	tion No	o. wit	1 State	Cod	e:	Ι	\Box	\Box		\Box		\Box	
d) Hospital PAN						\Box			\sqsubseteq]	e) N	Numbe	er of in	patient	t beds					f) Fa	cilities	availa	ble in	the ho	spital	:	i. OT:		Yes		No	,		ii.	ICU:		'es		No
iii. Others:						_	_	_																															
DECLARATION BY THE	HOSPITAL							_																										(Pl	ease i	ead ve	ery ca	refully	/)
We hereby declare th forfeited.	at the inform	ation furni	shed in t	his Cla	aim Form	ı is trı	ue & c	xorrec'	t to the	e bes	t of our	knowle	edge a	nd beli	ief. If w	e hav	e made	any f	alse oi	untru	e state	ment,	supp	ress oi	conc	ealmer	it of an	nu ma	terial fa	act, o	ur righ	nt to c	laim u	ınder	this cla	aim sha	all be		
Date:					1																				Г													\neg	
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Place:							_														Signat	ure of	the in	sured:	_														
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		DATA	ELEME	NT			_	_	_					SECT	TION A	\ - DF		ESCR OF F															FOF	RMAT					
a) Name of Hospita						_		_			Enter	r the n	iame o							_							Nam	e of I	ospital	l in fi									
b) Hospital ID				_		_	_	_	_		_		umber														-		ed by t										
c) Type of Hospital								_			$\overline{}$				ork or i	non n	etwork	nospit	al								_		ght opt										
d) Name of treating	doctor					_	_	_							eating												-		loctor i										
e) Qualification Enter the c f) Registration No. with State Code Enter the c																								-		ons of													
g) Phone No. Enter the registration number of the doctor along with the state code Enter the phone number of doctor											Enter	the re	egistrat	tion nu	ımber d	of the	doctor	along	with th	ne stat	e code	1					As al	iocat	ed by t	пе М	edical	Cour	ncil of	ındia					
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g) i none ivo.			_	_	_	_		_	_		$\overline{}$	r the p	hone r		r of doo		OF TH	IE PA				D					Inclu	de S	D cod	e wit	n telep	hone	num						

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 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) Type of Admission	Indicate type of admission of patient	Tick the right option								
j) If Maternity		<u> </u>								
Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format								
Gravida Status	Enter Gravida status if maternity	Use standard format								
k) Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option								
	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 Number	Enter pre-authorization number	As allotted by TPA								
e) If authorization by network hospital not obtained, give 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										
Medico Legal	Indicate whether test conducted	Tick Yes or No								
Reported To Police	Indicate whether injury is medico legal	Tick Yes or No								
FIR No.	Indicate whether police report was filed	Tick Yes or No								
If not reported to police, give reason	Enter first information report number	As issued by police authorities								
in not reported to police, give reason	Enter reason for not reporting to police SECTION D – CLAIM DOCUMENTS SUBMITTED-CHECK LIST	Open Text								
Indicate which supporting documents are submitted	020110119 0241111900011111119001111111901111111									
manada minar dapporting decamente die dabriikted	SECTION E - DETAILS IN CASE OF NON NETWORK HOSPITAL									
a) Address	T	tested Otest Otest Die Orde								
b) Phone No.	Enter the full postal address	Include Street, City and Pin Code								
c) Registration No. with State Code	Enter the phone number of hospital	Include STD code with telephone number								
d) Hospital PAN	Enter the registration number of the doctor along with the state code	As allocated by the Medical Council of India								
e) Number of Inpatient Beds	Enter the permanent account number	As allotted by the Income Tax department								
f) Facilities available in the hospital	Enter the number of inpatient beds	Digits								
1,1 dominate arangere in the mospital	Indicate facilities available in the hospital SECTION F - DECLARATION BY THE INSURED	Tick the right option. If others, please specify								
Dood declaration earsfully and mention date (in deluminary format)										
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and si	yıı.									