To ensure priority processing, please complete all sections in CAPITAL letters. Please tick ☑ in the relevant boxes.

Royal Sundaram
General Insurance

CLAIM FORM FOR HEALTH INSURANCE POLICIES

OTHER THAN TRAVEL AND PERSONAL ACCIDENT

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

(Guidance for filling claim form - **Part A** is available on our website: www.royalsundaram.in)

PART A

(TO BE FILLED IN BY THE INSURED)

DETAILS OF PRIMARY INSURED (PROPOSER)

SECTION A

a) Policy No. b) Sl. No./ Certificate No.

c) Membership No./ TPA ID No.

d) Name

e) Address

City State

Pin Code Land Line (with STD Code)

MOST IMPORTANT

PLEASE PROVIDE ACTIVE EMAIL ID ONLY AS CLAIMS CORRESPONDENCE WILL BE DONE TO THIS EMAIL ID.

Mobile No. Email ID

Alternate Email ID

DETAILS OF INSURANCE HISTORY

SECTION B

a) Currently covered by any other Mediclaim/Health Insurance ☐ Yes ☐ No

b) If yes, Company Name

Policy No. c) Date of commencement of first Insurance without break D D M M Y Y Y Y

d) Sum Insured (Rs.) e) Have you been hospitalized in the last four years since inception of the contract? ☐ Yes ☐ No f) Date D D M M Y Y Y Y

g) Diagnosis

DETAILS OF INSURED PERSON HOSPITALIZED

SECTION C

a) Name

b) Gender ☐ Male ☐ Female c) Age Y Y Years M M Months d) Date of Birth D D M M Y Y Y Y

e) Relationship to Primary insured ☐ Self ☐ Spouse ☐ Child ☐ Father ☐ Mother ☐ Other (Please Specify) ____________

f) Occupation ☐ Doctor ☐ Service ☐ Self Employed ☐ Homemaker ☐ Student ☐ Retired ☐ Other (Please Specify) ____________

g) Address (if different from above)

City State

Pin Code Land Line (with STD Code)

DETAILS OF HOSPITALIZATION

SECTION D

a) Name & Address of Hospital where Admitted

City State

Pin Code Land Mark

b) Room Category occupied ☐ Day care ☐ Single occupancy ☐ 3 or more beds per room ☐ Any other category, Pls specify____________

c) Hospitalization due to ☐ Injury ☐ Illness ☐ Maternity d) Date of Injury/Date Disease first detected D D M M Y Y Y Y

e) Date of Admission D D M M Y Y Y Y Time H H : M M f) Date of Discharge D D M M Y Y Y Y Time H H : M M

g) In case of maternity, 1 Date of Delivery D D M M Y Y Y Y 2 Gravida Status ____________

h) If Injury, give cause ☐ Self inflicted ☐ Road Traffic Accident ☐ Substance Abuse/Alcohol Consumption

1. If Medico legal ☐ Yes ☐ No 2. Reported to police ☐ Yes ☐ No 3. MLC Report & Police FIR attached ☐ Yes ☐ No

i) System of Medicine____________

DETAILS OF CLAIM

SECTION E

a) Details of the treatment expenses claimed

1. Pre-hospitalization Expenses Rs. [ ]
2. Hospitalization Expenses Rs. [ ]
3. Post-hospitalization Expenses Rs. [ ]
4. Health-Check up Cost Rs. [ ]
5. Ambulance Charges Rs. [ ]
6. Others Rs. [ ]

Total (1 to 6) Rs. [ ]

b) Claim for Domiciliary Hospitalization ☐ Yes ☐ No (If yes, please provide summary of bills in separate sheet)

c) Details of Lump sum / cash benefit claimed:

1. Hospital Daily Cash Rs. [ ]
2. Surgical Cash Rs. [ ]
3. Critical Illness Benefit Rs. [ ]
4. Convalescence Rs. [ ]
5. Pre/Post hospitalization Lump sum benefit: Rs. [ ]
6. Others________________ Rs. [ ]

Total (1 to 6) Rs. [ ]

Claim Documents to be 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
- ☐ Doctor's request for investigation
- ☐ Investigation Reports (Including CT/MRI/USG/HPE/ECG)
- ☐ Doctor's prescription for medicines purchased outside the hospital
- ☐ Test report and prescription relating to first consultation for the illness
- ☐ Hospital advance and final receipts
- ☐ FIR/MLC in case of accident injury and English translation of the same if it is in any other language
- ☐ KYC document (Address proof, ID proof only for claims exceeding Rs. 1 Lakh)
- ☐ Cancelled Cheque leaf of the bank account held in the name of the primary insured

DETAILS OF BILLS ENCLOSED

SECTION F

Sl. No	Bill No	Date	Issued by	Towards	Amount (Rs)
1		DDMMYYYY		Hospital Main Bill	
2		DDMMYYYY		Pre-hospitalization Bills: (Nos____)	
3		DDMMYYYY		Post-hospitalization Bills: (Nos____)	
4		DDMMYYYY		Pharmacy Bills: (Nos_____)	
5		DDMMYYYY			
6		DDMMYYYY			
7		DDMMYYYY			
8		DDMMYYYY			
9		DDMMYYYY			
10		DDMMYYYY			

Note : Please attach separate sheet if necessary

PLEASE PROVIDE YOUR BANK DETAILS: (Please attach cancelled cheque leaf of bank account in the name of primary insured without fail)

SECTION G

a) PAN [ ]

b) Account Number [ ]

c) Bank Name and Branch [ ]

d) IFSC Code [ ]

DECLARATION BY THE INSURED

SECTION H

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 Y Y Place [ ]

Signature of the Primary Insured [ ]

To ensure priority processing, please complete all sections in CAPITAL letters. Please tick ☑ in the relevant boxes.

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

(Guidance for filling claim form- **Part B** is available on our website: www.royalsundaram.in)

Royal Sundaram

General Insurance

SECTION A

DETAILS OF HOSPITAL

a) Name of the hospital

b) Hospital ID
(For Office use only)

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

d) Name of the treating Doctor

e) Qualification

f) Registration No. with State Code

g) Phone

SECTION B

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient:

b) IP Registration Number

c) Gender ☐ Male ☐ Female c) Age Y Y Years M M Months d) Date of Birth D D M M Y Y Y Y

f) Type of Admission ☐ Emergency ☐ Planned ☐ Day Care ☐ Maternity

g) Date of Admission D D M M Y Y Y Y Time H H : M M

h) Date of Discharge D D M M Y Y Y Y Time H H : M M

i) If Maternity

1.Date of Delivery D D M M Y Y Y Y 2.Gravida Status ____________

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

SECTION C

DETAILS OF AILMENT DIAGNOSED

a)	ICD 10 Codes	Description	Duration
1. Primary Diagnosis			M M Y Y Y Y
2. Additional Diagnosis			M M Y Y Y Y
3. Co-morbidities			M M Y Y Y Y
4. Co-morbidities			M M Y Y Y Y
	ICD 10 PCS Codes		
1. Procedure(1)			
2. Procedure(2)			
3. Procedure(3)			
4. Details of any other Procedure			

b) Hospitalization due to Injury ☐ Yes ☐ No If Yes, give cause

1. ☐ Self-inflicted ☐ Road Traffic Accident ☐ Substance abuse/alcohol consumption

2. If Injury due to Substance abuse/alcohol consumption, Test Conducted to establish this: ☐ Yes ☐ No

If Yes, details of tests conducted____________

3. If Medico legal ☐ Yes ☐ No 4. Reported to Police ☐ Yes ☐ No 5. FIR No.

6. If not reported to police, give reason____________

c) When did the patient start suffering with the complaint? ______________________

Date of first consultation (prior to hospitalisation) | D | D | M | M | Y | Y | Y | Y |

d) Please give previous medical history of the patient [ ]

e) Is the patient suffering from any of the following diseases. If "yes" Please mention the duration below.

		Say Yes/No	Duration in Year	Duration in Month
1.	Bronchial Asthma			
2.	Chronic Obstructive Pulmonary disease			
3.	Hypertension			
4.	Diabetes			
5.	Heart ailment			
6.	Osteoarthritis			
7.	Cerebro vascular attack			
8.	Seizure disorder			
9.	Renal/Kidney Disorder			
10.	Any other			

f) Is the ailment a complication of a pre-existing disease or condition? If Yes , please give details [ ]

g) History of alcoholism ☐ Yes ☐ No
If yes : No of years ______________
Quantity consumed per day ______________

h) History of Smoking/ Tobacco chewing ☐ Yes ☐ No
If yes : No of years ______________
Units consumed per day ______________

ADDITIONAL DETAILS IN CASE OF NON-NETWORK HOSPITAL

SECTION D

a) Address of the Hospital [ ]

b) Hospital Registration No [ ]

c) Hospital Registered with [ ]

City [ ] State [ ]

d) Hospital PAN [ ] e) Number of Inpatient beds [ ]

f) Facilities available in the hospital: 1. OT ☐ Yes ☐ No 2. ICU ☐ Yes ☐ No 3. Doctor/Round the clock Nurses ☐ Yes ☐ No
4. Others ______________________

DECLARATION BY THE HOSPITAL (PLEASE READ VERY CAREFULLY)

SECTION E

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, insured's right to claim under this policy shall be forfeited.

Date | D | D | M | M | Y | Y | Y | Y | Place [ ]

Signature and Seal of the Hospital Authority [ ]

PR14048/MAY14

Authorization Letter (Mandatory)

Date:

From:

To:

The Manager/ Medical Superintendent,
Medical Records

Dear Sir

Reg : Authorization Letter.

Name of the Patient:______________________________

IP Number_________________________ (First admission) in __________________________Hospital

IP Number_________________________ (Second admission) in _______________________Hospital

IP Number_________________________(Third admission) in __________________________Hospital

I consent and authorize M/s Royal Sundaram Alliance Insurance Company and their Authorized Service Providers to seek medical information from your hospital and share copies of indoor case sheets and such ther relevant medical records and / or meet the Medical Practitioner who has at any time attended on the patient for the hospitalization dated .... to ....

Thanking you,

Yours sincerely,

Signature of the Proposer

Signature of the Patient