FORM 2: CLAIM FORM

IFFCO TOKIO GENERAL INSURANCE COMPANY LIMITED

CLAIM FORM - PART A (TO BE FILLED IN BY INSURED)

IFFCO-TOKIO GENERAL INSURANCE
Muskurate Raho

INSURANCE DETAILS

Policy No		SNo/ Certificate No:			
Company/ TPA ID No		Name of Proposer			
Address of Proposer (Primary Insured)					
Name of Claimant					
Relation to proposer		Date of Birth		Age	
Address					
Gender	Male / Female	Occupation			
Telephone No		Mobile No			
E-mail ID, if any					
Insurance History	Date of commencement of first Insurance for the person				
Are you presently covered with any other Mediclaim / Health Insurance?			Y/N		
If Y, give details - Company / Policy No / Sum Insured (Attach Policy copies)					
Primary Insured's Bank Account particulars		PAN No.			
Account Number		Bank Name			
Branch		IFSC Code			

HOSPITALIZATION DETAILS

Name of the Hospital where admitted					
Room Type-Day care / Single / Twin sharing etc…					
Past Hospitalisation	Y/N	Month and Yr		DIAGNOSIS:	
Hospitallisation due to: Illness / Injury / Maternity		Details			
Date of Injury / Disease first detected / LMP					
If injury, how it occurred					
If injury, whether Medico legal	Y/N	If MLC, reported to police?		Y/N (Enclose MLC /FIR)	
Is claim is for **Domiciliary Hospitalisation?**		Y/N (If Y, provide details in annexur			

EXPENSES AND BILLING DETAILS

Pre-hospitalisation Expenses	Rs.	Hospitalisation Expenses	Rs.
Post-hospitalisation Expenses	Rs.	Health-Check up Cost	Rs.
Ambulance Charges	Rs.	Others	Rs.
Details of Lumpsum / cash benefit claimed:			
Hospital Daily Cash	Surgical Cash		Critical Illness benefit
Convalescence:	Pre / Post hosp lumpsum benefit:		Others

Details of bills enclosed (attach separate sheet, if space inadequate)

Sl.	Bill No	Date	Issued By	Towards	Amount

Details of Claim Documents submitted - CHECK LIST

Claim Form Duly signed		Y	N	Pre-hosp Bills: _____ Nos	Y	N
Copy of the claim intimation		Y	N	Post-hosp Bills: _____ Nos	Y	N
Hospital Discharge Summary		Y	N	Investigation Reports	Y	N
Operation Theatre Notes		Y	N	Doctor request for investigation	Y	N
Hospital Main Bill		Y	N	ECG	Y	N
Hospital Break-up Bill		Y	N	Pharmacy Bills	Y	N
Hospital Bill Payment Receipt		Y	N	MLC Report & Police FIR	Y	N
Doctor\s Prescriptions		Y	N	Any other, please specify	Y	N

Date: Signature of the Primary Insured / Claimant

CLAIM FORM - PART B			
TO BE FILLED IN BY THE HOSPITAL			
Name of the Hospital			Hosp ID
Type of Hospital	Network	Non Network	
In case of non network , please provide below details			
Address of the Hospital with Pin Code			
Telephone No		Registration no.	
Number of Inpatient beds		PAN	
Other Facilities available in the hospital		OT	Y/N
ICU	Y/N	Others	
Details of the patient admitted			
Name of the patient		IP Registration Number	
Gender		Age	
Date of Admission		Time of Admission	
Date of Discharge		Time of Discharge	
Ailment Diagnosed (Primary)			
ICD 10-CM Code	Primary	Additional	Co-
Details of Procedure/s			
ICD 10 PCS Code	Proc 1	Proc 2	Proc 3
Type of Admission	Emergency	Planned	Day-care | Maternity
Date of delivery if Maternity		Gravida Status	
8. Is the treatment for an injury? If, Y, details.			
Was it self inflicted?	Y/N	Whether RTA	Y/N
If MLC, notified to police?	Y/N	MLC / FIR No.	
If MLC not notified, give reasons			
Was the Injury/ disease caused due to Substance abuse / Alcohol consumption			Y/N
If Y, whether any test was conducted to establish this? If Y, please attach Report			Y/N
Is present ailment a complication of Pre-existing disease		Y/N	
If Y, specify details			
Whether Pre-authorisation obtained - Y/N		If Y, Pre Auth Number	
If authorisation by network hospital not obtained, reason?			
Name of Treating Doctor		Registration No	
Mobile No		Qualification	

13. Claim Documents submitted (CHECK LIST)	
Claim Form Duly signed	Investigation Reports
Original Pre-authorisation request	Investigation Reports (Including CT / MRI / USG / HPE)
Copy of the preauthorisation approval letter	Doctor's Reference Slip for investigation
Hospital Discharge Summary	ECG
Operation Theatre Notes	Pharmacy Bills
Hospital Main Bill	MLC Report & Police FIR
Hospital Break-up Bill	Any other, please specify
Date:	Signature of the Primary Insured / Claimant