

TO BE FILLED IN BY THE INSURED

The issue of this Form is not to be taken as an admission of liability
(To be filled in block letters)

[illegible]

DETAILS OF INSURANCE HISTORY																												
a) Currently covered by any other Mediclaim/Health Insurance																				Yes				No				
b) If yes, Company Name																												
Policy No.																				Sum Insured (₹)								
c) Date of commencement of first Insurance without break															DD / MM / YYYY			(Copies of Policies to be attached)										
d) Have you been hospitalized in the last 4 years? (since inception of the contract)															Yes				No				Date		DD / MM / YYYY			
															Diagnosis													
e) Have you been covered by any other Mediclaim/Health Insurance in last 4 years																				Yes				No				
f) If yes, Company Name																												

DETAILS OF INSURED PERSON HOSPITALIZED																												
a) Name																												
b) Gender	Male				Female				c) Age	years			months			d) Date of Birth	<u>DD</u> / <u>MM</u> / <u>YYYY</u>											
e) Relationship to Primary insured				Self				Spouse				Child				Father				Mother								
				Other				(Please Specify)																				
f) Occupation				Service				Self Employee				Homemaker				Student				Retired								
				Other				(Please Specify)																				
Address (if different from above)																												
		City																										
		State																										
		Ph. No.																										

DETAILS OF HOSPITALIZATION																												
a) Name of Hospital where Admitted																												
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 of Disease first detected/Date of Delivery																							DD / MM / YYYY					
e) Date of Admission	DD / MM / YYYY				f) Time		HH	MM	g) Date of Discharge				DD / MM / YYYY				h) Time		HH	MM								
i) If injury give cause		Self inflicted				Road Traffic Accident																						
Substance Abuse/Alcohol consumption						i. if Medico legal																Yes		No				
ii. Reported to police		Yes		No	iii. MLC Report & Police FIR attached																Yes		No					
j) System of Medicine																												
k) Date of Surgery		DD / MM / YYYY						l) Claim Intimated																Yes		No		
i. Intimated to whom		SBU		Intermediaries				Call Centre				Health Claims Team																
ii. Intimation No. & date																				DD / MM / YYYY								
iii. If not Intimated, reason?																												

DETAILS OF CLAIM														
a) Details of the treatment expenses claimed														
i. Pre-hospitalization Expenses	₹							ii. Hospitalization Expenses	₹					
iii. Post-hospitalization expenses	₹							iv. Health-Check up Cost	₹					
v. Ambulance Charges	₹							vi. Others (code)						
vii. Pre-hospitalization period	days						Total		₹					
								viii. Post hospitalization period	days					
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	₹							ii. Surgical Cash	₹					
iii. Critical Illness Benefit	₹							iv. Convalescence	₹					
v. Pre/Post hospitalization Lump sum benefit	₹							vi. Others						
								Total	₹					
Claim Documents Submitted - Check List								Operation Theatre Notes						
Claim Form Duly signed								ECG						
Copy of the claim intimation								Doctor's request for investigation						
Hospital Main Bill								Investigation Reports (CT/MRI/USG/HPE)						
Hospital Break - up Bill								Doctor's Prescriptions						
Hospital Bill Payment Receipt								Pre-Hosp. Bills						
Hospital Discharge Summary								Post-Hosp. Bills						
Pharmacy Bill								Others						

DETAILS OF BILLS ENCLOSED								
Sl. No.	Bill No.	Date	Issued by	Towards (Hospitalization/Pre-hospitalization/Post-hospitalization)	Amount (₹)			
1		<u>DD / MM / YYYY</u>						
2		<u>DD / MM / YYYY</u>						
3		<u>DD / MM / YYYY</u>						
4		<u>DD / MM / YYYY</u>						
5		<u>DD / MM / YYYY</u>						
6		<u>DD / MM / YYYY</u>						
7		<u>DD / MM / YYYY</u>						
8		<u>DD / MM / YYYY</u>						
9		<u>DD / MM / YYYY</u>						
10		<u>DD / MM / YYYY</u>						

Do you want to opt for Automatic Reinstatement of Sum Insured in the event of a claim? If, Yes, applicable premium at short period rates would be deducted from the claim amount due to you. This reinstated sum will not be available for the same hospitalization. It will be available for treatment (other than certain chronic diseases) including the same illness or disease but separate independent case of hospitalization which are not case of relapse within 45 days of first hospitalization. Please contact the agent/our office for further details:

Yes		No	
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DETAILS OF PRIMARY INSURED'S BANK ACCOUNT (Please submit a cancelled cheque copy for NEFT)														
a) PAN							b) Account Number							
c) Bank Name and Branch														
d) Cheque/DD Payable details							e) IFSC Code							

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.

Place: _____

Date: DD/MM/YYYY

Signature of the Insured

Important:

1. Please submit copy of valid Photo ID.
2. For claimed amount above 1 lac, it is mandatory to submit the KYC (Know your customer) form.

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
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Please include the original preauthorization request form in lieu of PART A

DETAILS OF HOSPITAL																													
a)	Name of the Hospital																												
b)	Hospital ID							c)	Type of Hospital	Network		Non Network		(If non network fill section E)															
d)	Name of the treating doctor																												
e)	Qualification							f)	Registration No. with State Code																				
								g)	Ph No.																				

DETAILS OF THE PATIENT ADMITTED																													
a)	Name of the Patient																												
b)	IP Registration Number							c)	Gender	Male		Female		d)	Age	Years		Months											
e)	Date of birth							f)	Date of Admission									g)	Time	HH		MM							
h)	Date of Discharge							i)	Time					HH		MM													
j)	Type of Admission	Emergency						Planned					Day Care					Maternity											
k)	If Maternity	i. Date of Delivery						DD / MM / YYYY					ii. Gravida Status																
l)	Status at time of discharge	Discharge to home						Discharge to another hospital					Deceased																
m)	Total Claimed Amount							₹																					

DETAILS OF AILMENT DIAGNOSED (PRIMARY)																												
a)		ICD 10 Codes												Description														
	i. Primary Diagnosis																											
	ii. Additional Diagnosis																											
	iii. Co-morbidities																											
	iv. Co-morbidities																											
b)		ICD 10 Codes												Description														
	i. Procedure 1																											
	ii. Procedure 2																											
	iii. Procedure 3																											
	iv. Details of Procedure																											
c)	Present ailment is a complication of PED?	Yes		No		(If Yes, specify details)																						
d)	Pre-authorization obtained	Yes		No																								
e)	Pre-authorization Number																											
f)	If authorization by network hospital not obtained, give reason																											
g)	Hospitalization due to Injury	Yes		No		i. If Yes, give cause	Self-inflicted		Road Traffic Accident																			
	Substance abuse/alcohol consumption					ii. If Injury due 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.																	
	vi. If not reported to police give reason																											

CLAIM DOCUMENTS SUBMITTED - CHECK LIST			
Claim Form duly signed		Operation Theatre notes	Doctor's reference slip for investigation
Original Pre-authorization request		Hospital main bill	ECG
Copy of the Pre-authorization approval letter		Hospital break-up bill	Pharmacy bills
Copy of photo ID card of patient verified by hospital		Investigation reports	MLC report & Police FIR
Hospital Discharge summary		CT/MR/USG/HPE investigation reports	Original death summary from hospital where applicable
Any other, please specify			

ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL (Only fill in case of non-network hospital)																													
a)	Address of the Hospital																												
	City																												
	State																												
Pin Code																													
b)	Phone No.													c) Registration No.															
	Date of Registration													Expiry date of Registration															
	DD / MM / YYYY													DD / MM / YYYY															
	Name of the Registering Authority																												
d)	PAN													e) Number of Inpatient beds															
f)	Facilities available in the hospital													i. OT				Yes		No		ii. ICU				Yes		No	
	iii. Others																												

DECLARATION BY THE HOSPITAL (PLEASE READ VERY CAREFULLY)	
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, our right to claim under this claim shall be forfeited. The signature of the insured is taken on this form after Claim Form B is fully filled up by us. Hospital have required infrastructure to fulfill the hospital definition as per IRDA guideline, which is reproduced below: • Has at least 10 inpatient beds, in those towns having a population of less than 10,00,000 and 15 inpatient beds in all other places • Has fully qualified nursing staff under its employment round the clock • Has fully qualified doctor(s) in charge round the clock • Has a fully equipped operation theatre of its own where surgical procedures are carried out. • Maintains daily Medical records of patients and will make these accessible to the Company's authorized personnel.	

Place: _____

Date: DD/MM/YYYY

Signature of
Insured/Claimant

Signature and Seal of
the Hospital Authority