FORM 2: CLAIM FORM

IFFCO TOKIO GENERAL INSURANCE COMPANY LIMITED



	CLAI			RE LILLED IN BY	INSURED			NSURANC		
		IN		E DETAILS		,	luskura	te Raho		
Policy No				SNo/ Certificate No:						
Company/ TPA ID No			Name	Name of Proposer						
Address of Proposer (Pr	imary Insured)								
Name of Claimant										
Relation to proposer			Date o	f Birth			Age			
Address										
Gender	Male / Fema	le	Occupation							
Telephone No			Mobile No							
E-mail ID, if any										
Insurance History	Date of comr	nencement of firs	t Insuran	ce for the person						
Are you presently covere					Y.	/N				
If Y, give details - Comp	any / Policy No	o / Sum Insured (Attach Po	licy copies)						
Primary Insured's Bank	Account partic	ulars	PAN N	0.						
Account Number			Bank N	Bank Name						
Branch			IFSC C	Code						
		HOSE	PITALIZA	TION DETAILS						
Name of the Hospital wh	nere admitted									
Room Type-Day care / S	Single / Twin s	haring 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 (E	nclose ML	C /FIR)		
Is claim is for Domicilia				Y/N (If Y, provide details in annexur						
	, ,		_	BILLING DETAILS						
Pre-hospitalisation Expe	enses	Rs.	_	alisation Expenses	R	S.				
Post-hospitalisation Expenses		Rs.		Health-Check up Cost		Rs.				
Ambulance Charges		Rs.	_	Others		Rs.				
	sh benefit clai									
Details of Lumpsum / cash benefit clail Hospital Daily Cash		Surgical Cash			C	Critical Illness benefit				
Convalescence:		Pre / Post hosp lumpsum benefit:				Others				
Details of bills enclosed	(attach senara									
SI.	Bill No	Date	Inacoqui	Issued By		Towards	Δι	mount		
Oi.	Biii 140	Bate	1	looded By		10114140	<u> </u>	- Ilount		
							 			
	 		1				 			
										
		Letails of Claim D	Ocument	ts submitted - CHE	CKLIST					
Claim Form Duly signed		Y	N	Pre-hosp Bills:	Nos	Т	Υ	N		
Copy of the claim intima		Y	N	Post-hosp Bills:	Nos		Y	N		
Hospital Discharge Summary		Y	N				Y	N		
Operation Theatre Notes		Y		N Doctor request for investigat		,	Y	N		
Hospital Main Bill		Y		N ECG		'	Y	N		
Hospital Break-up Bill		Y	N				Y	N		
Hospital Bill Payment Receipt		Y	N				Y	N		
Doctor\s Prescriptions		Y	•	N Any other, please specify			Y	N		
Doctor's Frescriptions		l t	IN	Any other, please s	ppecity		ı	IN IN		
Date:				Signature of the Pr	imary Insure	ed / Claima	ınt			

TO BE FILLED IN BY THE HOSPITAL Name of the Hospital Network Non Network n case of non network , please provide below details Address of the Hospital with Pin Code Felephone No Registration no. Number of Inpatient beds PAN Details of the patient admitted Name of the patient admitted National admitted admitted admitted admitted atmitted admitted admitted atmitted admitted atmitted admitted atmitted	CLAIM FORM - PART B									
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Type of Hospital Network Non Network n case of non network , please provide below details Address of the Hospital with Pin Code Registration no.	Name of the Hospital	10221111								
n case of non network , please provide below details Address of the Hospital with Pin Code Felephone No Number of Inpatient beds PAN Dither Facilities available in the hospital CU Y/N Others Details of the patient admitted Name of the patient admitted Age Date of Admission Date of Discharge Name of Discharge Nament Diagnosed (Primary) CD 10-CM Code Primary Maternity Sa is the treatment for an injury? If, Y, details. Was it self inflicted? Y/N Mhc / Fir No. If MLC, not notified, give reasons Was the Injury/ disease caused due to Substance abuse / Alcohol consumption Y/N Y/N Y/N Y/N Y/N Y/N Y/N Y/	•	Network		· · · · · · · · · · · · · · · · · · ·						
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Hospital Break-up Bill Any other, please specify	Operation Theatre Notes		Pharmacy Bills							
	Hospital Main Bill		MLC Report & Police FIR							
Date: Signature of the Primary Insured / Claimant	Hospital Break-up Bill			Any other, please specify						
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