



CLAIM FORM - PART A
IFFCO TOKIO GENERAL INSURANCE COMPANY LIMITED
 CIN: U74899DL2000PLC107621

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)

DETAILS OF PRIMARY INSURED:

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

c) Company/ TPA ID No:

d) Name:

e) Address:

City: State:

Pin Code: Phone No: Email ID:

DETAILS OF INSURANCE HISTORY:

a) Currently covered by any other Medclaim / Health Insurance: Yes No b) If yes, company name:

Policy No: Sum Insured (Rs.)
 (Copies of Policies to be attached)

c) Date of commencement of first Insurance without break:

d) Have you been hospitalized in the last 4 years? (since inception of the contract) Yes No Date: Dignosis:

e) Have you been covered by any other Medclaim / 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:

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:

Pin Code: Phone No: Email ID:

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:

e) Date of Admission: f) Time: : g) Date of Discharge: h) Time: :

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: k) Claim Intimated: Yes No i. Intimated to whom: SBU / Intermediaries / Call Centre / Health Claims Team

ii. Intimation No. & date: iii. If not Intimated, reason?

DETAILS OF CLAIM:

a) Details of the treatment expenses claimed

i. Pre-hospitalization Expenses:	Rs. <input type="text"/>	ii. Hospitalization Expenses:	Rs. <input type="text"/>
iii. Post-hospitalization expenses:	Rs. <input type="text"/>	iv. Health-Check up Cost:	Rs. <input type="text"/>
v. Ambulance Charges:	Rs. <input type="text"/>	vi. Others (code):	Rs. <input type="text"/>
		Total	Rs. <input type="text"/>
vii. Pre-hospitalization period:	days <input type="text"/>	viii. Post hospitalization period:	days <input type="text"/>

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:	Rs. <input type="text"/>	ii. Surgical Cash:	Rs. <input type="text"/>
iii. Critical Illness Benefit:	Rs. <input type="text"/>	iv. Convalescence:	Rs. <input type="text"/>
v. Pre/Post hospitalization Lump sum benefit:	Rs. <input type="text"/>	vi. Others:	Rs. <input type="text"/>
		Total	Rs. <input type="text"/>

Claim Documents Submitted - Check List:

- Claim Form Duly signed
- Copy of the claim intimation
- Hospital Main Bill
- Hospital Break - up Bill
- Hospital Bill Payment Receipt
- Hospital Discharge Summary
- Pharmacy Bill
- Operation Theatre Notes
- ECG
- Doctor's request for investigation
- Investigation Reports (CT / MRI / USG / HPE)
- Doctor's Prescriptions
- Pre-Hosp. Bills
- Post-Hosp. Bills
- Others

DETAILS OF BILLS ENCLOSED:

Sl No.	Bill No.	Date	Issued By	Towards (Hospitalization / Pre-hospitalization / Post-Hospitalization)	Amount (Rs)
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

Do you want to opt for Reinstatement of Sum Insured in the event of a claim?: **Yes / No**

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.

Date: Place: 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
IFFCO TOKIO GENERAL INSURANCE COMPANY LIMITED
 CIN: U74899DL2000PLC107621
TO BE FILLED IN BY THE HOSPITAL
 The issue of this Form is not to be taken as an admission of liability
 Please include the original preauthorization request form in lieu of PART A

(To be filled in block letters)

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) Phone 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: _____ h) Date of Discharge: _____ i) Time: _____
 j) Type of Admission: Emergency Planned Day Care Maternity k) If Maternity i. Date of Delivery: _____ Gravidia Status _____
 l) Status at time of discharge: Discharge to home Discharge to another hospital Deceased m) Total Claimed Amount: Rs. _____

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a) ICD 10 Codes	Description	b) ICD 10 PCS Codes	Description
i. Primary Diagnosis: _____	_____	i. Procedure 1: _____	_____
ii. Additional Diagnosis: _____	_____	ii. Procedure 2: _____	_____
iii. Co-morbidities: _____	_____	iii. Procedure 3: _____	_____
iv. Co-morbidities: _____	_____	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

<input type="checkbox"/> Claim Form duly signed	<input type="checkbox"/> Operation Theatre notes	<input type="checkbox"/> Doctor's reference slip for investigation
<input type="checkbox"/> Original Pre-authorization request	<input type="checkbox"/> Hospital main bill	<input type="checkbox"/> ECG
<input type="checkbox"/> Copy of the Pre-authorization approval letter	<input type="checkbox"/> Hospital break-up bill	<input type="checkbox"/> Pharmacy bills
<input type="checkbox"/> Copy of photo ID card of patient verified by hospital	<input type="checkbox"/> Investigation reports	<input type="checkbox"/> MLC report & Police FIR
<input type="checkbox"/> Hospital Discharge summary	<input type="checkbox"/> CT/MR/USG/HPE investigation reports	<input type="checkbox"/> Original death summary from hospital where applicable
<input type="checkbox"/> 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 _____ 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.

Date: _____ Place: _____
 Signature of Insured / Claimant: _____ Signature and Seal of the Hospital Authority: _____