



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)

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) Phone No. _____

B. 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: Gravida Statu _____
l) Status at time of discharge: Discharge to home Discharge to another hospital Deceased m) Total Claimed Amount: Rs. _____

C. DETAILS OF AILMENT DIAGNOSED (PRIMARY)

ICD 10 Codes	Description	ICD 10 Codes	Description
i. Primary Diagnosis: <input type="text"/>	<input type="text"/>	i. Procedure 1: <input type="text"/>	<input type="text"/>
ii. Additional Diagnosis: <input type="text"/>	<input type="text"/>	ii. Procedure 2: <input type="text"/>	<input type="text"/>
iii. Co-morbidities: <input type="text"/>	<input type="text"/>	iii. Procedure 3: <input type="text"/>	<input type="text"/>
iv. Co-morbidities: <input type="text"/>	<input type="text"/>	iv. Details of Procedure: <input type="text"/>	<input type="text"/>

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: _____

D. 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 _____		

E. 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: _____

F. 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: _____