



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:

Form fields for Primary Insured details: a) Policy No., b) SI. No./ Certificate No., c) Company/ TPA ID No., d) Name, e) Address, City, State, Pin Code, Phone No., Email ID.

DETAILS OF INSURANCE HISTORY:

Form fields for Insurance History: a) Currently covered by any other Medclaim / Health Insurance, b) If yes, company name, c) Date of commencement of first Insurance without break, d) Have you been hospitalized in the last 4 years?, e) Have you been covered by any other Medclaim / Health Insurance in last 4 years?

DETAILS OF INSURED PERSON HOSPITALIZED:

Form fields for Insured Person Hospitalized: a) Name, b) Gender, c) Age, d) Date of Birth, e) Relationship to Primary insured, f) Occupation, Address, City, State, Pin Code, Phone No., Email ID.

DETAILS OF HOSPITALIZATION:

Form fields for Hospitalization: a) Name of Hospital where Admitted, b) Room Category occupied, c) Hospitalization due to, 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) Injunctive cause, j) Reported to police, k) Claim Intimated, l) Intimation No. & date.

DETAILS OF CLAIM:

Form fields for Details of Claim: a) Details of the treatment expenses claimed (Pre-hospitalization, Post-hospitalization, Ambulance, Surgical, Convalescence), b) Claim for Domiciliary Hospitalization, c) Details of Lump sum / cash benefit claimed, d) Claim Documents Submitted - Check List.

DETAILS OF BILLS ENCLOSED:

Table with 6 columns: Sl No., Bill No., Date, Issued By, Towards (Hospitalization / Pre-hospitalization / Post-Hospitalization), Amount (Rs).

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)

Form fields for Bank Account: 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.

Date: [DD][MM][YY] 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: \_\_\_\_\_ Gravidity 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: \_\_\_\_\_