FORM 2: CLAIM FORM

IFFCO TOKIO GENERAL INSURANCE COMPANY LIMITED



| | CLAI | | | RE LILLED IN BY | INSURED | | | NSURANCE | | |
|-------------------------------|------------------|----------------------------------|------------|---------------------------------------|--------------|--------------------------|-----------|----------|--|--|
| | | IN | _ | E DETAILS | | - / | duskura | 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 | lle | 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 | 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 | | ation? | | Y/N (If Y, provide details in annexur | | | | | | |
| | | | _ | BILLING DETAILS | | | | | | |
| Pre-hospitalisation Expe | nses | Rs. | Hospita | alisation Expenses | R | ls. | | | | |
| Post-hospitalisation Expenses | | Rs. | | Health-Check up Cost | | Rs. | | | | |
| Ambulance Charges | | Rs. | _ | Others | | Rs. | | | | |
| Details of Lumpsum / ca | sh benefit clai | med: | | | <u> </u> | | | | | |
| Hospital Daily Cash | | Surgical Cash | | | C | Critical Illness benefit | | | | |
| Convalescence: | | Pre / Post hosp lumpsum benefit: | | | | Others | | | | |
| Details of bills enclosed | (attach separa | | | | | | | | | |
| SI. | Bill No | Date | 1 | Issued By | | Towards | A | mount | | |
| | | | | , | | | 1 | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | D | etails of Claim D | ocument | ts submitted - CHE | CK LIST | | | | | |
| Claim Form Duly signed | | T Y | N | Pre-hosp Bills: | Nos | | Υ | l N | | |
| Copy of the claim intima | | Y | l N | Post-hosp Bills: | Nos | | Y | N | | |
| Hospital Discharge Summary | | Y | l N | | | | Y | N | | |
| Operation Theatre Notes | | Y | | N Doctor request for investigat | | 1 | Y | N | | |
| Hospital Main Bill | | Y | N | ' | | · | 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 of Teachpholia | | ' | 14 | nary outer, please s | poony | | ' | 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 | | | | | | | | | |
|--|--|--------------------|-------------------------|--|---------------------|--|--|--|--|--|
| Name of the Hospital Network Non Network N | | | | | | | | | | |
| 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 | | | | | | | | |
| Address of the Hospital with Pin Code Registration no. Registration no. | | | | | | | | | | |
| Registration no. Number of Inpatient beds Number of Inpatient Admitted Name of the patient IP Registration Number Sender Name of the patient Age Name of Horizonta Number Name of Admission Nate of Discharge Name of | · | 20.011 40.41.0 | | | | | | | | |
| Aumber of Inpatient beds PAN | Address of the Hospital with Pin Code | | | | | | | | | |
| Other Facilities available in the hospital OT Y/N Others CU Y/N Others Details of the patient admitted Name of the patient Page Primary Primary Additional Co-Details of Procedure/s CD 10 PCS Code Primary Additional Co-Details of Procedure/s Type of Admission Procedure/s Type of Admission Procedure/s Nas it self inflicted? Y/N Whether RTA Y/N Primary MultC / FIR No. If MLC not notified, give reasons Nas the Injury/ disease caused due to Substance abuse / Alcohol consumption Y/N spresent allment a complication of Pre-existing disease Y/N for spression by the pre-authorisation obtained - Y/N Registration No Qualification Procedure/s Procedu | Telephone No | | | Registration no. | | | | | | |
| CU Y/N Others Details of the patient admitted Name of the patient Gender | Number of Inpatient beds | | | PAN | | | | | | |
| Details of the patient admitted Name of the patient Sender Age Age Age Age Age Aliment Diagnosed (Primary) CD 10-CM Code CD 40 Primary Additional Co-Details of Procedure/s CD 10 PCS Code Proc 1 Proc 2 Planned Day-care Maternity Date of Admission Emergency Planned Day-care Maternity Date of delivery if Maternity As it self inflicted? Y/N MLC , notified to police? Was the Injury/ disease caused due to Substance abuse / Alcohol consumption Y/N Y/N Spresent ailment a complication of Pre-existing disease Y/N Y/N Spreserit ailment a complication obtained - Y/N Authority details Whether Pre-authorisation by network hospital not obtained, reason? Name of Treating Doctor Authority Signer Authorisation by network hospital not obtained, reason? Name of Treating Doctor Authority Signer Authorisation Reports Investigation Reports (Including CT / MRI / USG / HPE) Copy of the pre-authorisation approval letter Doctor's Reference Slip for investigation Holds Report Spolice FIR Doctor's Reference Slip for investigation Holds Report Spolice FIR Any other, please specify | Other Facilities available in the hospita | | | ОТ | Y/N | | | | | |
| Name of the patient Age Date of Admission Time of Admission Time of Admission Date of Admission Time of Discharge Time of Discharge Time of Discharge Details of Procedure/s CD 10-CM Code Primary Additional Co-Details of Procedure/s CD 10 PCS Code Proc 1 Proc 2 Proc 3 Type of Admission Emergency Planned Day-care Maternity Date of delivery if Maternity Gravida Status Als Is the treatment for an injury? If, Y, details. Was it self inflicted? Y/N Whether RTA Y/N MLC / FIR No. If MLC, notified to police? Y/N MLC / FIR No. If MLC not notified, give reasons Was the Injury disease caused due to Substance abuse / Alcohol consumption Y/N spresent ailment a complication of Pre-existing disease Y/N If Y, whether any test was conducted to establish this? If Y, please attach Report Y/N spresent ailment a complication of Pre-existing disease Y/N If Y, specify details Whether Pre-authorisation obtained - Y/N If Y, pre Auth Number If authorisation by network hospital not obtained, reason? Warme of Treating Doctor Registration No Qualification Dualification Dualification Pre-authorisation request Investigation Reports Investigation Reports Driginal Pre-authorisation approval letter Doctor's Reference Slip for investigation Reports Copy of the preauthorisation approval letter Doctor's Reference Slip for investigation Copyration Theatre Notes Pharmacy Bills Hospital Break-up Bill Any other, please specify | ICU | Y/N | | Others | | | | | | |
| Age Date of Admission Time of Admission Date of Discharge Date of Date o | Details of the patient admitted | | | | | | | | | |
| Date of Admission Date of Discharge Time of Discharge | Name of the patient | | | IP Registration Number | | | | | | |
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| CD 10-CM Code Primary Additional Co- Details of Procedure/s CD 10 PCS Code Proc 1 Proc 2 Proc 3 Type of Admission Emergency Planned Day-care Maternity Date of delivery if Maternity Gravida Status 3. Is the treatment for an injury? If, Y, details. Was it self inflicted? Y/N Whether RTA Y/N MLC, notified to police? Y/N MLC / FIR No. If MLC not notified, give reasons Was the Injury/ disease caused due to Substance abuse / Alcohol consumption Y/N If Y, whether any test was conducted to establish this? If Y, please attach Report Y/N If Y, specify details Whether Pre-authorisation obtained - Y/N If Y, Pre Auth Number If authorisation by network hospital not obtained, reason? Name of Treating Doctor Registration No Wobile No Qualification 13. Claim Documents submitted (CHECK LIST) Claim Form Duly signed Investigation Reports Original Pre-authorisation approval letter Doctor's Reference Slip for investigation Topy of the preauthorisation approval letter Doctor's Reference Slip for investigation Doctor's Reference Slip for investigation Hospital Discharge Summary Deparation Theatre Notes Pharmacy Bills MLC Report & Police FIR Any other, please specify | Date of Discharge | | | Time of Discharge | | | | | | |
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| CD 10 PCS Code | ICD 10-CM Code | Primary | | Additional | Co- | | | | | |
| Emergency Planned Day-care Maternity Date of delivery if Maternity Gravida Status Gravi | Details of Procedure/s | | | | • | | | | | |
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| 8. Is the treatment for an injury? If, Y, details. Was it self inflicted? Y/N Whether RTA Y/N f MLC, notified to police? Y/N MLC / FIR No. f MLC not notified, give reasons Was the Injury/ disease caused due to Substance abuse / Alcohol consumption Y/N f Y, whether any test was conducted to establish this? If Y, please attach Report Y/N s present ailment a complication of Pre-existing disease Y/N f Y, specify details Whether Pre-authorisation obtained - Y/N If Y, Pre Auth Number f authorisation by network hospital not obtained, reason? Name of Treating Doctor Registration No Wobile No Qualification 13. Claim Documents submitted (CHECK LIST) Claim Form Duly signed Investigation Reports Original Pre-authorisation request Investigation Reports (Including CT / MRI / USG / HPE) Copy of the preauthorisation approval letter Doctor's Reference Slip for investigation Hospital Discharge Summary ECG Operation Theatre Notes Pharmacy Bills Hospital Break-up Bill Any other, please specify | Type of Admission | | | Planned | Day-care Maternit | | | | | |
| Was it self inflicted? Y/N MLC / FIR No. MLC / F | Date of delivery if Maternity | | | Gravida Status | | | | | | |
| Was it self inflicted? Y/N MLC / FIR No. MLC / F | 8. Is the treatment for an injury? If, Y, | details. | | • | | | | | | |
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| f Y, specify details Whether Pre-authorisation obtained - Y/N | If Y, whether any test was conducted to | establish this? If | e attach Report | Y/N | | | | | | |
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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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