HDFC ERGO General Insurance Company Limited



Claim Form

HDFC ERGO Group Health Insurance

CLAIM FORM – PART A TO BE FILLED IN BY THE INSURED

Issuance of this form is not a proof of admissibility of liability

SECTION A - DETAILS (F OF PRIMARY INSURED				
Policy Number	SI No/Certificate No.:				
Company/ TPA ID No.:	2				
Name Address					
Address City	State				
Pin Code Phone		Mobile Mobile			
Email ID		INIOUILE			
	OF INSURANCE HISTORY				
a) Currently covered by any other mediclaim health insurance	Yes No				
b) Date of commencement of first insurance without break	D D M M Y Y Y Y				
c) If Yes, Company Name					
Policy No.					
Sum Insured					
d) Have you been hospitalized in the last four years since inception of the contract	Yes No DDMMY	YYYY			
Diagnosis e) Previously covered by any other Mediclaim/Health insurance	Yes No				
f) If yes, Company Name					
	URED PERSON HOSPITALISED				
a) Name	UNED PERSON HOSPITALISED				
a) Relationship(Self/spouse/Child/Father/Mother/Other)	c) Date of Birth	d) Age Mths/yrs			
e) Address (If different than above)					
f) Gender Male Female	g) Occupation	Service/Self-employed/Homemaker/student/ Retired/ Others			
h) Telephone No	i) Mobile No	i) Mobile No			
j) E-mail ID, if any					
SECTION D - DETAILS	OF HOSPITALISATION				
a) Name of the Hospital where admitted					
b) Room Category occupied	Daycare/Single Occupancy/Twin Sharing/	3 or more beds per room			
c) Hospitalization due to	Illness / Injury/ Maternity				
d) Date of Injury/ Date of disease first detected/ Date of delivery e) Date of admission	DD/MM/YYYY				
e) Date of admission f) Time	DD/MM/YYYY HH/MM				
g) Date of discharge	DD/MM/YYYY				
h) Time	HH/MM				
i) If injury, give cause	Self-Inflicted/Road Traffic Accident/ Substa	ance Abuse/ Alcohol Consumption			
i) If Medico legal Yes No	ii) Reported to police?	Yes No			
iii) MLC Report, & Police FIR attached?	j) System of medicine	Allopathic/Other systems of medicine			
SECTION E - DI	TAILS OF CLAIM				
A.Claim under Hospitalization Cover					
i) In-Patient Hospitalization Yes No	ii) Pre-hospitalization Expenses	No			
iii) Post-hospitalization Expenses	iv) Day Care Procedures Yes	No			
v) Domiciliary Hospitalization Yes No (if yes, please provide details in annexure)	vi) Road Ambulance Cover Yes	No			
vii) Organ Donor					
Please tick the applicable Optional Cover claimed under Hospitalization Cover:					
i) Hospital Cash Yes No	< <please details="" provide="">></please>				
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ii) Preventive Health Che	ck Up	Yes	No		<	<please details="" provide="">></please>		
iii) Restore Benefit Yes No			< <please details="" provide="">></please>					
iv) Alternative Treatment	Alternative Treatment Yes No		< <please details="" provide="">></please>					
v) Second Medical Opinio) Second Medical Opinion Yes No		< <ple><<ple>ease provide details>></ple></ple>					
vi) Double Restore Benef	vi) Double Restore Benefit Yes No		< <please details="" provide="">></please>					
vii) Maternity Expenses	<u>' </u>		<please details="" provide="">></please>					
viii) Pre and Post Natal Expenses Yes No			<	<please details="" provide="">></please>				
ix) Infertility Cover		Yes	No			<please details="" provide="">></please>		
x) Accidental Death		Yes	□ No		<	<please details="" provide="">></please>		
xi) Permanent Disableme	ent -	Yes				<please details="" provide="">></please>		
xii) OPD Cover		Yes				<please details="" provide="">></please>		
xii) Double Sum Insured	for Critical Illness	Yes				<- Please provide details>>		
xiii) Critical Illness (Benef		Yes				<please details="" provide="">></please>		
Claim Documents Sub				Naim		t list of additional docum	onto for Heavital Ca	ah alaima
Duly filled and signe	1	nospii		intimation letter, if any			•	rtificate along with time of
Duly lilled and signe	ed Claim i Oim		Сору от	intimation letter, if any	ad	mission and discharge f	or Hospital cash be	enefit
Hospital Main Bill			Hospital	bill break up		st consultation letter from		
☐ Hospital Bill Payme	nt Receipt		Hospital	Discharge summary		rtificate from treating Mo iology	edical Practitioner,	specifying the duration and
Pharmacy Bill			Operatio	n theatre notes			egarding abuse of	Alcohol/intoxicating agent if
Investigation / diagr			Doctors	request for investigations	ар	olicable		
ECG	ent receipt		Prescript	tions				
Copy of the Networ				R copy of applicable				
KYC Documents	ale		implant s	stickers for all implants				
Tro Boodinonto				ing surgeries				
				SECTION F - DETAILS	OF BILL	S ENCLOSED		
Sr.no. Bill No.	Date			SECTION F - DETAILS Issued By	OF BILI	S ENCLOSED Towards		Amount (Rs)
Sr.no. Bill No.	Date	Υ	YY		OF BILI			Amount (Rs)
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CLAIM FORM - PART B 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 pre-authorization request form in lieu of PART A

SECTION A - DETAILS OF HOSPITAL					
Name of the Hospital where treated		Hospital ID			
Type of Hospital Network Non Network (If non network fill section E		H	ospital ID		
Name of the treating Doctor					
Qualification Qualification		Registration No with state Code			
Phone		Tregress assert to this state doub			
riole	SECTION B. DETAILS	OF DATIENT ADMITTED			
a) Name of the nationt	SECTION B - DETAILS	b) IP Registration Number			
a) Name of the patient c) Gender	Male Female	d) Age	YY/MM		
e) Date of Birth		47.95	1777		
f) Date of Admission		g) Time of Admission	HH/MM		
h) Date of Discharge	DDMMYYYYY	i) Time of Discharge	HH/MM		
j) Type of Admission	Emergency/Planned/Daycare/Maternity	k) If Maternity			
i) Date of Delivery		ii) Gravida Status			
I) Status at time of discharge	Discharged to Home Discharged to another Hospital Deceased	Total Claimed Amount			
	SECTION C - DETAILS OF AILN	IENTS DIAGNOSED (PRIMARY)			
a) ICD 10 Codes	Primary Diagnosis	Additional Diagnosis	Co-morbidities		
Details of Procedure/s done					
b) ICD 10 PCS	Procedure 1	Procedure 2	Procedure 3		
i) Pre-authorization obtained	Yes No	ii) Pre-authorization No			
c) If authorization by network hospital not obtained	d, give reason				
f) Hospitalisation due to Injury	Yes No	i) If yes, give cause			
Self inflicted?	Yes No Road Traffic Accident	Yes No Substance Abuse /Alco	phol Consumption Yes No		
ii) If Injury due to Substance abuse / alcohol consu	umption, Test Conducted to establish this:	Yes No iii) Medico Legal	Yes No		
iv) Reported to Police	Yes No	v) FIR No			
vi) If not reported to Police give reasons					
	SECTION D - CLAIM DOCUME	NTS SUBMITTED - CHECKLIST			
Claim form duly filled and signed		☐ Investigation reports			
Pre authorization Request		CT/MRI/USG/HPE investigation Report			
Copy of Pre-authorization approval L		Doctor's reference slip for Investigation			
Copy of photo ID card of patient veril	fled by Hospital	☐ ECG			
Hospital Discharge Summary Operation Theatre Notes		☐ Pharmacy Bills ☐ MLC Report & Police FIR			
Hospital Main Bill		Death summary from hospital where applicable			
Hospital break up Bill		Any other, PI specify			
SECTION E - DETAILS IN CASE OF NON NETWORK HOSPITAL					
a) Address of the Hospital		b) Phone No:			
c) Registration no with State Code		d) Hospital PAN			
e) No of In-patient Beds		f) Facilities available in Hospital			
i) OT	Yes No	ii) ICU	Yes No		
iii) Others					
SECTION F - DECLARATION BY HOSPITAL 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					
Date: DDMMYYYYY	Place:		Signature of Insured		

LIST OF ENCLOSURES FOR SUBMISSION OF CLAIM

Note:

- When original bills, receipts, prescriptions, reports and other documents are submitted to the other insurer or to the reimbursement provider, verified photocopies attested by such other 1. organization/provider have to be submitted.
- If original bills, receipts, prescriptions, reports and other documents are submitted to Us and Insured Person requires same for claiming from other organization/provider, then on request from the Insured Person We will provide attested copies of the bills and other documents submitted by the Insured Person.

 If below mentioned documents are not provided in full or are insufficient for Us to consider the claim, then We may request additional information or documentation.
- 3.

coverments approved Photo ID & Age Proof	Government approved Photo ID & Age Proof Copy of the Hospital's Registration Certificate/Hospital Registration number in the absence of main claim documents Copy of the Hospital's Registration Certificate/Hospital Registration number in case of hospitalization in any non network hospital of HDFC ERGO Health Insurance Limited or certificate from hospital authorities providing facilities available including number of beds. Discharge Card / Day Care Summary / Transfer Summary Final hospital bill with all deposits and final payment receipt and refund receipt(s), if advance amount refunded invoice with payment receipt and implant stickers for all implants used during surgeries e.g. lens sticker and invoice in cataract Surgery, stent invoice and sticker in Angioplasity Surgery. All previous consultation papers indicating history and treatment details for current Illness and advice for current history and treatment details for current Illness and advice for current history and invoice reports (including imaging and laboratory) along with prescription by Medical Practitioner and invoice / bill with receipt from diagnostic centre All medicine / pharmacy bills along with prescription by Medical Practitioner and invoice / bill with receipt from diagnostic centre History of alcohol consumption or any intoxication certified by first treating doctor in case of accidental cases. Copy of Death Summary and copy of Death Certificate (in death claims only) Pre and Post-Operative Imaging reports Copy of Indocrocase papers with nursing sheet detailing medical history of the patient, treatment details, and patient's progress (to be submitted wherever required by the insurer). Invoice for Vaccination and apyment receipt; Invoice for Vaccination and apyment receipt amen, photograph of the Proposer. Invoice for Vaccination and apyment receipt and proposer, the same document requirement would be for nominee/legal heir of proposer (NOC in favour of 1 or more than 1 undisputedly selected legal heir(s) by remaining legal heir(
Copy of dain inflantation lateral reference of Callam Inflantation Number in the absence of main dain documents	Copy of claim intimation letter / reference of Claim Intimation Number in the absence of main claim documents Copy of the Hospital's Registration Certificate/Hospital Registration number in case of hospital/cation in any non network hospital of HDFC ERGO Health insurance Limited or certificate from hospital authorities providing facilities available including number of beds. Discharge Card / Day Care Summary / Transfer Summary Final hospital bill with all deposit and final payment receipt and refund receipt(s), if advance amount refunded invoice in cataract Surgery, stent invoice and sticker in Angioplasty Surgery. All previous consultation papers indicating history and treatment details for current Illness and advice for current hospitalization. All diagnostic reports (including imaging and laboratory) along with prescription by Medical Practitioner and invoice / bill with receipt from diagnostic centre All medicine / pharmacy bills along with prescription by Medical Practitioner and invoice / bill with receipt from diagnostic centre All medicine / pharmacy bills along with prescription by Medical Practitioner and invoice / bill with receipt from diagnostic centre All previous consultation and payment receipt with receipt from diagnostic eventre in the patient of the						
copy of the Hospital's Registration Certificate/Hospital Registration number in case of hospitalization in any non network inspital of Hospital Endocre 2018 of the Institute of the American Management (and the Institute of the Institute of Books) and the Institute of the Institute of Books and I	□ Copy of the Haspital's Registration Certificate/Hospital Registration number in case of hospital altaholities available including number of bads. Including number of bads. Discharge Card / Day Care Summary / Transfer Summary Final hospital bill with all deposit and final payment receipt and refund receipt(s), if advance amount refunded						
Inspect of HDFC ERIOD Fleath Insurance Limited or certificate from hospital authorities providing facilities available including number of bedies.	hospital of HDFC ERGO Health Insurance Limited or certificate from hospital authorities providing facilities available including number of beds.						
Finit hospital bill with all deposit and final payment receipt and implant stickers for all implants sused during surgeries e.g. lens sticker and invoice in casted with review and sticker in Angiopalssy' Surgery.	Final hospital bill with all deposit and final payment receipt and refund receipt(s), if advance amount refunded Invoice with payment receipt and implant stickers for all implants used during surgeries e.g. lens sticker and invoice in cataract Surgery, stent invoice and sticker in Anjoplasty Surgery. All previous consultation papers indicating history and treatment details for current Illness and advice for current hospitalization. All diagnostic reports (including imaging and laboratory) along with prescription by Medical Practitioner and invoice / bill with receipt from diagnostic centre All medicine / pharmacy bills along with prescription by Medical Practitioner MLC / Fir Copy – in Accidental cases only History of alcohol consumption or any intoxication certified by first treating doctor in case of accidental cases. Copy of Death Summary and copy of Death Certificate (in death claims only) Pre and Post-Operative Imaging reports Copy of Indoor case papers with nursing sheet detailing medical history of the patient, treatment details, and patient's progress (to be submitted wherever required by the insurer). Invoice for Vaccination and payment receipt KYC documents (in all claims above Rs 1 lakh) - (Ration Card/ Driving License/ Aadhar Card/ Passport /any other Government authorized identity proof of the Proposer carrying name, photograph & address) and duly filled KYC form with 1 signed across passport size coloured photograph of the Proposer. With Common other insurer. Duly filled NEFT form with cancelled blank cheque (with IFSC code, A/C number, and name mentioned on cheque leaf) Settlement lister(s) copy; (sies) of payment receipts, and entire certified copy of paid claims in case of partial claims este of partial claims and signed Claim Form. Photocopy of ID card / Photocopy of current year policy. Duly filled Discharge Summary with date of admission & discharge, clinical history, past history / procedure details/ Day care summary from the hospital. Inspirate Consolida						
motion with payment receipt and implant sickers for all implants used during surgeries e.g. lens sticker and invoice in cataract Surgery, stent invoice and sciker in Angolipasis Surgery. All previous consultation papers indicating history and treatment details for current liness and advice for current hospitalization. All diagnostic reports (including imaging and laboratory) along with preceipt from diagnostic centre All medicine / pharmacy bills along with prescription by Medical Practisioner All medicine / pharmacy bills along with prescription by Medical Practisioner MLC / Fir Copy - in Accidental cases only History of alcohol consumption or any intoxication certified by first treating doctor in case of accidental cases. Copy of Death Summary and copy of Death Certificate (in death claims only) Pra and Post-Operative imaging reports Copy of Indox Summary and copy of Death Certificate (in death claims only) Pra and Post-Operative imaging reports Copy of Indox Certificate (in death claims only) Pra and Post-Operative imaging reports Copy of Indox Certificate (in death claims only) Pra and Post-Operative imaging reports Copy of Indox Certificate (in death claims only) Pra and Post-Operative imaging reports Copy of Indox Certificate (in death claims only) Pra and Post-Operative imaging reports Copy of Indox Certificate (in death claims only) Pra and Post-Operative imaging reports Copy of Indox Certificate (in death claims only) Pra and Post-Operative imaging reports Copy of Indox Certificate (in death claims only) Pra and Post-Operative imaging reports Copy of Indox Certificate (in death claims only) Copy of Indox Certificate (in death claims on the certificate (in control on the indox on the certificate (in the certificate	Invoice with payment receipt and implant stickers for all implants used during surgeries e.g. lens sticker and invoice in cataract Surgery, stent invoice and sticker in Angioplasty Surgery.						
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Consultation documents and bills, payment receipt with prescription.							
Copy of the discharge Summary of the main claim.(except for out patient dental claim)	Copy of the Discharge Summary of the main claim.(except for out patient dental claim)						

	Organ Donation/Transplantation					
	In addition to the documents of general hospitalization.					
	Organ Function test / blood test proving organ failure.					
	Treatment Certificate issued by the Transplant Surgeon of the hospital concerned.					
	Ambular	ice Benefit				
	Duly filled and signed Claim Form.					
	Photocopy of ID card / Photocopy of current year policy.					
	□ Bills with Payment Receipt.					
Ш	Treating Doctor's consultation prescription indicating Emergency Hospitalization					
	Hospital Cash Benefit					
	Duly filled and signed Claim Form.					
lП	Discharge card / day care summary / transfer summary					
	Final Hospital Bill					
	Previous consultation papers indicating history and treatment details for current a	ailment.				
	Diagnostic test reports (including imaging and laboratory) along with the Medical					
	receipt from the diagnostic centre.					
	MLC / FIR copy – in Accidental cases only					
	Death summary & death certificate (in death claims only)					
	Preventive H	ealth Check up				
	Duly filled and signed Claim Form.					
	Health check up test reports					
	Bill and receipt from the diagnostic centre.					
	For Dea	nth Cases				
	In addition to the In-patient Treatment documents:					
Ιп	Death Summary from the hospital.					
	Copy of the Death certificate from treating doctor or the hospital authority.					
IH	Copy of the Legal heir certificate, if the claim is for the death of the principle insured.					
IH	Bank Account Details of nominee/legal heir with a copy of cancelled cheque					
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1 (Customer Identification Procedure (as per KYC norms of IRDAI)					
	Customer Identification Procedure (as per KYC norms of IRDAI)					
	Customer Identification Procedure (as per KYC norms of IRDAI) Please submit the following documents in case of claim amount exceeds Rs. 100,000					
F	, . , , , , , , , , , , , , , , , , , ,	Passport/ PAN Card/ Voter's Identity Card/ Driving License/ Letter from a recognized public authority or public servant verifying the identity and residence of the customer				