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 OF OF PRIMARY INSURED

Policy Number

Company/ TPA ID No.:

SI No/Certificate No.:

Name

Address

City

State

Pin Code

Phone

Mobile

Email ID

SECTION B - DETAILS 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 D D M M Y Y Y Y
Diagnosis	
e) Previously covered by any other Mediclaim/Health insurance	☐ Yes ☐ No
f) If yes, Company Name	

SECTION C - DETAILS OF INSURED PERSON HOSPITALISED

a) Name			
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	
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	DD/MM/YYYY		
e) Date of admission	DD/MM/YYYY		
f) Time	HH/MM		
g) Date of discharge	DD/MM/YYYY		
h) Time	HH/MM		
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	Allopathic/Other systems of medicine

SECTION E - DETAILS OF CLAIM

A.Claim under Hospitalization Cover			
i) In-Patient Hospitalization	☐ Yes ☐ No	ii) Pre-hospitalization Expenses	☐ Yes ☐ No
iii) Post-hospitalization Expenses	☐ Yes ☐ No	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	☐ Yes ☐ No		
Please tick the applicable Optional Cover claimed under Hospitalization Cover:			
i) Hospital Cash	☐ Yes ☐ No	<<Please provide details>>	

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ii) Preventive Health Check Up	☐ Yes ☐ No	<<Please provide details>>
iii) Restore Benefit	☐ Yes ☐ No	<<Please provide details>>
iv) Alternative Treatment	☐ Yes ☐ No	<<Please provide details>>
v) Second Medical Opinion	☐ Yes ☐ No	<<Please provide details>>
vi) Double Restore Benefit	☐ Yes ☐ No	<<Please provide details>>
vii) Maternity Expenses	☐ Yes ☐ No	<<Please provide details>>
viii) Pre and Post Natal Expenses	☐ Yes ☐ No	<<Please provide details>>
ix) Infertility Cover	☐ Yes ☐ No	<<Please provide details>>
x) Accidental Death	☐ Yes ☐ No	<<Please provide details>>
xi) Permanent Disablement	☐ Yes ☐ No	<<Please provide details>>
xii) OPD Cover	☐ Yes ☐ No	<<Please provide details>>
xii) Double Sum Insured for Critical Illness	☐ Yes ☐ No	<<Please provide details>>
xiii) Critical Illness (Benefit Based)	☐ Yes ☐ No	<<Please provide details>>

Claim Documents Submitted Check List: Hospitalization Claim		**Check list of additional documents for Hospital Cash claims**
☐ Duly filled and signed Claim Form	☐ Copy of intimation letter, if any	☐ Copy of Discharge Summary / Discharge Certificate along with time of admission and discharge for Hospital cash benefit
☐ Hospital Main Bill	☐ Hospital bill break up	☐ First consultation letter from treating Medical Practitioner
☐ Hospital Bill Payment Receipt	☐ Hospital Discharge summary	☐ Certificate from treating Medical Practitioner, specifying the duration and aetiology
☐ Pharmacy Bill	☐ Operation theatre notes	☐ MLC/FIR copy/ certificate regarding abuse of Alcohol/intoxicating agent if applicable
☐ Investigation / diagnostic Reports with bills and payment receipt	☐ Doctors request for investigations	
☐ ECG	☐ Prescriptions	
☐ Copy of the Network Provider's Registration Certificate	☐ MLC/FIR copy of applicable	
☐ KYC Documents	☐ implant stickers for all implants used during surgeries	

SECTION F - DETAILS OF BILLS ENCLOSED

Sr.no.	Bill No.	Date	Issued By	Towards	Amount (Rs)
		D D M M Y Y Y Y			

SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

a) PAN	b) Account Number
c) Bank Name/ Branch	d) Payable details: Cheque/ DD
e) IFSC Code	e) *please attach a cancelled cheque pertaining to the same
f) MICR No	*please attach a cancelled cheque pertaining to the same

Note:
It is agreed that the Policyholder/Claimant will intimate in writing to HDFC ERGO General Insurance Co. Ltd. about any change in bank account details.
In an event Insured person bears expenses for treatment please provide account details of Insured Persons in the above format along with proof of incurring such expenses..

SECTION H - 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: D D M M Y Y Y Y

Place:_____

Signature of Insured

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)

Name of the treating Doctor

Qualification | Registration No with state Code

Phone

SECTION B - DETAILS OF PATIENT ADMITTED

a) Name of the patient		b) IP Registration Number	
c) Gender	☐ Male ☐ Female	d) Age	YY/MM
e) Date of Birth	D D M M Y Y Y Y		
f) Date of Admission	D D M M Y Y Y Y	g) Time of Admission	HH/MM
h) Date of Discharge	D D M M Y Y Y Y	i) Time of Discharge	HH/MM
j) Type of Admission	Emergency/Planned/Daycare/Maternity	k) If Maternity	
i) Date of Delivery	D D M M Y Y Y Y	ii) Gravida Status	
l) Status at time of discharge	Discharged to Home Discharged to another Hospital Deceased	Total Claimed Amount	

SECTION C - DETAILS OF AILMENTS 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, 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 /Alcohol Consumption	☐ Yes ☐ No	
ii) If Injury due to Substance abuse / alcohol consumption, Test Conducted to establish this:			☐ Yes ☐ No (If yes, attach reports)	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 DOCUMENTS SUBMITTED - CHECKLIST

☐ Claim form duly filled and signed	☐ Investigation reports
☐ Pre authorization Request	☐ CT/MRI/USG/HPE investigation Report
☐ Copy of Pre-authorization approval Letter	☐ Doctor's reference slip for Investigation
☐ Copy of photo ID card of patient verified by Hospital	☐ ECG
☐ Hospital Discharge Summary	☐ Pharmacy Bills
☐ Operation Theatre Notes	☐ MLC Report & Police FIR
☐ Hospital Main Bill	☐ Death summary from hospital where applicable
☐ Hospital break up Bill	☐ Any other, Pl 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: D D M M Y Y Y Y

Place:_____

Signature of Insured

LIST OF ENCLOSURES FOR SUBMISSION OF CLAIM

Note:

1. 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 organization/provider have to be submitted.
2. 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.
3. 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.

List of Documents for Reimbursement Claims:	
☐	Completely filled claim form, duly signed (by claimant/proposer) and stamped (by hospital).
☐	Government approved Photo ID & Age Proof
☐	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 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 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 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
☐	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. ***
☐	Duly filled NEFT form with cancelled blank cheque (with IFSC code, A/C number, and name mentioned on cheque leaf)
☐	Settlement letter(s), copy(-ies) of payment receipts, and entire certified copy of paid claims in case of partial claim settlement from other insurer.

*** In case of death of 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(s).

In-patient Treatment /Day Care Procedures	
☐	Duly filled and signed Claim Form.
☐	Photocopy of ID card / Photocopy of current year policy.
☐	Detailed Discharge Summary with date of admission & discharge, clinical history, past history / procedure details/ Day care summary from the hospital.
☐	Consolidated hospital bill with break up of each Item, duly signed by the insured.
☐	Payment Receipt of the hospital bill.
☐	First Consultation letter and subsequent Prescriptions.
☐	Bills, payment receipts and Reports for investigation.
☐	Medicine bills and receipts with corresponding Prescriptions.
☐	Invoice/Sticker of implants/bills for Implants (viz. Stent /PHS Mesh/ IOL etc.) with payment receipts

In-patient Treatment /Day Care Procedures	
	In addition to the In-patient Treatment documents:
☐	Copy of the First Information Report from Police Department / Copy of the Medico-Legal Certificate.
	In Non Medico legal cases
☐	Treating Doctor's Certificate giving details of injuries (How, when and where injury sustained)
	In Accidental Death cases
☐	Copy of Post Mortem Report & Death Certificate (If conducted)

Pre and Post-hospitalization	
☐	Duly filled and signed Claim Form.
☐	Photocopy of ID card / Photocopy of current year policy.
☐	Medicine bills, payment receipt with prescriptions.
☐	Investigations bills, payment receipt with prescriptions and report.
☐	Consultation documents and bills, payment receipt with prescription.
☐	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.

Ambulance Benefit	
☐	Duly filled and signed Claim Form.
☐	Photocopy of ID card / Photocopy of current year policy.
☐	Bills with Payment Receipt.
☐	Treating Doctor's consultation prescription indicating Emergency Hospitalization

Hospital Cash Benefit	
☐	Duly filled and signed Claim Form.
☐	Discharge card / day care summary / transfer summary
☐	Final Hospital Bill
☐	Previous consultation papers indicating history and treatment details for current ailment.
☐	Diagnostic test reports (including imaging and laboratory) along with the Medical prescription & copy of invoice / bill and receipt from the diagnostic centre.
☐	MLC / FIR copy – in Accidental cases only
☐	Death summary & death certificate (in death claims only)

Preventive Health Check up	
☐	Duly filled and signed Claim Form.
☐	Health check up test reports
☐	Bill and receipt from the diagnostic centre.

For Death Cases	
	In addition to the In-patient Treatment documents:
☐	Death Summary from the hospital.
☐	Copy of the Death certificate from treating doctor or the hospital authority.
☐	Copy of the Legal heir certificate, if the claim is for the death of the principle insured.
☐	Bank Account Details of nominee/legal heir with a copy of cancelled cheque

Customer Identification Procedure (as per KYC norms of IRDAI)	
Please submit the following documents in case of claim amount exceeds Rs. 100,000	
Legal name and any other names used (Any one of the mentioned documents)	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
Proof of Residence (Any one of the mentioned documents)	Telephone bill/ Bank account statement/ Letter from any recognized public authority/ Electricity bill/ Ration card