

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 preauthorisation 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																
Registration No with state Code											Phone No:					

SECTION B – DETAILS OF PATIENT ADMITTED

a) Name of the patient																									
b) IP Registration Number																c) Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female							
d) Date of Birth	D	D	M	M	Y	Y	Y	Y	e) Age	Y	Y	M	M												
f) Date of Admission	D	D	M	M	Y	Y	Y	Y	g) Time of Admission	H	H	M	M												
h) Date of Discharge	D	D	M	M	Y	Y	Y	Y	i) Time of Discharge	H	H	M	M												
j) Type of Admission	<input type="checkbox"/> Emergency <input type="checkbox"/> Planned <input type="checkbox"/> Daycare <input type="checkbox"/> Maternity																								
k) Status at time of discharge	<input type="checkbox"/> Discharged to Home <input type="checkbox"/> Discharged to another Hospital <input type="checkbox"/> Deceased										l) 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
a) Pre-authorization obtained	<input type="checkbox"/> Y <input type="checkbox"/> N	b) Pre-authorization No.	
f) If authorization by network hospital not obtained, give reason			
g) Hospitalisation due to Injury	<input type="checkbox"/> Y <input type="checkbox"/> N	l) If yes, give cause	
Self inflicted?	<input type="checkbox"/> Y <input type="checkbox"/> N	Road Traffic Accident	<input type="checkbox"/> Y <input type="checkbox"/> N Substance Abuse / Alcohol Consumption <input type="checkbox"/> Y <input type="checkbox"/> N
ii) If Injury due to Substance abuse / alcohol consumption, Test Conducted to establish this:	<input type="checkbox"/> Y <input type="checkbox"/> N (If yes, attach reports)		
iii) Medico Legal	<input type="checkbox"/> Y <input type="checkbox"/> N		
iv) Reported to Police	<input type="checkbox"/> Y <input type="checkbox"/> N		
v) FIR No			
vi) If not reported to Police give reasons			

SECTION D – CLAIM DOCUMENTS SUBMITTED – CHECKLIST

<input type="checkbox"/> Claim form duly filled and signed	<input type="checkbox"/> Investigation reports
<input type="checkbox"/> Original Pre authorization Request	<input type="checkbox"/> CT/MRI/USG/HPE investigation Report
<input type="checkbox"/> Copy of Pre-authorization approval Letter	<input type="checkbox"/> Doctor's reference slip for Investigation
<input type="checkbox"/> Copy of photo ID card of patient verified by Hospital	<input type="checkbox"/> ECG
<input type="checkbox"/> Hospital Discharge Summary	<input type="checkbox"/> Pharmacy Bills
<input type="checkbox"/> Operation Theatre Notes	<input type="checkbox"/> Original death summary from hospital where applicable
<input type="checkbox"/> Hospital Main Bill	<input type="checkbox"/> Any other, PI specify

SECTION E – DETAILS IN CASE OF NON NETWORK HOSPITAL

Address of the Hospital

 Phone No. Registration No. with State Code
 Hospital PAN No of In-patient Beds Facilities available in Hospital: OT ICU 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:
 Place: Signature and seal of the Hospital Authority

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.

In-patient Treatment /Day Care Procedures

- Duly filled and signed Claim Form.
- Photocopy of ID card / Photocopy of current year policy.
- Original Detailed Discharge Summary with date of admission & discharge, clinical history, past history / procedure details/ Day care summary from the hospital.
- Original consolidated hospital bill with breakup of each Item, duly signed by the insured.
- Original payment Receipt of the hospital bill.
- First Consultation letter and subsequent Prescriptions.
- Original bills, original payment receipts and Reports for investigation.
- Original medicine bills and receipts with corresponding Prescriptions.
- Original invoice/Sticker of implants/bills for Implants (viz. Stent /PHS Mesh/ IOL etc.) with original payment receipts.

Pre and Post-hospitalisation expenses

- Duly filled and signed Claim Form.
- Photocopy of ID card / Photocopy of current year policy.
- Original Medicine bills, original payment receipt with prescriptions.
- Original Investigations bills, original payment receipt with prescriptions and report.
- Original Consultation bills, original payment receipt with prescription.
- Copy of the Discharge Summary of the main claim.

Hospital Cash Benefit

- 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.
- Death summary & death certificate (in death claims only)

Outpatient Treatment Expenses

- All original consultation/diagnostic/pharmacy bills along with prescription by Medical Practitioner

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