HDFC ERGO General Insurance Company Limited



HDFC Group Health Insurance Claim Form

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

The issue of this Form is not to be taken as an admission of liability

SECTION A – DETAILS OF PRIMARY INSURED						
a) Policy No. b) Sl. No/ Certificate No: c) Company/ TPA ID No						
d) Name						
e)Address						
Phone No Email ID						
SECTION B- DETAILS OF INSURANCE HISTORY						
a) Currently covered by any other Medi Claim Health Insurance. Yes No b) Date of commencement of first insurance without break DD MM YYYYY						
c) If Yes, Company Name						
Policy No. Sum Insured Sum Insured						
d) Have you been hospitalized in the last four years since inception of the contract Yes No b) Date b) Date b) Date						
Diagnosis Diagnosis						
e) Previously covered by any other Medi Claim / Health Insurance Yes No						
f) If yes, Company Name						
SECTION C- DETAILS OF INSURED PERSON HOSPITALISED						
a) Name						
b) Relationship Self spouse Child Father Mother Other						
c) Date of Birth DD MM YYYY d) Age YY MM						
e) Address (If different than above)						
f) Gender Male Female Occupation: Service Self Employed Homemaker Student Retired Others						
h) Telephone 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 f) Time						
g) Date of discharge DD MMM YYYY N h) Time DD MMM						
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						
J/ System of medicine						
SECTION E DETAILS OF CLAIM						
SECTION E- DETAILS OF CLAIM						
a) Claim under Hospitalization Cover						
i) In-Patient Hospitalization YES NO iii) Pre-hospitalization Expenses YES NO iii) Post-hospitalization Expenses YES NO						
iv) Day Care Procedures YES NO v) Domiciliary Hospitalization YES NO vi) Road Ambulance Cover YES NO						
vii) Organ Donor YES NO						



b) Plea	b) Please tick the applicable Optional Cover claimed under Hospitalization Cover:									
i) Hosp	pital Cash		YE	ES 1	NO O	<please details="" provide=""></please>				
ii) Prev	entive Healtl	tive Health Check Up YES NO <pre></pre>								
iii) Resto	ore Benefit		YE	ES 1	NO	Please provide details>				
iv) Alternative Treatment YES NO <				ES	NO	<please details="" provide=""></please>				
	С	laim Docu	ments 9	Submitte	d Check	List: Hospitalization Claim	Check list of additional documents for Critical	cal Illness claims		
☐ Dul	ly filled and	signed Cla	im Forn	n		Copy of intimation letter,if any	☐ Medical certificate confirming the diagr	nosis of Critical Illness		
☐ Hospital Main Bill				☐ Hospital bill break up	☐ Certificate from attending Medical Practitioner confirming the duration of illness					
☐ Hospital Bill Payment Receipt				☐ Hospital Discharge summary	First consultation letter and subsequen	t prescriptions				
☐ Pha	armacy Bill					Operation theatre notes	☐ Indoor case papers if applicable			
	restigation / cayment recei		Reports	with bill	s and	Doctors request for investigations	☐ FIR copy or medico legal certificate(wh	nerever applicable)		
☐ EC	G					☐ Prescriptions	☐ Photo ID and Age proof			
	Copy of the Network Provider's Registration Certificate			on	☐ MLC/FIR copy of applicable	Death Summary with Death Certificate	(In death claims only)			
☐ KYC Documents				implant stickers for all implants used during surgeries	☐ Invoice for Vaccination and payment re	eceipt				
						SECTION – F DETAILS OF B	SILLS ENCLOSED			
S no	Bill No	Date				Issued By	Towards	Amount (Rs)		
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					SECT	ION – G DETAILS OF PRIMARY IN	NSUBED'S BANK ACCOUNT			
					SECT	ION – G DETAILS OF PRIMARY IN	NSURED'S BANK ACCOUNT			
a) PAN					SECT		NSURED'S BANK ACCOUNT			
a) PAN	Name/ Prop				SECT	DON - G DETAILS OF PRIMARY IN b) Account Number				
c) Bank	Name/ Brand	ch			SECT	b) Account Number	d) Payable details: Cheque	DD		
c) Bank e) IFSC	Code	ch			SECT		d) Payable details: Cheque	DD		
c) Bank	Code	ch			SECT	b) Account Number	d) Payable details: Cheque	DD		

HDFC ERGO General Insurance Company Limited. IRDAI Reg. No. 146. CIN: U66030MH2007PLC177117. Registered & Corporate Office: 6th Floor, Leela Business Park, Andheri-Kurla Road, Andheri (East), Mumbai – 400 059. Health Claim Services Address: HDFC ERGO General Insurance Co. Ltd. Stellar IT Park, Tower - 1, 5th Floor, C - 25, Noida, Sector 62, 201301, Uttar Pradesh. Service No. 022 6158 2020/022 6234 6234. Email: healthclaims@hdfcergo.com. UIN: HDFC Group Health Insurance - HDFHLGP21116V012021.

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: 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 PARTA SECTION A - DETAILS OF HOSPITAL a) Name of the Hospital where treate 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: SECTION B - DETAILS OF PATIENT ADMITTED a) Name of the patient b) IP Registration Number c) Gender d) Age e) Date of Birth h) Date of Discharge f) Date of Admission D i) Time of Discharge H H M M 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 I) Status at time of discharge

Discharged to Home

Discharged to another Hospital

Deceased **Total Claimed Amount** SECTION C - DETAILS OF AILMENTS DIAGNISED (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 j) Pre-authorization No YES NO f) If authorization by network hospital not obtained, give reason

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YES

YES

NO

NO

Road Traffic

Accident

i) If yes, give cause

YES

NO

Substance Abuse /Alcohol

Consumption

YES

NO

g) Hospitalisation due to Injury

Self inflicted?



(f) If lating the Collector of the Latin by										
ii) If Injury due to Substance abuse / alcohol consumption, Test Conducted to establish this:	YES NO (If yes, attach reports	iii) Medico Legal	YE	ES N	Ю				
iv) Reported to Police YES NO			v) FIR No							
vi) If not reported to Police give reasons				•		,				
SECTION D - C	LAIM DOCUMENT	S SUBMITTED -	CHECKLIS	Т						
	1.									
Claim form duly filled and signed		ivestigation reports	r r D							
Pre authorization Request Copy of Pre-authorization approval Letter		T/MRI/USG/HPE inves								
Copy of photo ID card of patient verified by Hospital		CG	or investigation	1						
Hospital Discharge Summary		harmacy Bills								
Operation Theatre Notes		ILC Report & Police FI	R							
Hospital Main Bill	D	eath summary from ho	spital where ap	plicable						
Hospital break up Bill	A	ny other, PI specify								
SECTION E – DE	TAILS IN CASE O	F NON NETWOR	K HOSPITA	\L						
Address of the Hospital										
b) Phone NO: c) Regis	tration no with State	e Cod								
d) Hospital PAN e) No of	In-patient Beds									
f) Facilities available in Hospital OT YES NO	ICU YES	NO Othe	rs							
SECTI	ON F – DECLARA	TION BY HOSPIT	AL							
SECTI We hereby declare that the information furnished in this Claim Form is tr or concealment of any material fact, our right to claim under this claim sl	rue & correct to the best			ve made any	false or u	ntrue s	tatem	nent,	suppr	essior
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We hereby declare that the information furnished in this Claim Form is tr or concealment of any material fact, our right to claim under this claim sl Date: DIMMYYYYY Place: LIST OF El	rue & correct to the best hall be forfeited.	of our knowledge and	belief. If we ha	gnature ar	nd seal c	f the I	Hosp	oital .	Auth	ority
We hereby declare that the information furnished in this Claim Form is tr or concealment of any material fact, our right to claim under this claim sl Date: Date: DIMMYYYYY Place: LIST OF El Note: 1. When bills, receipts, prescriptions, reports and other document of the roganization/provider have to be submitted.	rue & correct to the best hall be forfeited. NCLOSURES FOR hents are submitted to the	of our knowledge and SUBMISSION OF e other insurer or to the	belief. If we ha Si CLAIM	gnature ar	nd seal c	f the I	Hosp	pital /	Authorized by s	ority
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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.
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)
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☐ 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).
n-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.
Road Traffic Accident
n 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
n 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. Bill 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 ailr Diagnostic test reports (including imaging and laboratory) along with the Medical pr 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						