HDFC ERGO General Insurance Company Limited

MOSQUITO DISEASE PROTECTION POLICY – GROUP



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

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a) Please tick the applicable Add on cover claimed:

Claim Documents Submitted Check List: Hospitalization Claim						
Duly filled and signed Claim Form	Copy of intimation letter, if any					
Hospital Main Bill	Hospital bill break up					
Hospital Bill Payment Receipt	Hospital Discharge summary					
Pharmacy Bill	Operation theatre notes					
Investigation Reports confirming the diagnosis (Including CT, MRI/USG/HPE, pathology reports)	Doctors request for investigations					
Prescriptions	□ Others					

SECTION – F DETAILS OF BILLS ENCLOSED

S. No	Bill No.				ate			Issued By	Towards		Am	ount	(Rs)	
		D	D	Μ	Μ	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	Μ	Μ	Y	Y	Y	Y				
Place:												

Signature of Insured

MOSQUITO DISEASE PROTECTION POLICY – GROUP

Operation Theatre Notes

Hospital Main Bill

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	SECTION A – DETAIL I I I	Image: Non Image: Non Image: Non Image: Non Image: Non	Network (If non no		i)	Gender		Image: Second
h) Date of Discharge j) Type of Admission k) Status at time of discharge Discharged to Home Discharged to another the discharge	l) care 🗌 Maternity	Time of Dischar	rge H H M					
a) ICD 10 Codes	Primary		Additional		Co-morbidities			
Details of Procedure/s done	Diagnosis		Diagnosis					
b) ICD 10 PCS	Procedure 1	1.01	Procedure 2		Procedure 3			
a) Pre-authorization obtainedf) If authorization by network hospital not obtained, give re		N	b) Pre-author	ization No.				
g) Hospitalisation due to Injury		N	I) If yes, give	cause				
Self inflicted?	Road Tra Accide		□ Y □	N Substance	e Abuse / onsumption		Y	□ N
ii) If Injury due to Substance abuse / alcohol consumption,	Test Conducted to establis	h this: 🗌 Y	N (If yes	, attach reports)				
iii) Medico Legal		□ Y						
iv) Reported to Police v) FIR No		□ Y	N					
vi) If not reported to Police give reasons								
SECTION D – CLAIM DOCUMENTS SUBMITTED – CHECKLIST								
Claim form duly filled and signed			tigation reports	entireties De				
Original Pre authorization Request Copy of Pre-authorization approval Letter				vestigation Report				
Copy of photo ID card of patient verified by Hospital		ECG	i a relerence sil	on investigation	1			
Hospital Discharge Summary			nacy Bills					

Any other, PI specify

Original death summary from hospital where applicable

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	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:	D D M M Y Y Y	Signature and seal of the Hospital Authority	
Place:			

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.

 If original bills, receipts, prescriptions, reports and other documents are submitted to Usand 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

HDFC ERGO General Insurance Company Limited. IRDAI Reg. No.146. CIN: U66030MH2007PLC177117. Registered & Corporate Office: 1st Floor, HDFC House, 165-166 Backbay Reclamation, H. T. Parekh Marg, Churchgate, Mumbai – 400 020. Trade Logo displayed above belongs to HDFC Bank Ltd and ERGO International AG and used by the Company under license. UIN: Mosquito Disease Protection Policy - Group - HDFHLGP22022V032122.