





Document Check List for Hospitalization Claim

Basic Claim Documents

- 1. Claim Form Duly filled with requisite information and signed by Insured & Hospital
- 2. Copy of the claim intimation
- 2. Original Hospital Main Bill
- 3. Original Hospital Bill break up (Where issued by the Hospital)
- 3. Original Hospital Bill Payment Receipt
- 4. Hospital Discharge Card/Summary
- 4. Original Pharmacy Bill with supporting prescriptions
- 5. Medical Investigation report: ECG/X-Ray/USG/CT/MRI/Histopathology/pathological and all other medical investigation report in support of diagnosis as advised by the treating doctor.
- 5. All Doctor's consultation note: confirming provisional & final diagnosis/advise for admission/medical complication/proposed line of treatment/past medical history
- 6. Original bills and receipts for claiming Ambulance charges(if any)

Pre & post hospitalization Claim documents:

- 1. Duly filled claim form(s)(If claimed Separately)
- 2. Pharmacy Bills with supporting prescriptions
- 3. Medical investigation test reports and payment receipts with doctor's advice note for such investigations.
- 4. All Doctor's consultation note with original bills and receipts for claiming Doctors fees,

By signing the claim form you are authorizing us to collect the following documents from the Hospital.If you have obtained these documents, then please submit the same

- a) Operation Theatre Notes in surgical cases
- b) Bar code sticker & Invoice for implants and prosthesis (if used)
- c) In case of Accidental Injuries, Medico Legal Certificate and/ or First information Report, where applicable and self statement giving description of the incident
- d) Indoor case papers

Details of Bill Enclosed

Sr.No	Bill No	Date						Issued By	Towards	Amount (Rs)					
1									Hospital Main Bill						
2									Pre Hospitalisation Bills--Nos						
3									Post Hospitalisation Bills--Nos						
4									Pharmacy Bills						
5															
6															
7															
8															
9															
10															



DETAILS OF POLICY HOLDER'S BANK ACCOUNT

a. PAN No.:	<div></div>
b. Account Number:	<div></div>
c. Bank Name and Branch:	<div></div>
d. Cheque / DD Payable details:	<div></div>
e. IFSC Code:	<div></div>

Enclose cancelled cheque of policy holder for NEFT payment  
Please note, NEFT would depend on location and bank of the insured. Alternatively cheque will be issued. Please note providing cheque details/cancelled cheque does not indicate admission of liability. The same would be applicable if the claim is tenable as per the terms and condition of the Policy

REASON FOR DELAY/NO INTIMATION

If claim is not intimated or intimated beyond stipulated time given in the Policy, provide reason for the same

.....

If the claim is submitted beyond stipulated time period given in the Policy document, provided reason for the same

.....

DECLARATION BY THE INSURED/CLAIMANT:

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

 Place:  Signature of the Insured

GUIDANCE FOR FILLING CLAIM FORM – PART A (To be filled in by the insured)		
DATA ELEMENT	DESCRIPTION	FORMAT
SECTION A - DETAILS OF PRIMARY INSURED		
a) Policy No.	Enter the policy number	As allotted by the insurance company
b) SI. No/ Certificate No.	Enter the social insurance number or the certificate number of social health insurance scheme	As allotted by the organization
c) Company TPA ID No.	Enter the TPA ID No	License number as allotted by IRDA and printed in TPA documents.
d) Name	Enter the full name of the policyholder	Surname, First name, Middle name
e) Address	Enter the full postal address	Include Street, City and Pin Code
SECTION B - DETAILS OF INSURANCE HISTORY		
a) Currently covered by any other Mediciam / Health insurance?	Indicate whether currently covered by another Mediciam / Health Insurance	Tick Yes or No
b) Date of Commencement of first Insurance	Enter the date of commencement of first insurance	Use dd-mm-yy format
c) Company Name	Enter the full name of the insurance company	Name of the organization in full
Policy No.	Enter the policy number	As allotted by the insurance company
Sum Insured	Enter the total sum insured as per the policy	In rupees
d) Have you been Hospitalized in the last four years since inception of the contract?	Indicate whether hospitalized in the last four years	Tick Yes or No
Date	Enter the date of hospitalization	Use mm-yy format
Diagnosis	Enter the diagnosis details	Open Text
e) Previously Covered by any other Mediciam/ Health insurance?	Indicate whether previously covered by another Mediciam / Health Insurance	Tick Yes or No
f) Company Name	Enter the full name of the insurance company	Name of the organization in full
SECTION C - DETAILS OF INSURED PERSON HOSPITALIZED		
a) Name	Enter the full name of the patient	Surname, First name, Middle name
b) Gender	Indicate Gender of the patient	Tick Male or Female
c) Age	Enter age of the patient	Number of years and months
d) Date of Birth	Enter Date of Birth of patient	Use dd-mm-yy format
e) Relationship to primary Insured	Indicate relationship of patient with policyholder	Tick the right option. If others, please specify.
f) Occupation	Indicate occupation of patient	Tick the right option. If others, please specify.

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. Customer Service Address: D-301, 3rd Floor, Eastern Business District (Magnet Mall), LBS Marg, Bhandup (West), Mumbai - 400 078. Customer Service No: 022 - 6234 6234 / 0120 - 6234 6234 | care@hdfcergo.com | www.hdfcergo.com. Trade Logo displayed above belongs to HDFC Ltd and ERGO International AG and used by the Company under license. UIN: Product Name – UIN: myjeevika Medisure Micro Insurance - IRDA/NL-HLT/L&TG/P-H/V.I/247/13-14



g) Address	Enter the full postal address	Include Street, City and Pin Code
h) Phone No	Enter the phone number of patient	Include STD code with telephone number
i) E-mail ID	Enter e-mail address of patient	Complete e-mail address
SECTION D - DETAILS OF HOSPITALIZATION		
a) Name of Hospital where admitted	Enter the name of hospital	Name of hospital in full
b) Room category occupied	Indicate the room category occupied	Tick the right option
c) Hospitalization due to	Indicate reason of hospitalization	Tick the right option
d) Date of Injury/Date Disease first detected/ Date of	Enter the relevant date	Use dd-mm-yy format
e) Date of admission	Enter date of admission	Use dd-mm-yy format
f) Time	Enter time of admission	Use hh:mm format
g) Date of discharge	Enter date of discharge	Use dd-mm-yy format
h) Time	Enter time of discharge	Use hh:mm format
i) If Injury give cause	Indicate cause of injury	Tick the right option
If Medico legal	Indicate whether injury is medico legal	Tick Yes or No
Reported to Police	Indicate whether police report was filed	Tick Yes or No
MLC Report & Police FIR attached	Indicate whether MLC report and Police FIR attached	Tick Yes or No
j) System of Medicine	Enter the system of medicine followed in treating the patient	Open Text
SECTION E - DETAILS OF CLAIM		
a) Details of Treatment Expenses	Enter the amount claimed as treatment expenses	In rupees (Do not enter paise values)
b) Claim for Domiciliary Hospitalization	Indicate whether claim is for domiciliary hospitalization	Tick Yes or No
c) Details of Lump sum/ cash benefit claimed	Enter the amount claimed as lump sum/ cash benefit	In rupees (Do not enter paise values)
d) Claim Documents Submitted-Check List	Indicate which supporting documents are submitted	Tick the right option
SECTION F - DETAILS OF BILLS ENCLOSED		
Indicate which bills are enclosed with the amounts in rupees		
SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT		
a) PAN	Enter the permanent account number	As allotted by the Income Tax department
b) Account Number	Enter the bank account number	As allotted by the bank
c) Bank Name and Branch	Enter the bank name along with the branch	Name of the Bank in full
d) Cheque/ DD payable details	Enter the name of the beneficiary the cheque/ DD should be made out to	Name of the individual/ organization in full
e) IFSC Code	Enter the IFSC code of the bank branch	IFSC code of the bank branch in full
SECTION H - DECLARATION BY THE INSURED		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.		



CLAIM FORM-PART B  
To be filled in by the Hospital

The issue of this form is not taken as an admission of liability

(To be filled in block letters)

a) Name of the hospital:

b) Hospital ID:

c) Type of Hospital: 

Network

Non Network

(If non network fill section E)

d) Name of the treating doctor: 

SURNAME

FIRSTNAME

MIDDLE

NAME

e) Qualification:

f) Registration No. with State Code:

g) Phone No.

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient: 

SURNAME

FIRSTNAME

MIDDLE

NAME

b) IP Registration Number:

c) Gender: 

Male

Female

d) Age: Years 

Y

Y

 Months 

M

M

e) Date of birth: 

D

D

M

M

Y

Y

f) Date of Admission: 

D

D

M

M

Y

Y

g) Time: 

H

H

:

M

M

h) Date of Discharge: 

D

D

M

M

Y

Y

i) Time: 

H

H

:

M

M

j) Type of Admission: 

Emergency

Planned

Day Care

Maternity

k) If Maternity

i. Date of Delivery: 

D

D

M

M

Y

Y

ii. Gravida Status:

l) Status at time of discharge: 

Discharge to home

Discharge to another hospital

Deceased

m) Total claimed amount

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a) ICD 10 Codes

Description

i. Primary Diagnosis:

ii. Additional Diagnosis:

iii. Co-morbidities:

iv. Co-morbidities:

b) ICD 10 PCS

Description

i. Procedure 1:

ii. Procedure 2:

iii. Procedure 3:

iv. Details of Procedure:

d) Pre-authorization obtained: 

Yes

No

e) Pre-authorization Number:

f) If authorization by network hospital not obtained, give reason:

g) Hospitalization due to Injury: 

Yes

No

i. If Yes, give cause 

Self-inflicted

Road Traffic Accident

Substance abuse / alcohol consumption

ii. If Injury due to Substance abuse / alcohol consumption, Test Conducted to establish this: 

Yes

No

 (If Yes, attach reports)

iii. If Medico legal: 

Yes

No

iv. Reported to Police: 

Yes

No

v. FIR no.

vi. If not reported to police give reason:

CLAIM DOCUMENTS SUBMITTED - CHECK LIST

- ☐ Claim Form duly signed

☐ Original Pre-authorization request

☐ Copy of the Pre-authorization approval letter

☐ Copy of photo ID card of patient verified by hospital

☐ Hospital Discharge summary

☐ Operation Theatre notes

☐ Hospital main bill

☐ Hospital break-up bill

☐ Investigation reports

☐ CT/MR/USG/HPE investigation reports

☐ Doctor's reference slip for investigation

☐ ECG

☐ Pharmacy bills

☐ MLC report & Police FIR

☐ Original death summary from hospital where applicable

☐ Any other, please specify

ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)

a) Address of the Hospital: 

City:

State:

Pin Code:

b) Phone No.

c) Registration No. with State Code:

d) Hospital PAN:

e) Number of Inpatient beds

f) Facilities available in the hospital: 

i. OT: 

Yes

No

ii. ICU: 

Yes

No

iii. Others :

DECLARATION BY THE HOSPITAL (PLEASE READ VERY CAREFULLY)

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. Customer Service Address: D-301, 3rd Floor, Eastern Business District (Magnet Mall), LBS Marg, Bhandup (West), Mumbai - 400 078. Customer Service No: 022 - 6234 6234 / 0120 - 6234 6234 | care@hdfcergo.com | www.hdfcergo.com. Trade Logo displayed above belongs to HDFC Ltd and ERGO International AG and used by the Company under license. UIN: Product Name – UIN: myjeevika Medisure Micro Insurance - IRDA/NL-HLT/L&TGI/P-H/N.I/247/13-14



Claim Form

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

Place:

Signature and Seal of the Hospital Authority:



## GUIDANCE FOR FILLING CLAIM FORM – PART B (To be filled in by the hospital)

DATA ELEMENT	DESCRIPTION	FORM
<b>SECTION A - DETAILS OF HOSPITAL</b>		
a) Name of Hospital	Enter the name of hospital	Name of hospital in full
b) Hospital ID	Enter ID number of hospital	As allocated by the TPA
c) Type of Hospital	Indicate whether In network or non network hospital	Tick the right option
d) Name of treating doctor	Enter the name of the treating doctor	Name of doctor in full
e) Qualification	Enter the qualifications of the treating doctor	Abbreviations of educational qualifications
f) Registration No. with State Code	Enter the registration number of the doctor along with the state code	As allocated by the Medical Council of India
g) Phone No.	Enter the phone number of doctor	Include STD code with telephone number
<b>SECTION B – DETAILS OF THE PATIENT ADMITTED</b>		
a) Name of Patient	Enter the name of hospital	Name of hospital in full
b) IP Registration Number	Enter insurance provider registration number	As allotted by the insurance provider
c) Gender	Indicate Gender of the patient	Tick Male or Female
d) Age	Enter age of the patient	Number of years and months
e) Date of Birth	Enter date of admission	Use dd-mm-yy format
f) Date of Admission	Enter date of admission	Use dd-mm-yy format
g) Time	Enter time of admission	Use hh:mm format
h) Date of Discharge	Enter date of discharge	Use dd-mm-yy format
i) Time	Enter time of discharge	Use hh:mm format
j) Type of Admission	Indicate type of admission of patient	Tick the right option
k) If Maternity		
Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format
Gravida Status	Enter Gravida status if maternity	Use standard format
l) Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
m) Total claimed amount	Indicate the total claimed amount	In rupees (Do not enter paise values)
<b>SECTION C – DETAILS OF AILMENT DIAGNOSED (PRIMARY)</b>		
a) ICD 10 Code		
Primary Diagnosis	Enter the ICD 10 Code and description of the primary diagnosis	Standard Format and Open text
Additional Diagnosis	Enter the ICD 10 Code and description of the additional diagnosis	Standard Format and Open text
Co-morbidities	Enter the ICD 10 Code and description of the co-morbidities	Standard Format and Open text
b) ICD 10 PCS		
Procedure 1	Enter the ICD 10 PCS and description of the first procedure	Standard Format and Open text
Procedure 2	Enter the ICD 10 PCS and description of the second procedure	Standard Format and Open text
Procedure 3	Enter the ICD 10 PCS and description of the third procedure	Standard Format and Open text
Details of Procedure	Enter the details of the procedure	Open text
c) Pre-authorization obtained	Indicate whether pre-authorization obtained	Tick Yes or No
d) Pre-authorization Number	Enter pre-authorization number	As allotted by TPA
e) If authorization by network hospital not obtained, give reason	Enter reason for not obtaining pre-authorization number	Open text
f) Hospitalization due to injury	Indicate if hospitalization is due to injury	Tick Yes or No
Cause	Indicate cause of injury	Tick the right option
If injury due to substance abuse/alcohol consumption, test conducted to establish this	Indicate whether test conducted	Tick Yes or No
Medico Legal	Indicate whether injury is medico legal	Tick Yes or No
Reported To Police	Indicate whether police report was filed	Tick Yes or No
FIR No.	Enter first information report number	As issued by police authorities
If not reported to police, give reason	Enter reason for not reporting to police	Open Text
<b>SECTION D – CLAIM DOCUMENTS SUBMITTED-CHECK LIST</b>		
Indicate which supporting documents are submitted		

## Claim Form

## SECTION E – DETAILS IN CASE OF NON NETWORK HOSPITAL

a) Address	Enter the full postal address	Include Street, City and Pin Code
b) Phone No.	Enter the phone number of hospital	Include STD code with telephone number
c) Registration No. with State Code	Enter the registration number of the doctor along with the state code	As allocated by the Medical Council of India
d) Hospital PAN	Enter the permanent account number	As allotted by the Income Tax department
e) Number of Inpatient beds	Enter the number of inpatient beds	Digits
f) Facilities available in the hospital	Indicate facilities available in the hospital	Tick the right option. If others, please

## SECTION F - DECLARATION BY THE HOSPITAL

Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign and stamp
--