

**CHOLAMANDALAM MS GENERAL INSURANCE COMPANY LIMITED**

Registered Office: 2nd Floor, "DARE House", 2, N.S.C. Bose Road, Chennai - 600 001.

Toll free: 1800 208 9100 | T: +91 (0) 44 4044 5400 | E: customercare@cholams.murugappa.com | website: www.cholainsurance.com

IRDA Regn. No.123 | PAN: AABCC6633K | CIN: U66030TN2001PLC047977

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**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

- IN-PATIENT HOSPITALIZATION CLAIM     
  CRITICAL ILLNESS     
  HOSPITAL DAILY CASH     
  HEALTH CHECK UP  
 PRE AND POST CLAIM     
  OUT-PATIENT CLAIM     
  OTHERS

**SECTION A – DETAILS OF PRIMARY INSURED**

|                               |   |               |
|-------------------------------|---|---------------|
| a. Policy No                  |   | Membership No |
| b. Certificate No             |   |               |
| c. Company / TPA ID No        |   |               |
| d. ABHA ID No                 |   |               |
| e. Name (In Block Letters)    |   |               |
| f. Address (In Block Letters) |   |               |
| Phone No                      |   | Email ID      |
| WhatsApp No                   | <input type="checkbox"/> I hereby provide my consent for Chola MS to communicate through Whatsapp |               |

**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                             | DD/MM/YYYY                  |
| 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      Date: MM/YYYY |
| 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   |                  |               |   |
| b. Relationship (Self/spouse/Child/Father/Mother/Other) | c. Date of Birth | d. Age        | Yrs      months   |
| e. Address (If different than above)                    |                  |               |   |
| f. Gender   | Male / Female    | g. Occupation | Service/Self-employed/<br>Homemaker/student/<br>Retired/ Others |
| h. Telephone No   | i. Mobile No     |               |   |
| j. E-mail ID, if any                                    |                  |               |   |

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**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 admission  |  | HH/MM   |                                      |
| g. Date of discharge   |  | DD/MM/YYYY  |                                      |
| h. Time discharge  |  | 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  | 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) Critical illness              | YES / NO  | viii) Hospital Daily cash        | YES / NO |

**b) Please tick the applicable Optional Cover claimed under Hospitalization Cover:**

|                                   |          |                            |
|-----------------------------------|----------|----------------------------|
| i) Hospital Cash                  | YES / NO | <<Please provide details>> |
| 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>> |

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| Claim Documents Submitted Check List: Hospitalization Claim                              |  | Check list of additional documents for Hospital Cash claims   |
|--|--|---|
| <input type="checkbox"/> Duly filled and signed Claim Form                               | <input type="checkbox"/> Copy of intimation letter, if any                       | <input type="checkbox"/> Copy of discharge summary/discharge certificate along with time of admission and discharge for hospital cash benefit     |
| <input type="checkbox"/> Hospital main bill  | <input type="checkbox"/> Hospital bill break up                                  | <input type="checkbox"/> First consultation letter from treating medical practitioner   |
| <input type="checkbox"/> Hospital bill payment receipt                                   | <input type="checkbox"/> Hospital discharge summary                              | <input type="checkbox"/> Certificate from treating medical practitioner, specifying the duration and aetiology                                    |
| <input type="checkbox"/> Pharmacy bill   | <input type="checkbox"/> Operation theatre notes                                 | <input type="checkbox"/> MLC/FIR copy/ certificate regarding abuse of alcohol/intoxicating agent if applicable                                    |
| <input type="checkbox"/> Investigation/diagnostic Reports with bills and payment receipt | <input type="checkbox"/> Doctors request for investigations                      | <input type="checkbox"/> Cancelled cheque copy with primary insured name printed or bank pass book copy with clear name/account no./ bank details |
| <input type="checkbox"/> ECG   | <input type="checkbox"/> Prescriptions   |   |
| <input type="checkbox"/> Copy of the network provider's registration certificate         | <input type="checkbox"/> MLC/FIR copy of applicable                              |   |
| <input type="checkbox"/> KYC documents   | <input type="checkbox"/> Implant stickers for all implants used during surgeries |   |

**SECTION F – DETAILS OF BILLS ENCLOSED**

| Sno | Bill No | Date |   |   |   |   |   | Issued By | Towards               | Amount (Rs) |  |  |  |
|-----|---------|------|---|---|---|---|---|-----------|-----------------------|-------------|--|--|--|
|     |         | D    | D | M | M | Y | Y |           |                       |             |  |  |  |
|     |         |      |   |   |   |   |   |           | Hospitalization bills |             |  |  |  |
|     |         |      |   |   |   |   |   |           | Pre-Hospitalization   |             |  |  |  |
|     |         |      |   |   |   |   |   |           | Post-Hospitalization  |             |  |  |  |
|     |         |      |   |   |   |   |   |           |                       |             |  |  |  |
|     |         |      |   |   |   |   |   |           |                       |             |  |  |  |
|     |         |      |   |   |   |   |   |           |                       |             |  |  |  |
|     |         |      |   |   |   |   |   |           |                       |             |  |  |  |
|     |         |      |   |   |   |   |   |           |                       |             |  |  |  |
|     |         |      |   |   |   |   |   |           | Total Amount          |             |  |  |  |

**SECTION G – DETAILS OF PRIMARY INSURED'S BANK ACCOUNT**

|                                      |  |
|--------------------------------------|--|
| a) Name of the primary insured       |  |
| b) Account number                    |  |
| c) PAN number of the primary insured |  |
| d) Bank name/ Branch                 |  |
| e) Payee Name                        |  |
| f) IFSC Code                         |  |

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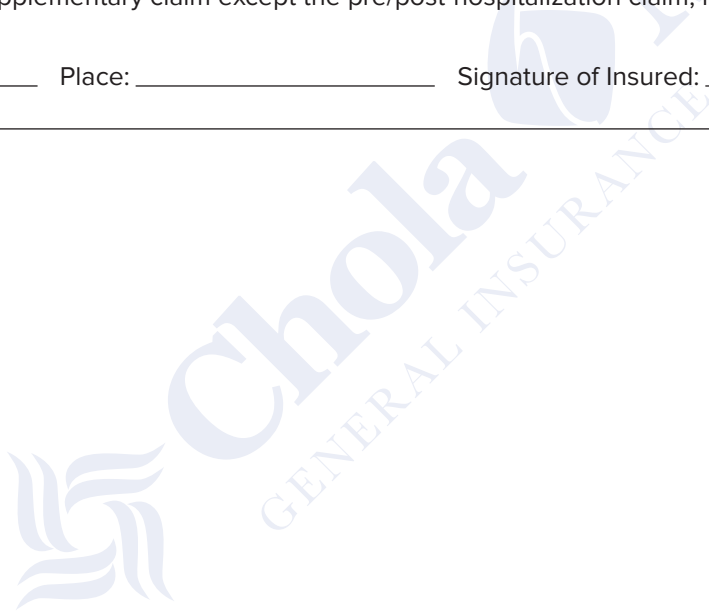
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|   |  |
|---|--|
| g) *Attach a cancelled cheque pertaining to the same name of the account holder must be printed on the cheque   |  |
| h) MICR No  |  |
| i) CKYC of the primary insured  |  |
| <p><b>Note:</b><br/>Enclose NEFT documents (Cancelled Cheque or Bank passbook clear copy)<br/>Please send all original documents along with duly filled and signed Claim form to the address mentioned on the Top of the Claim form<br/>Please mention as "Health Claim Documents" on the TOP of the envelop and mention the complete sender address along with mobile number without fail.</p> |  |

**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: \_\_\_\_\_



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**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**

|                                       |         |  |
|---------------------------------------|---------|--|
| a) Name of the Hospital where treated |         | b) Hospital Registration No                  |
| 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                      | Male/Female  | d) Age                    | YY/MM |
| e) Date of birth               | DD/MM/YYYY   |                           |       |
| f) Date of admission           | DD/MM/YYYY   | g) Time of admission      | HH/MM |
| h) Date of discharge           | DD/MM/YYYY   | i) Time of discharge      | HH/MM |
| j) Type of admission           | Emergency/Planned/Daycare/<br>Maternity                          | k) If Maternity           |       |
| i) Date of delivery            | DD/MM/YYYY   | ii) Gravida status        |       |
| l) Status at time of discharge | Discharged to Home<br>Discharged to another Hospital<br>Deceased | Total claimed amount      |       |

**SECTION C – DETAILS OF AILMENTS DIAGNOSED (PRIMARY)**

|   |                              |                                       |               |
|---|------------------------------|---------------------------------------|---------------|
| a) ICD 10 Codes   | Primary Diagnosis            | Additional Diagnosis                  | Comorbidities |
| Details of procedures done  |                              |                                       |               |
| b) ICD 10 PCS   | Procedure 1                  | Procedure 2                           | Procedure 3   |
| i) Pre-authorization obtained   | Y/N                          | j) Pre-authorization No               |               |
| f) If authorization by network hospital not obtained, give reason                             |                              |                                       |               |
| g) Hospitalisation due to Injury  | Y/N                          | i) If yes, give cause                 |               |
| Self-inflicted?   | Y/N                          | Road traffic accident                 | Y/N           |
|   |                              | Substance abuse / Alcohol consumption | Y/N           |
| ii) If Injury due to substance abuse / alcohol consumption, Test Conducted to establish this: | Y/N ( If yes, attach reports | iii) Medico legal                     | Y/N           |
| iv) Reported to Police  |                              | v) FIR No                             |               |
| vi) If not reported to police give reasons  |                              |                                       |               |

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**SECTION D – CLAIM DOCUMENTS SUBMITTED – CHECK-LIST**

|  |   |
|--|---|
| <input type="checkbox"/> Claim form duly filled and signed                     | <input type="checkbox"/> Investigation reports                        |
| <input type="checkbox"/> 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"/> MLC report & Police FIR                      |
| <input type="checkbox"/> Hospital main bill                                    | <input type="checkbox"/> Death summary from hospital where applicable |
| <input type="checkbox"/> Hospital break up bill                                | <input type="checkbox"/> Any other, PI 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                              | Y/N | ii) ICU                             | Y/N |
| 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: \_\_\_\_\_ Place: \_\_\_\_\_ Signature and seal of the Hospital Authority \_\_\_\_\_

**CLAIM INTIMATION**

Chola MS has arrangements with more than 11000 hospitals across India for availing of cashless facility. For availing benefit through reimbursement mode, advance intimation of at least 48 hours to Chola MS is required for planned hospitalisation and intimation within 24 hours for emergency hospitalisation. This would help us to pre-process your claim for a smooth experience. For more details call toll free number for Claim intimation at 1800-208-9100 or Mail: [customercare@cholams.murugappa.com](mailto:customercare@cholams.murugappa.com)

**EXCLUDED HOSPITALS**

Expenses incurred towards the treatment in any hospital specifically excluded by Chola MS and disclosed in our website / notified to the policyholders are not admissible. However, in case of life-threatening situations or following an accident, expenses incurred for the treatment up to the stage of stabilization are payable but not the complete claim. Please refer our website [www.cholainsurance.com](http://www.cholainsurance.com) for latest list of excluded hospitals and reach us at 1800-208-9100 or Mail: [customercare@cholams.murugappa.com](mailto:customercare@cholams.murugappa.com) for any further clarification on this.

Please refer our website for latest list of Excluded Hospitals before Hospitalization, as we will not consider any claim from these hospitals. Please reach us at our tollfree number/mail ID given above for any further clarification on this.