

Address:

Landmark

Area

City/Town District

Pin Code State

E-Mail

Phone

DETAILS OF HOSPITALIZATION

(SECTION D)

Name of Hospital: where Admitted

Room Category occupied: Day Care Single occupancy Twin sharing 3 or more beds per room

Hospitalization due to: Injury Illness Maternity

Date of injury/Date Disease first detected/Date of Delivery:

Date of Admission: Time:

Date of Discharge: Time:

If Injury give cause: Self Inflicted Road Traffic Accident Substance Abuse/Alcohol Consumption

If Medico legal Yes No

Reported to police Yes No

MLC Report & Police FIR attached Yes No

System of Medicine

DETAILS OF CLAIM

(SECTION E)

Details of the treatment expenses claimed:

Pre-hospitalization Expenses	Rs. <input type="text"/>	Hospitalization Expenses	Rs. <input type="text"/>
Post-hospitalization Expenses	Rs. <input type="text"/>	Health-Check up Cost	Rs. <input type="text"/>
Ambulance Charges	Rs. <input type="text"/>	Other (Code) <input type="text"/>	Rs. <input type="text"/>
		Total	Rs. <input type="text"/>

Pre-hospitalization period: days Post-hospitalization period: days

Claim for Domiciliary Hospitalization: Yes No (If yes, provide details in annexure)

Details of Lump sum/cash benefit claimed

Hospital Daily Cash	Rs. <input type="text"/>	Surgical Cash	Rs. <input type="text"/>
Critical Illness Benefit	Rs. <input type="text"/>	Convalescence	Rs. <input type="text"/>
Pre/Post hospitalization Lump sum benefit	Rs. <input type="text"/>	Other	Rs. <input type="text"/>
		Total	Rs. <input type="text"/>

CLAIM DOCUMENTS SUBMITTED-CHECK LIST

- Claim Form duly signed
- Hospital Main Bill
- Hospital Bill Payment Receipt
- Pharmacy Bill
- ECG
- Investigation Reports (Including CT/MRI/USG/HPE)
- Copy of the claim intimation, if any
- Hospital Break-up Bill
- Hospital Discharge Summary
- Operation Theatre Notes
- Doctor's request for investigation
- Doctors Prescription
- Others

Sl. No.	DATA ELEMENT	DESCRIPTION	FORMAT
e.	Previously Covered by any other Mediclaim/Health Insurance?	Indicate whether previously covered by another Mediclaim/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.
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 Delivery	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 date of admission	Use hh-mm format
g.	Date of discharge	Enter date of discharge	Use dd-mm-yy format
h.	Time	Enter date 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 failed	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 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 to be taken as an admission of liability. Please include the original preauthorization request form in lieu of PART A

Please fill-up this form in **CAPITAL LETTERS**

DETAILS OF HOSPITAL

(SECTION A)

Name of the Hospital:

Hospital ID:

Type of Hospital: Network Non Network (If non network fill section E)

Name of the treating Doctor:

First Name Middle Name Surname

Qualification:

Registration No.:
(with State Code)

Phone No.:

DETAILS OF THE PATIENT ADMITTED

(SECTION B)

Name of the Patient:

First Name Middle Name Surname

IP Registration Number:

Gender:

Male Female

Age: Years Months

Date of Birth:

Date of Admission:

Time:

Date of Discharge:

Time:

Type of Admission: Emergency Planned Day Care Maternity

If Maternity: i) Date of Delivery: i) Gravida Status:

Status at time of discharge: Discharge to home Discharge to another hospital Deceased

Total claimed amount:

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

(SECTION C)

ICD 10 Codes: Description

- i) Primary Diagnosis _____
- ii) Additional Diagnosis _____
- iii) Co-morbidities _____
- iv) Co-morbidities _____

ICD 10 PCS: Description

- i) Procedure 1 _____
- ii) Procedure 2 _____
- iii) Procedure 3 _____
- iv) Details of Procedure _____

Pre-authorization obtained: Yes No

Pre-authorization Number:

If authorization by network hospital not obtained, give reason: _____

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 report)

GUIDANCE FOR FILLING CLAIM FORM-PART B (To be filled in by the Hospital)

Sl. No.	DATA ELEMENT	DESCRIPTION	FORMAT
SECTION A: DETAILS OF HOSPITAL			
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 qualification of the treating doctor	Abbreviations of educational qualification
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
SECTION B: DETAILS OF THE PATIENT ADMITTED			
a.	Name of Patient	Enter the name of hospital	Name of hospital in full
b.	IP Registration Number	Enter insurance provider registration number	As allocated 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)
SECTION C: DETAILS OF AILMENT DIAGNOSED (PRIMARY)			
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

Sl. No.	DATA ELEMENT	DESCRIPTION	FORMAT
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
SECTION D: CLAIM DOCUMENTS SUBMITTED-CHECK LIST			
	Indicate with supporting documents are submitted		
SECTION E: ADDITIONAL 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 allocated 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 specify
SECTION F: DECLARATION BY THE HOSPITAL			
	Read declaration carefully and mention date (in dd-mm-yy format), place (open text) and sign and stamp		