HDFC ERGO General Insurance Company Limited

Claim Form - my:health Suraksha

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 D D M M Y Y Y Y

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 D D M M Y Y Y Y

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 D D M M Y Y Y Y d) Age D D M M Y Y Y Y

e) Address (If different than above)

f) Gender ☐ Male ☐ Female ☐ Transgender g) Occupation: ☐ Service ☐ Self Employed ☐ Homemaker ☐ Student ☐ Retired Others _____

h) Telephone No I) Mobile 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) Hospitalisation due to ☐ Illness ☐ Injury ☐ Maternity

d) Date of Injury/ Date of disease first detected/ Date of delivery D D M M Y Y Y Y e) Date of admission D D M M Y Y Y Y f) Time H H M M

g) Date of discharge D D M M Y Y Y Y h) Time H H M M

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 ☐

j) System of medicine ☐ Allopathic ☐ Other systems of medicine

SECTION E- DETAILS OF CLAIM

a) Details of the treatment expenses claimed under Hospitalisation Cover

I) Hospitalisation Expenses		ii) Ambulance Charges	
iii) Pre-hospitalisation Expenses		iv) Post-hospitalisation Expenses	
v) Organ Donor Expenses		vi) Air Ambulance Cover	
vii) Alternative Treatments		viii) Non- Medical Expenses	

b) Details of the treatment expenses claimed under Parent and Child Cover – Basic/Booster

I) Maternity Expenses		ii) Infertility Treatment Expenses	
iii) Pre natal/ Post Natal Expenses		iv) Vaccination Expenses	
v) New Born Baby Expenses			
		Total	

c) Claim for Domiciliary Hospitalization YES ☐ NO ☐ (if yes, please provide details in annexure)

d) Claim for Preventive Health Check up YES ☐ NO ☐

Please tick the applicable Optional Cover/Add on cover claimed:		
I) Hospital Cash	☐	Please mention the number of days claimed for:
ii) Major Illness Benefit	☐	Please mention the Critical Illness claimed for:
iii) my:health Hospital Cash	☐	Please mention the number of days claimed for:
iv) my:health Critical Illness Benefit	☐	Please mention the Critical Illness claimed for:
v) E Opinion	☐	
vi) Outpatient Dental Treatment	☐	
vii) External Medical Aids	☐	

Claim Documents Submitted Check List: Hospitalization Claim		**Check list of additional documents for Critical Illness claims**
☐ Duly filled and signed Claim Form	☐ Copy of intimation letter, if any	☐ Medical certificate confirming the diagnosis of Critical Illness
☐ Hospital Main Bill	☐ Original Hospital bill break up	☐ Certificate from attending Medical Practitioner confirming the duration of illness
☐ Original Hospital Bill Payment Receipt	☐ Original Hospital Discharge summary	☐ First consultation letter and subsequent prescriptions
☐ Pharmacy Bill	☐ Operation theatre notes	☐ Indoor case papers if applicable
☐ Original Investigation / diagnostic Reports with original bills and payment receipt	☐ Doctors request for investigations	☐ FIR copy or medico legal certificate (wherever applicable)
☐ ECG	☐ Prescriptions	☐ Photo ID and Age proof
☐ Copy of the Network Provider's Registration Certificate	☐ MLC/FIR copy of applicable	☐ Death Summary with Death Certificate (In death claims only)
☐ KYC Documents	☐ implant stickers for all implants used during surgeries	☐ Original invoice for Vaccination and payment receipt

SECTION – F DETAILS OF BILLS ENCLOSED

S. No	Bill No.	Date						Issued By	Towards	Amount (Rs)							
		D	D	M	M	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 M M Y Y Y Y

Place:

Signature of Insured

HDFC ERGO General Insurance Company Limited

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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 preauthorisation request form in lieu of PART A

SECTION A – DETAILS OF HOSPITAL

a) Name of the Hospital where treated
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 ☐ Male ☐ Female ☐ Transgender
d) Date of Birth D D M M Y Y Y Y
e) Age Y Y M M
f) Date of Admission D D M M Y Y Y Y
g) Time of Admission H H M M
h) Date of Discharge D D M M Y Y Y Y
I) Time of Discharge H H M M
j) Type of Admission ☐ Emergency ☐ Planned ☐ Daycare ☐ Maternity
k) Status at time of discharge ☐ Discharged to Home ☐ Discharged to another Hospital ☐ Deceased
l) Total Claimed Amount

SECTION C – DETAILS OF AILMENTS DIAGNOSED (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	
c) Pre-authorization obtained	☐ Yes ☐ No		d) Pre-authorization No.			
e) If authorization by network hospital not obtained, give reason						
f) Hospitalisation due to Injury	☐ Yes ☐ No		g) If yes, give cause			
Self inflicted?	☐ Yes ☐ No	Road Traffic Accident	☐ Yes ☐ No	Substance Abuse / Alcohol Consumption	☐ Yes ☐ No	
ii) If Injury due to Substance abuse / alcohol consumption, Test Conducted to establish this: ☐ Yes ☐ No (If yes, attach reports)						
iii) Medico Legal ☐ Yes ☐ No						
iv) Reported to Police ☐ Yes ☐ No						
v) FIR No						
vi) If not reported to Police give reasons						

SECTION D – CLAIM DOCUMENTS SUBMITTED – CHECKLIST

☐ Claim form duly filled and signed	☐ Investigation reports
☐ Original Pre authorization Request	☐ CT/MRI/USG/HPE investigation Report
☐ Copy of Pre-authorization approval Letter	☐ Doctor's reference slip for Investigation
☐ Copy of photo ID card of patient verified by Hospital	☐ ECG
☐ Hospital Discharge Summary	☐ Pharmacy Bills
☐ Operation Theatre Notes	☐ MLC Report & Police FIR
☐ Hospital Main Bill	☐ Original death summary from hospital where applicable
☐ Hospital break up Bill	☐ Any other, Pl specify

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: i) OT | ☐ Yes ☐ No ii) ICU | ☐ Yes ☐ No

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: D D M M Y Y Y Y

Place:

Signature and seal of the Hospital Authority

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.
2. If original bills, receipts, prescriptions, reports and other documents are submitted to **Us** and 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 break up 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.

Road Traffic Accident

In 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)

For Death Cases

In addition to the In-patient Treatment documents:

- ☐ Original 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.

Pre and Post-hospitalization/Vaccination/Pre post natal/Out patient dental 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 documents and bills, original payment receipt with prescription.
- ☐ Copy of the Discharge Summary of the main claim. (except for out patient dental claim)

Organ Donation/Transplantation

In 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.

- ☐ Original Bill with Original Payment Receipt.
- ☐ Treating Doctor's consultation prescription indicating Emergency Hospitalization.

Critical Illness Benefit

- ☐ Duly filled and signed Claim Form.
- ☐ Medical certificate confirming the diagnosis of Critical Illness
- ☐ Certificate from attending Medical Practitioner confirming that the duration of Illness
- ☐ Discharge certificate/ card from the Hospital, if any
- ☐ Investigation test reports confirming the diagnosis,
- ☐ First consultation letter and subsequent prescriptions
- ☐ Indoor case papers if applicable
- ☐ Specific documents to confirm the diagnosis of respective Critical Illness
- ☐ In the cases where Critical Illness arises due to an accident, FIR copy or medico legal certificate ,wherever conducted.

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 ailment.
- ☐ Diagnostic test reports (including imaging and laboratory) along with the Medical prescription & copy of invoice / bill and receipt from the diagnostic centre.
- ☐ 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
- ☐ Original bill and receipt from the diagnostic centre.

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