

REIMBURSEMENT CLAIM FORM

TO BE FILLED BY THE INSURED
The issue of this Form is not to be taken as an admission of liability

(To be Filled in block letters)

-DETAILS OF PRIMARY INSURED:

a) Policy No.:		b) Sl. No/ Certificate no.	
c) Company / TPA ID (MA ID)No:			
d) Name:			
e) Address:			
City:		State:	
Pin Code		Phone No:	
		Email ID:	

- DETAILS OF INSURANCE HISTORY:

a) Currently covered by any other Medicaclaim / Health Insurance: ☐ Yes ☐ No b) Date of commencement of first Insurance without break: DD MM YY YY YY
c) If yes, company name: Policy No. Sum insured (Rs.) d) Have you been hospitalized in the last four years since inception of the contract? ☐ Yes ☐ No Date: MM YY YY
Diagnosis: e) Previously covered by any other Medicaclaim /Health insurance :: ☐ Yes ☐ No
f) If yes, company name:

- DETAILS OF INSURED PERSON HOSPITALIZED:

a) Name: S U R N A M E F I R S T N A M E M I D D L E N A M E

b) Gender Male ☐ Female ☐ c) Age years Y Y Months M M d) Date of Birth D D M M Y Y Y Y

e) Relationship to Primary insured: Self ☐ Spouse ☐ Child ☐ Father ☐ Mother ☐ Other ☐ (Please Specify)

f) Occupation Service ☐ Self Employed ☐ Home Maker ☐ Student ☐ Retired ☐ Other ☐ (Please Specify)

g) Address (if different from above) :

City: State:
Pin Code: Phone No: Email ID:

- DETAILS OF HOSPITALIZATION:

a) Name of Hospital where Admitted:

b) Room Category occupied: Day care ☐ Single occupancy ☐ Twin sharing ☐ 3 or more beds per room ☐

c) Hospitalization due to: Injury ☐ Illness ☐ Maternity ☐

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

e) Date of Admission: f) Time:

g) Date of Discharge: h) Time: :

i) If injury give cause: Self inflicted ☐ Road Traffic Accident ☐ Substance Abuse / Alcohol Consumption ☐ j) If Medico legal ☐ Yes ☐ No

ii) Reported to Police ☐ ☐ iii. MLC Report & Police FIR attached ☐ Yes ☐ No j) System of Medicine:

-DETAILS OF CLAIM:

a) Details of the Treatment expenses claimed			
i. Pre -hospitalization expenses	Rs.	ii. Hospitalization expenses	Rs.
iii. Post-hospitalization expenses	Rs.	iv. Health-Check up cost:	Rs.
v. Ambulance Charges:	Rs.	vi. Others (code):	Rs.
		Total	
		Rs.	
vii. Pre -hospitalization period: days		viii. Post -hospitalization period: days	
b) Claim for Domiciliary Hospitalization: ☐ Yes ☐ No (If yes, provide details in annexure)			
c) Details of Lump sum / cash benefit claimed:			
i. Hospital Daily cash:	Rs.	ii. Surgical Cash:	Rs.
iii. Critical Illness benefit:	Rs.	iv. Convalescence:	Rs.
v. Pre/Post hospitalization Lump sum benefit:	Rs.	vi. Others:	Rs.
		Total	
		Rs.	

Claim Documents Submitted - Check List:

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

- DETAILS OF BILLS ENCLOSED:

Sl. No.	Bill No.	Date	Issued by	Towards	Amount (Rs)
1.		D D M M Y Y		Hospital main Bill	
2.		D D M M Y Y		Pre-hospitalization Bills: Nos	
3.		D D M M Y Y		Post-hospitalization Bills: Nos	
4.		D D M M Y Y		Pharmacy Bills	
5.		D D M M Y Y			
6.		D D M M Y Y			
7.		D D M M Y Y			
8.		D D M M Y Y			
9.		D D M M Y Y			
10.		D D M M Y Y			

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT:

[illegible]- **DECLARATION BY THE INSURED:**

I hereby declare that the information furnished in the 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 the Insured

(IMPORTANT: PLEASE TURN OVER)

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

(To be Filled in block letters)

DETAILS OF HOSPITAL

a) Name of the hospital:
a) Hospital ID: c) Type of Hospital: Network : ☐ Non Network : ☐ (if non network fill section E)
c) Name of the treating doctor:
e) Qualification: f) Registration No. with State Code: g) Phone No.

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient:
b) IP Registration Number: c) Gender: Male ☐ Female ☐ d) Age: Years Months e) Date of birth:
f) Date of Admission: g) Time: h) Date of Discharge: i) Time:
j) Type of Admission: Emergency ☐ Planned ☐ Day Care ☐ Maternity ☐ k) If Maternity ☐ i) Date of Delivery: 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	b)	ICD 10 PCS	Description
i. Primary Diagnosis			i. Procedure 1:		
ii. Additional Diagnosis:			ii. Procedure 2:		
iii. Co-morbidities:			iii. Procedure 3:		
iv. Co-morbidities:			iv. Details of Procedure:		

c) Pre-authorization obtained: ☐ Yes ☐ No d) Pre-authorization Number:
e) If authorization by network hospital not obtained, give reason:
f) 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 | ☐ Investigation reports |
| ☐ Original Pre-authorization request | ☐ CT/MR/USG/HPE investigation reports |
| ☐ Copy of the 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 reports & Police FIR |
| ☐ Hospital main bill | ☐ Original death summary from hospital where applicable |
| ☐ Hospital break-up bill | ☐ 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)

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:

SECTION A

SECTION B

SECTION C

SECTION D

SECTION E

SECTION F

Check list For Reimbursement claim

1. Claim form Part A (To be filled by insured)
2. Part B (To be filled by hospital)
3. Original discharge summary with Dr seal , sign and hospital seal
4. Original discharge bill with breakup bill (with treated dr seal ,sign & hospital seal)
5. Payment Receipts(Advance receipts, final payment receipts/all bills have cash recieved seal
6. Medicines bills with prescription
7. Lab bills with reports and requisition form
8. Investigation report prior to the admission
9. Bank details of employee (copy of passbook or cheque leaf. Account no , IFSC code and name should be clear)
10. Copy of Govt ID proof of patient and employee (if child , id proof of employee with child's birth certificate

Note :- Only while processing the claim will we be able to confirm if there would be any further medical requirement.