

## REIMBURSEMENT CLAIM FORM

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

(To be Filled in block letters)

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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 ease include the original preauthorization request form in lieu of PART A

(To be Filled in block letters)

DETAILS OF HOSPITAL	zation request form in lieu of PART A
a) Name of the hospital:  a) Hospital ID:  c) Type of Hospital:  c) Name of the treating doctor:  s U R N A M E F I F  e) Qualification:  f) Registration No. with State Code:	Network :       Non Network :       (if non network fill section E)         IST NAME MIDD LENNAME         g) Phone No.
DETAILS OF THE PATIENT ADMITTED	
a) Name of the Patient:    S U R N A M E   F   F	d) Age: Years Y Y Months M M e) Date of birth: D D M M Y Y h) Date of Discharge: D D M M Y Y i) Time: H H M M  rmity i) Date of Delivery: D D M M Y Y ii) Gravida Status:
ICD 40 Cadas	10040,000
a) ICD 10 Codes Description  I. Primary Diagnosis	b) ICD 10 PCS Description  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 le	
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  v. FIR No.  vi. If not reported to police give reason:	If Yes, attach reports) iii. If Medico legal: Yes No iv. Reported to Police Yes No
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 reports & 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	PF NON-NETWORK HOSPITAL)
a) Address of the Hospital  City:  Pin Code:  b) Phone No.  d) Hospital PAN:  iii. Others:	State: C) Registration No. with State Code: No ii. ICU Yes No
DECLARATION BY THE HOSPITAL  We hereby declare that the information furnished in this Claim Form is true & correct to the best of our knowledge and belie our right to claim under this claim shall be forfeited.	(PLEASE READ VERY CAREFULLY)  f. If we have made any false or untrue statement, suppression or concealment of any material fact,
•	r r
Date: D D M M Y Y  Place: Signature and Seal of the H	C C C C C C C C C C C C C C C C C C C

Signature and Seal of the Hospital Authority:

## **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
- 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.