

**CLAIM FORM - PART A**

**TO BE FILLED BY THE INSURED**

Issue of this form is not to be taken as admission of liability

(To be filled in block letters)

**DETAILS OF PRIMARY INSURED**

(SECTION A)

- a) Policy No: ..... (b) Claim Intimation No:
- c) SI No / Certificate No: ..... (d) Company ID No: .....
- e) Name:.....
- f) Address:.....  
..... City:.....  
State:..... Pin Code.....  
Email ID:..... Phone No.....

**DETAILS OF INSURANCE HISTORY**

(SECTION B)

- a) Currently covered by any other Mediciam / Health insurance: Yes  No
- b) If yes, Company Name: .....  
Policy No: ..... Sum Insured (Rs): .....
- c) Date of commencement of first insurance without break:         (Copies of policies to be attached)
- d) Have you been hospitalized in the last 4 years: Yes  No   
If yes, Date:       Diagnosis:.....
- e) Previously covered by any other Mediciam / Health insurance: Yes  No
- f) If yes, Company Name: .....

**DETAILS OF INSURED PERSON HOSPITALIZED**

(SECTION C)

- a) Name: .....
- b) Gender: Male  Female  (c) Age: Years   Months   d) Date of Birth:
- e) Relationship to Primary Insured: Self  Spouse  Child  Father  Mother   
Others  (Please Specify).....
- f) Occupation: Homemaker  Self Employed  Service  Student  Retired   
Others  (Please specify).....



g) Address (If different from above) : .....  
 .....City: .....  
 State : ..... Pin Code : .....  
 Email ID : ..... Phone No : .....

**DETAILS OF HOSPITALIZATION**

(SECTION D)

a) Name of Hospital where admitted : .....  
 ..... No of IP beds.....

b) Date of Admission: 

D	D
---	---

M	M
---	---

Y	Y
---	---

 c) Time 

H	H
---	---

M	M
---	---

d) Date of discharge: 

D	D
---	---

M	M
---	---

Y	Y
---	---

 e) Time 

H	H
---	---

M	M
---	---

f) Room category occupied: Day care  Single Occupancy  Twin Sharing  3 or more beds per room

g) Hospitalization due to: Injury  Illness  Maternity

h) Date of injury / Date Disease first detected /Date of delivery: 

D	D
---	---

M	M
---	---

Y	Y
---	---

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

j) System of Medicine: Allopathic  Ayurvedic  Homeopathic  Others.....

**DETAILS OF CLAIM**

(SECTION E)

a) Details of the treatment expenses claimed

i) Pre-hospitalization Expenses: Rs.....  
 ii) Hospitalization Expenses: Rs.....  
 iii) Post-hospitalization Expenses: Rs.....  
 iv) Health-Checkup Cost: Rs.....  
 v) Ambulance charges: Rs.....  
 vi) Others (code): .....  
 Total : Rs.....  
 (vii) Pre-hospitalization period: Days.....  
 (viii) Post-hospitalization period Days.....

b) Claim for Domiciliary Hospitalization:

Yes  No

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 (code): Rs.....  
 Total : Rs.....

NB:- PLEASE FURNISH BILL DETAILS IN ANNEXURE-3



**CLAIM DOCUMENTS SUBMITTED - CHECK LIST****(SECTION F)**

- |  |   |
|--|---|
| <input type="checkbox"/> Claim Form duly signed        | <input type="checkbox"/> Operation Theatre Notes                          |
| <input type="checkbox"/> Hospital Discharge Summary    | <input type="checkbox"/> Doctor's request for investigation               |
| <input type="checkbox"/> Hospital Main Bill            | <input type="checkbox"/> Investigation reports (Including CT/MRI/USG/HPE) |
| <input type="checkbox"/> Hospital Break-up Bill        | <input type="checkbox"/> ECG / X - Rays                                   |
| <input type="checkbox"/> Pharmacy Bills                | <input type="checkbox"/> Doctor's Prescription                            |
| <input type="checkbox"/> Hospital Bill Payment Receipt | <input type="checkbox"/> Others   |

**DETAILS OF PRIMARY INSURED'S BANK ACCOUNT****(SECTION G)**

- a) PAN : ..... b) Bank Account No:.....
- c) Bank Name & Branch:.....
- d) Cheque / DD Payable details..... e) IFSC Code:.....

**DECLARATION BY THE INSURED****(SECTION H)**

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, my right to claim reimbursement shall be forfeited. I also consent and 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 and that I will not be making any supplementary claim except the pre / post-hospitalization claim, if any

Date: 

D	D	M	M	Y	Y
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Place: .....

Signature of the insured.....

GUIDANCE FOR FILLING CLAIM FORM-PART A		
DATA ELEMENT	DESCRIPTION	FORMAT
<b>SECTION A - DETAILS OF PRIMARY INSURED</b>		
a) Policy No.	Enter the policy number	As allotted by the insurance company
b) Claim intimation No.	Enter claim intimation No.	As allotted by the organization
c) Sl. No./Certificate No.	Enter the social insurance number or the certificate number of social health insurance scheme	As allotted by the organization
d) Company TPA ID No.	Enter the TPA ID No.	License number as allotted by IRDA and printed in TPA documents
e) Name	Enter the full name of the policy holder	Surname, First name, Middle name
f) Address	Enter the full postal address	Include Street, City and Pin Code
<b>SECTION B - DETAILS OF INSURANCE HISTORY</b>		
a) Currently covered by any other Mediciam / Health Insurance ?	Indicate whether currently covered by another Mediciam / Health Insurance	Tick Yes or No
b) Company Name	Enter full name of the insurance company	Name of the organization in full
Policy No.	Enter the policy number	As allotted by the insurance company
Sum Insured	Enter the total sum insured as per the policy	In rupees
c) Date of Commencement of first Insurance without break	Enter the date of commencement of first insurance	Use dd-mm-yy format
d) Have you been hospitalized in the last 4 years	Indicate whether hospitalized in the last 4 years	Tick Yes or No
Date	Enter the date of hospitalization	Use dd-mm-yy format
Diagnosis	Enter the diagnosis details	Open Text
e) Previously Covered by any other Mediciam / Health Insurance ?	Indicate whether previously covered by another Mediciam / Health Insurance	Tick Yes or No
f) Company Name	Enter the name of the insurance company	Name of the organization in full
<b>SECTION C - DETAILS OF INSURED PERSON HOSPITALIZED</b>		
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
Phone No	Enter the phone number of patient	Include STD code with telephone number
E-mail ID	Enter e-mail address of patient	Complete e-mail address
<b>SECTION D - DETAILS OF HOSPITALIZATION</b>		
a) Name of Hospital where admitted	Enter the name of hospital	Name of hospital in full
b) Date of admission	Enter date of admission	Use dd-mm-yy format
c) Time	Enter time of admission	Use hh-mm format
d) Date of discharge	Enter date of discharge	Use dd-mm-yy format
e) Time	Enter time of discharge	Use hh-mm format
f) Room category occupied	Indicate the room category occupied	Tick the right option
g) Hospitalization due to	Indicate reason of hospitalization	Tick the right option
h) Date of Injury / Date Disease first detected / Date of Delivery	Enter the relevant date	Use dd-mm-yy 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 filed	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
<b>SECTION E - DETAILS OF CLAIM</b>		
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 for 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)
NB :- Please furnish the details of all bills claimed on the attached format {Annexure -3}		
<b>SECTION F - CLAIM DOCUMENTS SUBMITTED-CHECK LIST</b>		
Claim Documents Submitted - Check List	Indicate which supporting documents are submitted	Tick the right option
<b>SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT</b>		
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
<b>SECTION H - DECLARATION BY THE INSURED</b>		
Read declaration carefully and mention date (in dd : mm : yy format), place and sign		



**CLAIM FORM - PART - B**

**TO BE FILLED BY THE HOSPITAL**

Issue of this form is not to be taken as admission of liability

(To be filled in block letters)

**DETAILS OF THE HOSPITAL**

(SECTION A)

- a) Name of the Hospital.....
- 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..... Email ID:.....

**DETAILS OF THE PATIENT ADMITTED**

(SECTION B)

- 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

**DETAILS OF AILMENT DIAGNOSED (PRIMARY)**

(SECTION C)

a) ICD 10 Codes	Description
(i) Primary Diagnosis : .....	.....
(ii) Additional Diagnosis : .....	.....
(iii) Co-morbidities : .....	.....
(iv) Co-morbidities : .....	.....
b) ICD 10 PCS	Description
(i) Procedure 1 : .....	.....
(ii) Procedure 2 : .....	.....
(iii) Procedure 3 : .....	.....
(iv) Details of Procedure : .....	.....



- c) Date of First Consultation for the diagnosed illness :
- d) Present ailment is a complication of PED ? Yes  No  (If yes, Specify details).....
- e) Pre-authorization obtained : Yes  No  f) Pre-authorization number:.....
- g) If network hospital, reason for not obtaining authorization :.....
- h) 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: Y/N  (If yes, attached 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**

(SECTION D)

- |  |  |
|--|--|
| <input type="checkbox"/> Claim form duly signed                                | <input type="checkbox"/> Investigation reports                                 |
| <input type="checkbox"/> Original Pre-authorization request                    | <input type="checkbox"/> Doctor's reference slip for investigation             |
| <input type="checkbox"/> Copy of the Pre-authorization approval letter         | <input type="checkbox"/> CT/MRI/USG/HPE investigation reports                  |
| <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"/> Hospital main bill                                    | <input type="checkbox"/> MLC report & Police FIR                               |
| <input type="checkbox"/> Hospital break-up bill                                | <input type="checkbox"/> Original death summary from hospital where applicable |
| <input type="checkbox"/> Operation Theatre notes                               | <input type="checkbox"/> Any other, please specify                             |

**DETAILS TO BE FILLED INCASE OF NON-NETWORK HOSPITAL ONLY**

(SECTION E)

- a) Address of the hospital.....
- .....
- City..... State.....
- Pin Code..... b) Phone No.....
- c) Registration No..... d) PAN..... e) No. of IP Beds.....
- f) Facilities available in the hospital (i) OT : Yes  No  (ii) ICU : Yes  No
- (iii) Others :.....



**DECLARATION BY THE INSURED**

(PLEASE READ VERY CAREFULLY)

(SECTION F)

I hereby declare that the information furnished in this claim form is true and 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, my right to claim reimbursement shall be forfeited. I also consent and authorize TPA / Insurance Company to seek necessary medical information / documents from the 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 and that I will not be making any supplementary claim except the pre / post hospitalization claim,if any.

Date 

DD	MM	YY
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Place.....

Signature of the Insured .....

**DECLARATION BY THE HOSPITAL**

(PLEASE READ VERY CAREFULLY)

(SECTION G)

We hereby declare that the information furnished in this claim form is true and correct to the best of our knowledge and belief. If we made any false or untrue statement, suppression or concealment of any material fact, the right to claim for the treatment shall be forfeited. The signature of insured is taken on this form after Claim Form B is fully filled up by us.

Date 

DD	MM	YY
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Place.....

Signature and seal:

(i) Treating doctor .....

(ii) Hospital Authority .....

**Not to be Faxed/Scanned**

**GUIDANCE FOR FILLING CLAIM FORM-PART B**

DATA ELEMENT	DESCRIPTION	FORMAT
<b>SECTION A - DETAILS OF HOSPITAL</b>		
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 qualifications of the treating doctor	Abbreviations of educational qualifications
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
<b>SECTION B - DETAILS OF THE PATIENT ADMITTED</b>		
a) Name of Patient	Enter the name of hospital	Name of hospital in full
b) IP Registration Number	Enter insurance provider registration number	As allotted 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 birth of patient	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
<b>SECTION C - DETAILS OF AILMENT DIAGNOSED (PRIMARY)</b>		
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) Date of first consultation for the diagnosed illness	Enter the first consultation date for the diagnosed illness	Use dd-mm-yy format
d) Present ailment is a Complication of PED	Indicate whether present ailment is a complication of some pre-existing disease	Tick Yes or No
e) Pre-authorization obtained	Indicate whether pre-authorization obtained	Tick Yes or No
f) Pre-authorization Number	Enter pre-authorization number	As allotted by TPA
g) If network hospital, reason for not obtaining authorization	Enter reason for not obtaining pre-authorization number	Open text
h) 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 the reason for not reporting to police	Open Text
<b>SECTION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST</b>		
Indicate which supporting documents are submitted		
<b>SECTION E - DETAILS TO BE FILLED IN CASE OF NON-NETWORK HOSPITAL ONLY</b>		
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.	Enter the registration number of patient	As allocated by the Hospital
d) PAN	Enter the permanent account number	As allotted 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
<b>SECTION F - DECLARATION BY THE INSURED</b>		
Read declaration carefully and mention date (in dd-mm-yy format), place and sign.		
<b>SECTION G - DECLARATION BY THE HOSPITAL</b>		
Read declaration carefully and mention date (in dd-mm-yy format), place and sign (Treating Doctor, Hospital authority) and stamp		





# Star Health and Allied Insurance Co. Ltd

Claim No ..... Policy No: .....

Patient Name: .....

## DETAILS OF BILLS CLAIMED

SI NO	BILL NO	BILL DATE	TOWARDS HOSPITALIZATION / PRE / POST	AMOUNT
			Hospital Main Bill	
1				
2				
3				
4				
5				
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25				
<b>TOTAL CLAIMED AMOUNT:</b>				

- NB: - 1. Please attach original pre and post hospitalization bills (if any)  
 2. For Lab, Investigations, X- rays, ECG, and Scans, please submit the films and reports. Or else, the amount claimed will not be allowed

Date .....

Signature of the Insured .....



FOR OFFICE USE :-

Sl. No.	Particulars	Amount	Total
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