CLAIM FORM - PART A' to 'CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT - PART A

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

/To I	oo Fill	nd in	block	letters)

DETAILS OF PRIMARY INSURED:		
a) Policy No.:	b) SI. No/ Certificate no.	
c) Company/ TPA ID No:		
d) Name: SURNAME FI	R S T N A M E M I D D L	E NAME
e) Address:		
		>
City:	State:	
Pin Code Phone No: Phone No:	Email ID:	
DETAILS OF INSURANCE HISTORY:		
	of commencement of first Insurance without break:	YYYY
c) If yes, company name:	Policy No.	Date: M M Y Y
Sum insured (Rs.) d) Have you been hospitalized in the last	t four years since inception of the contract? Yes No	Date: M M Y Y
Diagnosis:	e) Previously covered by any other Medic	claim /Health insurance : Yes No
f) If yes, company name:		
DETAILS OF INSURED PERSON HOSPITALIZED: :		
a) Name: SURNAME FI	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)	on T
f) Occupation Service Self Employed Home Maker Student	Retired Other (Please Specify)	
g) Address (if diffrent from above) :		
City:	State:	
Pin Code Phone No: Phone No:	Email ID:	
DETAILS OF HOSPITALIZATION: :		
a) Name of Hospital where Admited:		
b) Room Category occupied: Day care Single occupancy	Twin sharing 3 or more beds per room	
	d) Date of injury / Date Disease first detected /Date of Delivery:	M M Y Y Y Y
	M H g) Date of Discharge: D D M M Y Y	M M Y Y Y Y Y S C C C C C C C C C C C C C C
	Substance Abuse / Alcohol Consumption I) If Medico legal	Yes No
, , , , ,		
ii) Reported to Police iii. MLC Report & Police FIR attached	Yes No j) System of Medicine:	
ii) Reported to Police iii. MLC Report & Police FIR attached DETAILS OF CLAIM:	Yes No j) System of Medicine:	
		n Documents Submitted - Check List:
DETAILS OF CLAIM: a) Details of the Treatment expenses claimed		n Documents Submitted - Check List: Claim form duly signed
DETAILS OF CLAIM: a) Details of the Treatment expenses claimed I. Pre -hospitalization expenses Rs	Clain	Claim form duly signed Copy of the claim intimation, if any
DETAILS OF CLAIM: a) Details of the Treatment expenses claimed I. Pre -hospitalization expenses Rs.	spitalization expenses Rs	Claim form duly signed Copy of the claim intimation, if any Hospital Main Bill
DETAILS OF CLAIM: a) Details of the Treatment expenses claimed I. Pre -hospitalization expenses Rs.	spitalization expenses Rs	Claim form duly signed Copy of the claim intimation, if any Hospital Main Bill Hospital Break-up Bill
DETAILS OF CLAIM: a) Details of the Treatment expenses claimed I. Pre -hospitalization expenses Rs. ii. Hos iii. Post-hospitalization expenses Rs. iv. He v. Ambulance Charges: Rs. vi. Oth	spitalization expenses Rs	Claim form duly signed Copy of the claim intimation, if any Hospital Main Bill Hospital Break-up Bill
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DETAILS OF CLAIM: a) Details of the Treatment expenses claimed I. Pre -hospitalization expenses Rs.	spitalization expenses Rs	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
DETAILS OF CLAIM: a) Details of the Treatment expenses claimed I. Pre -hospitalization expenses Rs.	spitalization expenses Rs	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
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DETAILS OF CLAIM: a) Details of the Treatment expenses claimed I. Pre -hospitalization expenses Rs.	spitalization expenses Rs	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 Amount (Rs)
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(IMPORTANT: PLEASE TURN OVER)

DECL	APATION	J BY THE	INCLIBED

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 concealent of any material fact with respect to questions asked in relation to this claim, my right to claim reimbrusement 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	YYYY	Place:	Signature of the Insured	

	DATA ELEMENT	OR FILLING CLAIM FORM - PART A (To be filled in by the insured DESCRIPTION	FORMAT
		SECTION A - DETAILS OF PRIMARY INSURED	
a)	Policy No.	Enter the policy number	As allotted by the Insurance Company
_	500 VATE (\$000 \$1000 \$1000 \$1000)	Enter the social Insurance number or the certificate number of	2023 - 34 - 34 - 32 - 32 - 32 - 32 - 32 -
)	SI. No/ Certificate No.	social health insurance scheme	As allotted by the oraganization
(:)	Company TPA ID No.	Enter the TPA ID No.	Licence number as allotted by IRDA and printe in TPA documents.
i)	Name	Enter the full name of the policyholder	Surname, First name, Middle name
9)	Address	Enter the full postal address	Include Street, City and Pin code
		SECTION B -DETAILS OF INSURANCE HISTORY	
а)	Currently covered by any other Mediclaim / Health Insurance?	Indicate whether currently covered by another Mediclaim / Health Insurance	Tick Yes or No
)	Date of commencement of first Insurance without break	Enter the date of commencement of first Insurance	Use dd-mm-yy-forrmat
)	Company Name	Enter the 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
i)	Have you been Hospitalized in the last four years since Inception of the contract?	Indicate whether hospitalized in the last four years	Tick Yes or No
	Date	Enter the date of Hospitalization	Use mm-yy format
_	Diagnosis	Enter the diagnosis details	Open Text
)	Previously covered by any other Mediclaim / Health Insurance?	Indicate whether previously covered by another mediclaim / Health Insurance	Tick Yes or No
)	Company Name	Enter the full name of the Insurance Company	Name of the organization in full
	SECT	TION C -DETAILS OF INSURED PERSON HOSPITALIZED	
)	Name	Enter the full name of the patient	Surname, First name, Middle name
)	Gender	Indicate Gender of the patient	Tick Male or Female
)	Age	Enter age of the patient	Number of years and months
1)	Date of Birth	Enter Date of Birth of patient	Use dd-mm-yy format
)	Relationship to primary Insured	Indicate relationship of patient with policyholder	Tick the right option, if others, please specify
)	Occupation	indicate occupation of patient	Tick the right option. If others, please specify.
_	Address	Enter the full postal address	Include Street, City and Pin code
1)	Phone No	Enter the phone number of patient	Include STD code with telephone number
_	WO 19 (200)		600 00 to 10 to 100 to
)	E-mail ID	Enter e-mail address of patient SECTION D - DETAILS OF HOSPITALIZATION	Complete e-mail address
	Name of Handball observed with d		
1)	Name of Hospital where admited	Enter the name of hospital	Name of hospital in full
)	Room category occupied	indicate the room category occupied	Tick the right option Tick the right option
_		to the state of th	
;)	Hospitalization due to Date of injury/Date Disease first detected / Date of	indicate reason of hospitalization	500 BUILD MAD 10
;) i)	Date of injury/Date Disease first detected / Date of Delivery	indicate reason of hospitalization Enter the relevant date	Use dd-mm-yy format
;) i)	Date of injury/Date Disease first detected / Date of	Enter the relevant date Enter date of admission	500 BUILD MAD 10
i) l)	Date of injury/Date Disease first detected / Date of Delivery	Enter the relevant date	Use dd-mm-yy format
i) l) e)	Date of injury/Date Disease first detected / Date of Delivery Date of admission	Enter the relevant date Enter date of admission	Use dd-mm-yy format Use dd-mm-yy format
;) i) ;)	Date of injury/Date Disease first detected / Date of Delivery Date of admission Time	Enter the relevant date Enter date of admission Enter time of admission	Use dd-mm-yy format Use dd-mm-yy format Use hh-mm- format
(i) (i) (i) (i)	Date of injury/Date Disease first detected / Date of Delivery Date of admission Time Date of discharge	Enter the relevant date Enter date of admission Enter time of admission Enter date of discharge	Use dd-mm-yy format Use dd-mm-yy format Use hh-mm- format Use dd-mm-yy format
(i) (i) (i) (i)	Date of injury/Date Disease first detected / Date of Delivery Date of admission Time Date of discharge Time	Enter the relevant date Enter date of admission Enter time of admission Enter date of discharge Enter time of discharge indicate cause of injury indicate whether injury is medico legal	Use dd-mm-yy format Use dd-mm-yy format Use hh-mm- format Use dd-mm-yy format Use hh-mm- format
i) i) i) j)	Date of injury/Date Disease first detected / Date of Delivery Date of admission Time Date of discharge Time If injury give cause	Enter the relevant date Enter date of admission Enter time of admission Enter date of discharge Enter time of discharge indicate cause of injury	Use dd-mm-yy format Use dd-mm-yy format Use hh-mm- format Use dd-mm-yy format Use hh-mm- format Tick the right option
(a) (d) (e) (f) (g)	Date of injury/Date Disease first detected / Date of Delivery Date of admission Time Date of discharge Time If injury give cause If Medico legal	Enter the relevant date Enter date of admission Enter time of admission Enter date of discharge Enter time of discharge indicate cause of injury indicate whether injury is medico legal	Use dd-mm-yy format Use dd-mm-yy format Use hh-mm- format Use dd-mm-yy format Use hh-mm- format Tick the right option Tick Yes or No
(i) (i) (i) (i) (i) (i) (i)	Date of injury/Date Disease first detected / Date of Delivery Date of admission Time Date of discharge Time If injury give cause If Medico legal Reported to Police	Enter the relevant date Enter date of admission Enter time of admission Enter date of discharge Enter time of discharge indicate cause of injury indicate whether injury is medico legal indicate whether police report was filed	Use dd-mm-yy format Use dd-mm-yy format Use hh-mm- format Use dd-mm-yy format Use hh-mm- format Tick the right option Tick Yes or No Tick Yes or No
(c) (d) (d) (e) (f) (g) (n) (n)	Date of injury/Date Disease first detected / Date of Delivery Date of admission Time Date of discharge Time If injury give cause If Medico legal Reported to Police MLC Report & Police FIR attached	Enter the relevant date Enter date of admission Enter time of admission Enter date of discharge Enter time of discharge Enter time of discharge indicate cause of injury indicate whether injury is medico legal indicate whether police report was filed indicate whether MLC report and Police FIR attached	Use dd-mm-yy format Use hh-mm- format Use hh-mm- format Use hh-mm- format Use hh-mm- format Tick the right option Tick Yes or No Tick Yes or No Tick Yes or No
)))))))	Date of injury/Date Disease first detected / Date of Delivery Date of admission Time Date of discharge Time If injury give cause If Medico legal Reported to Police MLC Report & Police FIR attached	Enter the relevant date Enter date of admission Enter time of admission Enter date of discharge Enter time of discharge Enter time of discharge indicate cause of injury indicate whether injury is medico legal indicate whether police report was filed indicate whether MLC report and Police FIR attached Enter the system of medicine followed in treating the patient	Use dd-mm-yy format Use hh-mm- format Use hh-mm- format Use hh-mm- format Use hh-mm- format Tick the right option Tick Yes or No Tick Yes or No Tick Yes or No
(c) (d) (d) (e) (d) (d) (d) (d) (d) (d) (d) (d) (d) (d	Date of injury/Date Disease first detected / Date of Delivery Date of admission Time Date of discharge Time If injury give cause If Medico legal Reported to Police MLC Report & Police FIR attached System of Medicene	Enter the relevant date Enter date of admission Enter time of admission Enter date of discharge Enter date of discharge Enter time of discharge indicate cause of injury indicate whether injury is medico legal indicate whether police report was filed indicate whether MLC report and Police FIR attached Enter the system of medicine followed in treating the patient SECTION E - DETAILS OF CLAIM	Use dd-mm-yy format Use dd-mm-yy format Use hh-mm- format Use dd-mm-yy format Use hh-mm- format Tick the right option Tick Yes or No Tick Yes or No Tick Yes or No Open Text
(i) (i) (i) (i) (i) (i) (i) (i) (i) (i)	Date of injury/Date Disease first detected / Date of Delivery Date of admission Time Date of discharge Time If injury give cause If Medico legal Reported to Police MLC Report & Police FIR attached System of Medicene Details of Treatment Expences	Enter the relevant date Enter date of admission Enter time of admission Enter date of discharge Enter date of discharge Enter time of discharge indicate cause of injury indicate whether injury is medico legal indicate whether police report was filed indicate whether MLC report and Police FIR attached Enter the system of medicine followed in treating the patient SECTION E - DETAILS OF CLAIM Enter the amount claimed as treatment expences	Use dd-mm-yy format Use dd-mm-yy format Use hh-mm- format Use dd-mm-yy format Use hh-mm- format Tick the right option Tick Yes or No Tick Yes or No Tick Yes or No Open Text In rupees (Do not enter paise values)
(i) (i) (ii) (ii) (iii)	Date of injury/Date Disease first detected / Date of Delivery Date of admission Time Date of discharge Time If injury give cause If Medico legal Reported to Police MLC Report & Police FIR attached System of Medicene Details of Treatment Expences Claim for Domiciliary Hospitalization	Enter the relevant date Enter date of admission Enter time of admission Enter date of discharge Enter date of discharge Enter time of discharge indicate cause of injury indicate whether injury is medico legal indicate whether police report was filed indicate whether MLC report and Police FIR attached Enter the system of medicine followed in treating the patient SECTION E - DETAILS OF CLAIM Enter the amount claimed as treatment expences indicate whether claim is for domiciliary hospitalization	Use dd-mm-yy format Use dd-mm-yy format Use hh-mm- format Use dd-mm-yy format Use hh-mm- format Tick the right option Tick Yes or No Tick Yes or No Tick Yes or No Open Text In rupees (Do not enter paise values) Tick Yes or No
(i) (i) (i) (i) (i) (i) (i) (i) (i) (i)	Date of injury/Date Disease first detected / Date of Delivery Date of admission Time Date of discharge Time If injury give cause If Medico legal Reported to Police MLC Report & Police FIR attached System of Medicene Details of Treatment Expences Claim for Domiciliary Hospitalization Details of Lump sum/ Cash benifit claimed	Enter the relevant date Enter date of admission Enter time of admission Enter date of discharge Enter date of discharge Enter time of discharge indicate cause of injury indicate whether injury is medico legal indicate whether police report was filed indicate whether MLC report and Police FIR attached Enter the system of medicine followed in treating the patient SECTION E - DETAILS OF CLAIM Enter the amount claimed as treatment expences indicate whether claim is for domiciliary hospitalization Enter the amount claimed as lump sum / cash benefit	Use dd-mm-yy format Use dd-mm-yy format Use hh-mm- format Use dd-mm-yy format Use hh-mm- format Tick the right option Tick Yes or No Tick Yes or No Open Text In rupees (Do not enter paise values) Tick Yes or No In rupees (Do not enter paise values)
i) i) i) i) i) ii)	Date of injury/Date Disease first detected / Date of Delivery Date of admission Time Date of discharge Time If injury give cause If Medico legal Reported to Police MLC Report & Police FIR attached System of Medicene Details of Treatment Expences Claim for Domiciliary Hospitalization Details of Lump sum/ Cash benifit claimed	Enter the relevant date Enter date of admission Enter time of admission Enter date of discharge Enter date of discharge Enter time of discharge indicate cause of injury indicate whether injury is medico legal indicate whether police report was filed indicate whether MLC report and Police FIR attached Enter the system of medicine followed in treating the patient SECTION E - DETAILS OF CLAIM Enter the amount claimed as treatment expences indicate whether claim is for domiciliary hospitalization Enter the amount claimed as lump sum / cash benefit indicate which supporting documents are submitted	Use dd-mm-yy format Use dd-mm-yy format Use hh-mm- format Use dd-mm-yy format Use hh-mm- format Tick the right option Tick Yes or No Tick Yes or No Tick Yes or No Open Text In rupees (Do not enter paise values) Tick Yes or No In rupees (Do not enter paise values)
	Date of injury/Date Disease first detected / Date of Delivery Date of admission Time Date of discharge Time If injury give cause If Medico legal Reported to Police MLC Report & Police FIR attached System of Medicene Details of Treatment Expences Claim for Domiciliary Hospitalization Details of Lump sum/ Cash benifit claimed Claim documents Submitted-Check List	Enter the relevant date Enter date of admission Enter time of admission Enter date of discharge Enter date of discharge Enter time of discharge indicate cause of injury indicate whether injury is medico legal indicate whether police report was filed indicate whether MLC report and Police FIR attached Enter the system of medicine followed in treating the patient SECTION E - DETAILS OF CLAIM Enter the amount claimed as treatment expences indicate whether claim is for domiciliary hospitalization Enter the amount claimed as lump sum / cash benefit indicate which supporting documents are submitted	Use dd-mm-yy format Use dd-mm-yy format Use hh-mm- format Use dd-mm-yy format Use hh-mm- format Tick the right option Tick Yes or No Tick Yes or No Open Text In rupees (Do not enter paise values) Tick Yes or No In rupees (Do not enter paise values)
(i) (i) (i) (i) (i) (i) (i) (ii) (ii) (Date of injury/Date Disease first detected / Date of Delivery Date of admission Time Date of discharge Time If injury give cause If Medico legal Reported to Police MLC Report & Police FIR attached System of Medicene Details of Treatment Expences Claim for Domiciliary Hospitalization Details of Lump sum/ Cash benifit claimed Claim documents Submitted-Check List	Enter the relevant date Enter date of admission Enter time of admission Enter date of discharge Enter date of discharge Enter time of discharge indicate cause of injury indicate whether injury is medico legal indicate whether police report was filed indicate whether MLC report and Police FIR attached Enter the system of medicine followed in treating the patient SECTION E - DETAILS OF CLAIM Enter the amount claimed as treatment expences indicate whether claim is for domiciliary hospitalization Enter the amount claimed as lump sum / cash benefit indicate which supporting documents are submitted SECTION F - DETAILS OF BILLS ENCLOSED	Use dd-mm-yy format Use dd-mm-yy format Use dd-mm-yy format Use dd-mm-yy format Use hh-mm- format Tick the right option Tick Yes or No Tick Yes or No Open Text In rupees (Do not enter paise values) Tick Yes or No In rupees (Do not enter paise values)
(i) (i) (i) (i) (i) (i) (i) (i) (ii) (i	Date of injury/Date Disease first detected / Date of Delivery Date of admission Time Date of discharge Time If injury give cause If Medico legal Reported to Police MLC Report & Police FIR attached System of Medicene Details of Treatment Expences Claim for Domiciliary Hospitalization Details of Lump sum/ Cash benifit claimed Claim documents Submitted-Check List cate which bills are enclosed with the amount in rupees	Enter the relevant date Enter date of admission Enter time of admission Enter date of discharge Enter date of discharge Enter time of discharge indicate cause of injury indicate whether injury is medico legal indicate whether police report was filed indicate whether MLC report and Police FIR attached Enter the system of medicine followed in treating the patient SECTION E - DETAILS OF CLAIM Enter the amount claimed as treatment expences indicate whether claim is for domiciliary hospitalization Enter the amount claimed as lump sum / cash benefit indicate which supporting documents are submitted SECTION F - DETAILS OF BILLS ENCLOSED	Use dd-mm-yy format Use dd-mm-yy format Use dd-mm-yy format Use dd-mm-yy format Use hh-mm- format Tick the right option Tick Yes or No Tick Yes or No Open Text In rupees (Do not enter paise values) Tick Yes or No In rupees (Do not enter paise values) Tick the right option
(c) (d) (d) (e) (f) (g) (n) (n) (n) (d) (n) (n) (n) (n) (n) (n) (n) (n) (n) (n	Date of injury/Date Disease first detected / Date of Delivery Date of admission Time Date of discharge Time If injury give cause If Medico legal Reported to Police MLC Report & Police FIR attached System of Medicene Details of Treatment Expences Claim for Domiciliary Hospitalization Details of Lump sum/ Cash benifit claimed Claim documents Submitted-Check List cate which bills are enclosed with the amount in rupees SECTIO PAN Account Number	Enter the relevant date Enter date of admission Enter time of admission Enter date of discharge Enter time of discharge Enter time of discharge indicate cause of injury indicate whether injury is medico legal indicate whether police report was filed indicate whether MLC report and Police FIR attached Enter the system of medicine followed in treating the patient SECTION E - DETAILS OF CLAIM Enter the amount claimed as treatment expences indicate whether claim is for domiciliary hospitalization Enter the amount claimed as lump sum / cash benefit indicate which supporting documents are submitted SECTION F - DETAILS OF BILLS ENCLOSED	Use dd-mm-yy format Use dd-mm-yy format Use dd-mm-yy format Use dd-mm-yy format Use hh-mm- format Tick the right option Tick Yes or No Tick Yes or No Open Text In rupees (Do not enter paise values) Tick Yes or No In rupees (Do not enter paise values) Tick the right option As allotted by the Income Tax Department As allotted by the Bank
(c) (d) (e) (f) (g) (n) () (n) (d)	Date of injury/Date Disease first detected / Date of Delivery Date of admission Time Date of discharge Time If injury give cause If Medico legal Reported to Police MLC Report & Police FIR attached System of Medicene Details of Treatment Expences Claim for Domiciliary Hospitalization Details of Lump sum/ Cash benifit claimed Claim documents Submitted-Check List cate which bills are enclosed with the amount in rupees SECTIO	Enter the relevant date Enter date of admission Enter time of admission Enter date of discharge Enter time of discharge Enter time of discharge indicate cause of injury indicate whether injury is medico legal indicate whether police report was filed indicate whether MLC report and Police FIR attached Enter the system of medicine followed in treating the patient SECTION E - DETAILS OF CLAIM Enter the amount claimed as treatment expences indicate whether claim is for domiciliary hospitalization Enter the amount claimed as lump sum / cash benefit indicate which supporting documents are submitted SECTION F - DETAILS OF BILLS ENCLOSED N G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT Enter the permanent account number Enter the Bank account number Enter the Bank name along with the branch Enter the name of the beneficiary the cheque / DD should be	Use dd-mm-yy format Use dd-mm-yy format Use dd-mm-yy format Use dd-mm-yy format Use hh-mm- format Tick the right option Tick Yes or No Tick Yes or No Open Text In rupees (Do not enter paise values) Tick Yes or No In rupees (Do not enter paise values) Tick the right option As allotted by the Income Tax Department
(i) (i) (i) (i) (i) (i) (i) (i) (i) (i)	Date of injury/Date Disease first detected / Date of Delivery Date of admission Time Date of discharge Time If injury give cause If Medico legal Reported to Police MLC Report & Police FIR attached System of Medicene Details of Treatment Expences Claim for Domiciliary Hospitalization Details of Lump sum/ Cash benifit claimed Claim documents Submitted-Check List cate which bills are enclosed with the amount in rupees SECTIO PAN Account Number Bank Name and Branch	Enter the relevant date Enter date of admission Enter time of admission Enter date of discharge Enter date of discharge Enter time of discharge indicate cause of injury indicate whether injury is medico legal indicate whether Police report was filed indicate whether MLC report and Police FIR attached Enter the system of medicine followed in treating the patient SECTION E - DETAILS OF CLAIM Enter the amount claimed as treatment expences indicate whether claim is for domiciliary hospitalization Enter the amount claimed as lump sum / cash benefit indicate which supporting documents are submitted SECTION F - DETAILS OF BILLS ENCLOSED NG - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT Enter the permanent account number Enter the Bank account number Enter the Bank name along with the branch	Use dd-mm-yy format Use hh-mm- format Use hh-mm- format Use hh-mm- format Use hh-mm- format Tick the right option Tick Yes or No Tick Yes or No Open Text In rupees (Do not enter paise values) Tick Yes or No In rupees (Do not enter paise values) Tick the right option As allotted by the Income Tax Department As allotted by the Bank Name of the Bank in full

SECTION H

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	IOIII III IIEU OI PART A
a) Name of the hospital: a) Hospital ID: c) Type of Hospital: Network: c) Name of the treating doctor: S U R N A M E F I R S T N e) Qualification: f) Registration No. with State Code:	Non Network : (if non network fill section E) A M E M D D L E N A M E g) Phone No g) Phone No
DETAILS OF THE PATIENT ADMITTED	
a) Name of the Patient: S U R N A M E FIRST N	
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a) ICD 10 Codes Description b) I. Primary Diagnosis i. Procedure 1: ii. Additional Diagnosis: ii. Procedure 2:	ICD 10 PCS Description
iii. Co-morbidities: iii. Procedure 3:	
iv. Co-morbidities: iv. Details of Procedu	ure:
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 ii) If injury due to substance abuse / alcohol consumption, Test conducted to establish this: Yes No (If Yes, attach reports) v. FIR No No No CLAIM DOCUMENTS SUBMITTED - CHECK LIST	t Substance abuse / alcohol consumption iii. If Medico legal: Yes No iv. Reported to Police Yes No
□ Original Pre-authorization request □ CT/MR/U □ Copy of the Pre-authorization approval letter □ Doctor's □ Copy of Photo ID Card of patient Verified by hospital □ ECG □ Hospital Discharge summary □ Pharmac □ Operation Theatre Notes □ MLC rep □ Hospital main bill □ Original of	USG/HPE investigation reports reference slip for investigation by bills orts & Police FIR death summary from hospital where applicable r, 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. 1 d) Hospital PAN: e) Number of inpatient beds f) Facilities iii. Others:	c) Registration No. with State Code: I. OT Yes No ii. ICU Yes No
DECLARATION BY THE HOSPITAL	(DI EACE DEAD VEDV GAREEVE VA
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 fa our right to claim under this claim shall be forfeited.	(PLEASE READ VERY CAREFULLY) Is or untrue statement, suppression or concealment of any material fact,
Date: D D M M Y Y Place: Signature and Seal of the Hospital Authority:	

	GUIDANCE FOR FI	LLING CLAIM FORM - PART B (To be filled in by the hos	pital)
	DATA ELEMENT	DESCRIPTION	FORMAT
		SECTION A - DETAILS OF HOSPITAL	
a)	Name of the hospital:	Enter the name of hospital	Name of the 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
c)	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 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
		TION B - DETAILS OF THE PATIENT ADMITTED	
a)	Name of Patient	Enter the name of patient	Name of patient 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	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		
i.	Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format
ij	. Gravida Status	Enter Gravida status if maternity	Use standard format
I)	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 Code and description of the first procedure	Standard Format and Open text
	Procedure 2	Enter the ICD 10 Code and description of the second procedure	Standard Format and Open text
	Procedure 3	Enter the ICD 10 Code 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
_	If authorization by network hospital not obtained, give reason	Enter reason for not obtaining pre-authorization number	Open text
e)	, , ,		*
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 authrities
	If not reported to police, give reason	Enter reason for not reporting to police	Open text
	SEC ⁻	TION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST	•
Indica	ate which supporting documents are submitted		
	SECT	ION E - DETAILS IN CASE OF NON NETWORK HOSPITA	L
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 Hospital obtained from local body	As allocated by the City Corporation / Municipa
d)	Hospital PAN	like City Corporation / Municipality Enter the permanent account number	As allocated by the Income Tax Department
e)	Number of Inpatient beds	(S. 1995) 46. Matrix • • • • • • • • • • • • • • • • • • •	Digits
f)	Facilities available in the hospital	Enter the number of inpatient beds	Tick the right option. If others, please specify
'/	i domado avalidado in tile mospital	Indicate facilities available in the hospital	and right option. It outers, prease specify
		SECTION F - DECLARATION BY THE HOSPITAL	