CLAIM FORM - PART A TO BE FILLED IN BY THE INSURED The issue of this Form is not to be taken as an

(To be filled in block letters)

admission of liability DETAILS OF PRIMARY INSURED: a) Policy No: b) Sl. No/ Certificate No: c) Phs No./ TPA ID No: d) Name: e) Address: State: City: Pin Code: Phone No: Email ID: Insurance DETAILS OF INSURANCE HISTORY: □ No (Copies of Policies to be attached) b) Date of commencement of first Insurance without break: c) If yes, company name: Policy No. Sum Insured (Rs.) d) Have you been hospitalized in the last 4 years? ☐ Yes ☐ No Date: Diagnosis: e) Previously covered by any other Mediclaim / Health insurance : ☐ Yes □No f) If yes, Company Name DETAILS OF INSURED PERSON HOSPITALIZED: a) Name: b) Gender: ☐ Male ☐ Female c) Age: years months d) Date of Birth:s e) Relationship to Primary insured: Self ☐ Spouse ☐ Child ☐ Father ☐ Mother ☐ Other □ (Please Specify) Service \square Self Employed \square Homemaker \square Student \square Retired f) Occupation: Other □ (Please Specify) g) Address (if different from above): City: State: Pin Code: Phone No: Email ID:

a) Name of Hospital where Admitted: December 1 December 2 December 3 December 3 December 4 December 5 December 4 December 4 December 5 December 4 December 6 Decem	a) Na				_					
c) Hospitalization due to. Injury Illness d) Date of Injury Date Disease first detected IDate of Delivery: D D M M Y Y O Time: H H: M M g) Date of Discharge: D D M M Y Y O Time: H H: M M g) Date of Discharge: D D M M W Y Y O Time: H H: M M g) Date of Discharge: D D M M M Y Y O Time: H H: M M g) Date of Discharge: D D M M M Y Y O Time: H H: M M g) Date of Discharge: D D M M M W Y Y O Time: H H: M M g) Date of Discharge: D D M M M W Y Y O Time: H H: M M g) Date of Discharge: D D M M M W Y Y O Time: H H: M M g) Date of Discharge: D D M M M W Y Y O Time: H H: M M g) Date of Discharge: D D M M M W Y Y O Time: H H: M M g) Date of Discharge: D D M M M W Y Y O Time: H H: M M g) Date of Discharge: D D M M M W Y Y O Time: H H: M M g) Date of Discharge: D D M M M W Y Y O Time: H H: M M g) Date of Discharge: D D M M M W Y Y O Time: H H: M M g) Date of Discharge: D D D M M M W Y Y O Time: H H: M M g) Date of Discharge: D D D M M M W Y Y O Time: H H: M M g) Date of Discharge: D D D M M M W Y Y O Time: H H: M M g) Date of Discharge: D D D M M M W Y Y O Time: H H: M M g) Date of Discharge: D D D M M M W Y Y O Time: H H: M M g) Date of Discharge Submitted Check List I Time: D Date of the treatment expenses claimed Sort I Time: D Date of the treatment expenses claimed Sort I Time: D Date of the treatment expenses claimed Sort I Time: D Discharge Submitted Check List I Time: D Date of the treatment expenses claimed Sort I Time: D Date of the treatment expenses claimed Sort I Time: D Date of the treatment expenses claimed Sort I Time: D Date of the treatment expenses claimed Sort I Time: D Date of the treatment expenses claimed Sort I Time: D Date of the treatment expenses claimed Sort I Time: D Date of the treatment expenses claimed Sort I Time: D Date of the treatment expenses claimed Sort I Time: D Date of the treatment expenses claimed Sort I Time: D Date of the treatment expenses claimed Sort I Time: D Date of the treatment expenses claimed Sort I Time: D Date of the treatment expenses claimed Sort I Time: D Date of the		me of Hospital who	ere Adı	mitt	ed:					
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i) If Injury give cause: Self inflicted Road Traffic Accident Substance Abuse I 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: DETAILS OF CLAIM:	e) Dat	te of Admission:	D)	Μ	M	Y	f) Time: H H : M M g) Date of Discharge: D D	M M Y	Y
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d) Bank Name: e) Branch: f) Cheque / DD Payable details: DECLARATION BY THE INSURED:		y right to claim reimburse	ement sha	all be	forfeite	d. I also consen	t & authori		al / Medical Practition	er who has
d) Bank Name: e) Branch: f) Cheque / DD Payable details:	attende			nis cla	im is m	ade. I hereby de	eclare that	have included all the bills / receipts for the purpose of this claim & that I will not be making any si	upplementary claim ex	cept the

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

DETAILS OF HOSPITAL a) Name of the hospital: b) Hospital ID: c) Type of Hospital: Network \Box (If non Non Network □ network fill section E) d) 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 Μ h) Date of Discharge: f) Date of Admission: g) Time: Time: Н j) Type of Admission: Emergency Maternity □ Planned □ Day Care □ k) If Maternity i. Date of Delivery: ii. Gravida Status: 1) Status at time of discharge: Discharge to home □ Deceased □ Discharge to another hospital DETAILS OF AILMENT DIAGNOSED (PRIMARY) 0 ICD 10 Codes Description ICD 10 PCS Description i Primary i. Procedure 1: 80 Diagnosis: ii. Additional ii. Procedure 2: Diagnosis: iii. Coiii. Procedure 3: morbidities: iv Details of v. Co-Procedure morbidities: 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 \square 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 v. Reported to Police: □ Yes □ No v. FIR no (If Yes, specify details) CLAIM DOCUMENTS SUBMITTED - CHECK LIST Claim Form duly signed Investigation reports CTIMRIUSGIHPE investigation reports Original Pre-authorization request Doctor's reference slip for investigation Copy of the Pre-authorization approval letter 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

Any other, please specify

Hospital break-up bill

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.:	
d) Hospital PAN:	spital:
i. OT : □ Yes □ No ii. ICU : □ Yes □ No	1
iii. Others :	
DECLARATION BY THE INSURED (PLEASE READ VERY CAR 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 untru	
statement, suppression or concealment of any material fact, my right to claim reimbursement shall be forfeited. I also consent & authorize TPA I insurance company, to seek necessary medical information I documents from any hospital I Medical Practitioner who has attended on the person against whom this made. I hereby declare that I have included all the bills I receipts for the purpose of this claim & that I will not be making any supplementary claim except the prelpost hospitalization claim, if any.	claim is
Date: D D M M Y Y Place: Signature of the Insured:	
DECLARATION BY THE HOSPITAL: (PLEASE READ VERY CAR	EEHLIV
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 of the correct to the best of our knowledge and belief. If we have made any false of the correct to the best of our knowledge and belief.	or
untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited. The signature of the insured is ta on this form after Claim Form B is fully filled up by us	ken
Signature and Seal of the Hospital Authority	am
Date: D D M M Y Y Place:	1 n o
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