

CLAIM FORM - PART A TO BE FILLED BY THE INSURED (in block letters)

(The issue of this Form is not to be taken as an admission of liability)

DETAILS OF PRIMARY INSURED

	a)	Policy No. :							
	b)	Sl. No./Certificate No. : c) Company/TPA Id No. :							
A	d)	Name :							
SECTION	e)	Address :							
i i									
SS		City : State :							
		Pin Code : Email ID :							
		Fill Code . Enalt D							
	DETA	ILS OF INSURANCE HISTORY							
	a)	Currently covered by any other Mediclaim/Health Insurance : Yes No							
	b)								
	c)	Date of commencement of first Insurance without break : DDD MMM YYY If yes, Company Name :							
<u>m</u>	C)	Policy No. : Sum Insured (₹) :							
SECTION		Have you been hospitalised in the last four years since							
띮	d)	inception of the contract?							
S		Diagnosis :							
	e)	Previously covered by any other Mediclaim/Health Insurance :							
	f)	If Yes, Company Name :							
	DE	AILS OF INSURED PERSON HOSPITALISED							
	a)	Name : b) Gender : Male □ Female □							
	c)	Age : Years Y Y Months M M d) Date of D D M M Y Y Y Y							
	e)	Relation with Primary Insured : Self Spouse Child Father Mother							
	(e)	· · · · · · · · · · · · · · · · · · ·							
OZ		Other (Please Specify)							
SECTION C	f)	Occupation : Self							
SE		Other (Please Specify)							
	g)	Address :							
		City : State :							
		Pin Code : Email ID :							
	DE	TAILS OF HOSPITALISATION							
	a)	Name of Hospital where admitted :							
	b)	Room Category Occupied: Day care Single Occupancy Twin Sharing 3 or more beds per room							
	c)	Hospitalisation due to : Injury \square Illness \square Maternity \square							
۵	d)	Date of injury/Date of disease first detected/Date of Delivery							
8	e)	Date of Admission:							
SECTION D	g)	Date of Discharge: DD MM MYYY h) Time: HH: MM							
S	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 :							
		•							
ω i	ш DE	AILS OF CLAIM							

Navi Smart Health |UIN NAVHLIP23003V012223 | Claim Form Reimbursement Navi General Insurance Limited



	a)	Details of Treatm	ent exp	penses	s clain	ned (ir	n Rup	ees)		:			
	i)	Pre-hospitalisation	n Expe	enses		: ₹		ii)	Hospitalisation Expenses :		: ₹		
	iii)	Post-hospitalisat	ion Exp	enses		: ₹			iv)	Health	-Check up cost	: ₹	
	v)	Ambulance Char	ges			: =	₹			vi)	Others	(code):	₹
											Total	:	: ₹
	vii)	Pre-hospitalisation	n Perio	od: day	/s					viii)	Post-h	ospitalisation Period: days	
	b)	Claim for domicil	iary ho	spitalis	sation		:		Yes [] No	(If ye	s, provide details in annex	ure)
	c)	Details of Lump s	um/c	ash be	nefit o	claime	d (in	Rupe	es)	:			
	i)	Hospital Daily Ca	sh			:	₹				ii)	Surgical Cash	: ₹
	iii)	Critical Illness Be	nefit			:					— iv)	Convalescence	
	v)	Pre/Post hospital	isation	Lump	sum l	penefi			: ₹		— vi)	Others:	
	,										_ ′	Total	
												Total	
						Clain	ns Do	cume	ents Sub	omitted -	- Check	List	
		Claim form duly s	igned							Operat	ion Thea	tre Notes	
		Copy of the claim	intimo	ition, if	any					ECG			
		Hospital Main Bill								Doctor'	s reques	t for investigation	
		Hospital Break-u	p Bill							Investi	gation Re	ports (Including CT/MRI/U	ICG/HPE
		Hospital Bill Payn	nent Re	eceipt						Doctor'	s Prescr	iptions	
		Hospital Discharg	je Sum	mary						Others			
		Pharmacy Bill											
	DETAI	LS OF BILLS EN		- N									
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	SL No	DILL INO.		1	Dat		1		1880	led by	Tow		Amount (₹)
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	_		_								D	to a constant of the constant of the fitter	
	2		D	D	M	M	Υ	Υ				hospitalisation bills	
L Z	3		D	D	М	M	Υ	Υ			Post	-hospitalisation bills	
ION F	3					M	Y	Y			Post	•	
ECTION F	3 4 5		D	D	М	M	Y Y Y	Υ			Post	-hospitalisation bills	
SECTION F	3 4 5 6		D D	D D	M	M	Y Y Y	Y			Post	-hospitalisation bills	
SECTION F	3 4 5 6 7		D D	D D	M	M M	Y Y Y	Y Y Y			Post	-hospitalisation bills	
SECTION F	3 4 5 6 7 8		D D D	D D D	M M M	M M M	Y Y Y	Y Y Y			Post	-hospitalisation bills	
SECTION F	3 4 5 6 7 8 9		D D D D	D D D D	M M M M	M M M M	Y Y Y	Y Y Y			Post	-hospitalisation bills	
SECTION F	3 4 5 6 7 8		D D D D D	D D D D D	M M M M	M M M M M	Y Y Y Y Y Y	Y Y Y Y Y Y			Post	-hospitalisation bills	
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Navi Smart Health |UIN NAVHLIP23003V012223 | Claim Form Reimbursement

Navi General Insurance Limited



	GUIDANCE FOR F	FILLING CLAIM FORM — PART A (To be filled in by	the insured)
	DATA ELEMENT	DESCRIPTION	FORMAT
	· · · · · · · · · · · · · · · · · · ·	SECTION A - DETAILS OF PRIMARY INSURED	
a)	Policy No.	Enter the policy number	As allotted by the Insurance Company
b)	SI No./Certificate No.	Enter the Social Insurance number or the certificate number of social health insurance scheme	As allotted by the organisation
c)	Company TPA ID No.	Enter the TPA ID No.	License number as allocated by IRDAI and printed in TPA documents
d)	Name	Enter the full name of the policyholder	Surname, First name, middle name
e)	Address	Enter the full postal address	Include Street, City and Pin Code
	SE	CTION B - DETAILS OF INSURANCE HISTORY	
a)	Currently covered by any other Mediclaim/Health Insurance?	Indicate whether covered by another Mediclaim /Health Insurance	Tick Yes or No
b)	Date of commencement of first Insurance without break	Enter the date of commencement of first Insurance	Use dd-mm-yy format
c)	Company Name	Enter the full name of the Insurance Company	Name of the Organisation in ful
	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
d)	Have you been hospitalised in the last four years since inception of the contract?	Indicate whether hospitalised in the last four years	Tick Yes or No
	Date	Enter the date of hospitalisation	Use mm-yy format
	Diagnosis	Enter the diagnosis details	Open Text
e)	Previously covered by any other Mediclaim/Health Insurance?	Indicate whether previously covered by another mediclaim/Health Insurance	Tick Yes or No
f)	Company Name	Enter the full name of the Insurance Company	Name of the Organisation in ful
	SECTION	N C - DETAILS OF INSURED PERSON HOSPITALIS	
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)	Relation with Primary Insured	Indicate relation 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
h)	Phone No.	Enter the phone number of the patient	Include STD code with telephone number
i)	E-mail ID	Enter e-mail address of the patient	Complete e-mail address
		SECTION D - DETAILS OF HOSPITALISATION	
a)	Name of Hospital where admitted	Enter the name of Hospital	Name of Hospital in full
b)	Room category occupied	Indicate the room category occupied	Tick the right option
c)	Hospitalisation due to	Indicate reason of hospitalisation	Tick the right option
d)	Date of injury/Date of Disease first detected/Date of Delivery	Enter the relevant date	Use dd-mm-yy format
e)	Date of admission	Enter date of admission	Use dd-mm-yy format
f)	Time	Enter time of admission	Use hh-mm format



h) Time Enter time of discharge Use hh-mm format If injury give cause Indicate cause of injury Tick the right option		D	Te	Turning to
Indicate cause of injury If injury give cause Indicate whether injury is medico legal Reported to Police Indicate whether police report was filed Tick Yes or No Indicate whether police report and Police FIR attached Indicate whether MLC report and Police FIR attached Tick Yes or No Indicate whether MLC report and Police FIR attached Tick Yes or No Indicate whether MLC report and Police FIR attached Tick Yes or No Tick Yes or No Tick Yes or No Den Text SECTION E - DETAILS OF CLAIM In rupees (Do not enter paise expenses values) Indicate whether claim is for domiciliary hospitalisation Column for Domiciliary Hospitalisation Details of Lump sum/Cash benefit claimed Claim documents Submitted-Check List Indicate which supporting documents are submitted Check List SECTION F - DETAILS OF BILLS ENCLOSED Indicate which bills are enclosed with the amount in rupees SECTION I - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT Enter the Bank Account Number As allocated by the income to department As allotted by the Bank	g)	Date of Discharge	Enter date of discharge	Use dd-mm-yy format
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 Incidence FIR attached Inc	h)	Time	Enter time of discharge	Use hh-mm format
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 System of Medicine Enter the system of medicine followed in treating the patient SECTION E – DETAILS OF CLAIM Enter the amount claimed as treatment expenses expenses yalues) Claim for Domiciliary Hospitalisation Hospi	i)	If injury give cause	Indicate cause of injury	Tick the right option
MLC report & Police FIR attached actached attached attached attached actached attached actached attached actached attached actached attached actached attached attach		If Medico legal	Indicate whether injury is medico legal	Tick Yes or No
attached att		Reported to Police	Indicate whether police report was filed	Tick Yes or No
System of Medicine treating the patient SECTION E – DETAILS OF CLAIM Details of treatment expenses expenses In rupees (Do not enter paise expenses Values) Details of Laim for Domiciliary Hospitalisation Hospitalisati		•	attached	Tick Yes or No
Details of treatment expenses Enter the amount claimed as treatment expenses Claim for Domiciliary Hospitalisation Details of Lump sum/Cash benefit claimed Claim documents Submitted-Check List Enter the amount claimed as lump sum/cash benefit Claim documents Submitted-Check List Enter the amount claimed documents are submitted SECTION F - DETAILS OF BILLS ENCLOSED Indicate which bills are enclosed with the amount in rupees Enter the Details of Lump sum/cash benefit SECTION I - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT Enter the Permanent Account Number As allocated by the income to department As allotted by the Bank	j)	System of Medicine	The state of the s	Open Text
Details of treatment expenses expenses values			SECTION E - DETAILS OF CLAIM	
Hospitalisation hospitalisation Details of Lump sum/Cash benefit claimed benefit Claim documents Submitted-Check List Indicate which supporting documents are submitted SECTION F - DETAILS OF BILLS ENCLOSED Indicate which bills are enclosed with the amount in rupees SECTION I - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT Enter the Permanent Account Number As allocated by the income to department As allotted by the Bank	a)	Details of treatment expenses		1
benefit claimed benefit values) Claim documents Submitted- Check List Indicate which supporting documents are submitted SECTION F - DETAILS OF BILLS ENCLOSED Indicate which bills are enclosed with the amount in rupees SECTION I - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT As allocated by the income to department As allotted by the Bank	b)	•	1	Tick Yes or No
SECTION F - DETAILS OF BILLS ENCLOSED Indicate which bills are enclosed with the amount in rupees SECTION I - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT a) PAN Enter the Permanent Account Number As allocated by the income to department b) Account Number Enter the Bank Account Number As allotted by the Bank	c)	·		· · · · · · · · · · · · · · · · · · ·
Indicate which bills are enclosed with the amount in rupees SECTION I - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT	d)			Tick the right option
SECTION I - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT a) PAN Enter the Permanent Account Number As allocated by the income to department b) Account Number Enter the Bank Account Number As allotted by the Bank		:	SECTION F - DETAILS OF BILLS ENCLOSED	
As allocated by the income to department As allocated by the income to department As allotted by the Bank Enter the Bank Account Number As allotted by the Bank	Indi	cate which bills are enclosed with tl	he amount in rupees	
department Account Number department Account Number department b) Account Number Enter the Bank Account Number As allotted by the Bank		SECTION I	- DETAILS OF PRIMARY INSURED'S BANK ACC	TUUC
,	a)	PAN	Enter the Permanent Account Number	As allocated 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	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 /organisation in full	d)	Cheque/DD Payable Details	•	
IESC code of the bank branch	e)	IFSC Code		IFSC code of the bank branch
SECTION J - DECLARATION BY THE INSURED		S	ECTION J - DECLARATION BY THE INSURED	
Read declaration carefully and mention date (in dd-mm-yy format), place (open text) and sign.	Rec	ad declaration carefully and mention	n date (in dd-mm-w format), place (open text) ai	nd sian.



CLAIM FORM - PART B TO BE FILLED IN BY THE HOSPITAL (in block letters)

The issue of this Form is not to be taken as an admission of liability

Please include the original pre-authorisation request form in lieu of PART A

		Please IIIC	ude the origin	ш. р. о шиш.о.	.ouz.ooquooz.io					
	DET	AILS OF HOSPITAL								
	a)	Name of the Hospital	:							
	b)	Hospital ID	: -							
SECTION A	c)	Type of Hospital	: -	Network: □	Non Network: □	(If non network, fill section E)				
Ĕ	d)	Name of the treating doctor	:							
R	e)	Qualification	: -							
	f)	Registration No. with state o	ode :		g) ^l	Phone No. :				
	ĺ		-							
		DETAILS OF THE DATIFACT ADMITTED								
		AILS OF THE PATIENT ADMITT								
	a)	Name of the Patient	:							
	b)	IP Registration Number	:		c) Gender	Male □ Female □				
	d)	Age	: Years	YY	lonths M M					
	e)	Date of Birth	: D D) M M	YY					
m Z	f)	Date of Admission :	D D	MM	y y g)	Time: H H : M M				
SECTION B	h)	Date of Discharge :	D D	M	y y i)	Time: H H : M M				
SEC	j)	Type of Admission	: Emergence	y 🗆 Planne	d Day Care	Maternity 🗆				
	k)	If Maternity	: Date of De	elivery	: D D	M M Y Y				
			Gravida St	tatus	:					
	l)	Status at time of Discharge	: Disc	charge to home	□ Discharge to anot	ther hospital □ Deceased □				
	m)	Total claimed amount								
		AILS OF AILMENT DIAGNOSED								
	a)		(PRIMARY) ICD 10 Cod	des	Description					
		AILS OF AILMENT DIAGNOSED Primary Diagnosis		des	Description					
	a)	Primary Diagnosis		des	Description					
	a)			des	Description					
	a) i.	Primary Diagnosis		des	Description					
	a) i.	Primary Diagnosis		des	Description					
	a) i. ii.	Primary Diagnosis Additional Diagnosis		des	Description					
	a) i. ii.	Primary Diagnosis Additional Diagnosis		des	Description					
	i. ii.	Primary Diagnosis Additional Diagnosis Co-morbidities		des	Description					
	i. ii.	Primary Diagnosis Additional Diagnosis Co-morbidities			Description					
ON C	i. ii. iii.	Primary Diagnosis Additional Diagnosis Co-morbidities	ICD 10 Cod							
CTION C	a) i. ii. iiv.	Primary Diagnosis Additional Diagnosis Co-morbidities Co-morbidities	ICD 10 Cod							
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SECTION C	i. ii. iiv. b) i.	Primary Diagnosis Additional Diagnosis Co-morbidities Co-morbidities Procedure 1 Procedure 2	ICD 10 Cod							
SECTION C	i. ii. iiv. b) i. iii.	Primary Diagnosis Additional Diagnosis Co-morbidities Co-morbidities Procedure 1 Procedure 2 Procedure 3	ICD 10 Cod							
SECTION C	a) i. ii. iii. b) i. iii. iiv.	Primary Diagnosis Additional Diagnosis Co-morbidities Co-morbidities Procedure 1 Procedure 2 Procedure 3 Details of Procedure	ICD 10 PC	S	Description					
SECTION C	i. ii. iiv. b) i. iii.	Primary Diagnosis Additional Diagnosis Co-morbidities Co-morbidities Procedure 1 Procedure 2 Procedure 3	ICD 10 Cod	S No						

Navi Smart Health |UIN NAVHLIP23003V012223 | Claim Form Reimbursement Navi General Insurance Limited

Hospitalisation due to injury

E: insurance.help@navi.com | T: 1800 123 0004 | https://navi.com/insurance | CIN: U66000KA2016PLC148551 | IRDAI Registration Number: 155 | Registered Office: Vaishnavi Tech Square, 7th Floor, Iballur Village, Begur Hobli, Bengaluru, Karnataka-560102

Self-inflicted $\ \square$ Road Traffic Accident $\ \square$ Substance abuse/alcohol consumption $\ \square$

☐ Yes ☐ No



	ii. iii. v. vi.	If injury due to Substance abuse/alcohol consumption, establish this If Medico legal :	: U Yes U No (If yes, attach reports)
	CL	AIM DOCUMENTS SUBMITTED — CHECK LIST	
		Claim form duly signed	☐ Investigation reports
		Original Pre-authorisation request	☐ CT/MRI/USG/HPE investigation reports
0		Copy of the Pre-authorisation approval letter	☐ Doctor's reference slip for investigation
SECTION D		Hospital Discharge Summary	□ ECG
Ĕ		Operation Theatre Notes	☐ Pharmacy Bills
R		Hospital main bill	☐ MLC reports and Police FIR
		Copy of the photo ID card of the patient verified by Hospital	 Original death summary from hospital where applicable
		Hospital break-up bill	☐ Any other, please specify
SECTION E	a) c) e) f) iii.	Address : City : Pin Code : Registration No. with state code : Number of inpatient beds : Facilities available in the Hospital : i. O Others :	State :
SECTION F	We and to	d belief. If we have made any false or untrue stater claim under this claim shall be forfeited. te: DDD MMM YYY Treating D	the claim form is true and correct to the best of my knowledge ment, suppression or concealment of any material fact, our right Place: Doctor's Signature and Seal he Hospital Authority



	GUIDANCE FOR FIL	LING CLAIM FORM – PART B (To be filled in by t	he hospital)
	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 the hospital	As allocated by the TPA
٠,		Indicate whether in network or non network	,
c)	Type of Hospital	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 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 the doctor	Include STD code with telephone number
	SECT	TION B - DETAILS OF THE PATIENT ADMITTED	
a)	Name of the 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 ans 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
	ii. Gravida	Enter gravida status if maternity	Use standard format
13	Charters are times and alice have a	Indicate status of patient at time of	Tiel, also sieles essiene
l)	Status at time of discharge	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 INSURED PERSON HOSPITALISI	ED
a)	ICD 10 Code		
	Primary Diagnosis	Enter the ICD 10 Code and description of the	Standard Format and Open
	· -	primary diagnosis Enter the ICD 10 Code and description of the	Standard Format and Open
	Additional Diagnosis	additional diagnosis	text
	Co-morbidities	Enter the ICD 10 Code and description of the Co-morbidities	Standard Format and Open text
b)	ICD 10 PCS	- Thorotaline	20/12
<u>.,</u>	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-authorisation obtained	Indicate whether pre-authorisation obtained	Tick Yes or No
d)	Pre-authorisation Number	Enter pre-authorisation number	As allotted by TPA
,	If authorisation by network		,
e)	hospital not obtained, give reason	Enter reason for not obtaining pre- authorisation number	Open text
f)	Hospitalisation due to injury	Indicate if hospitalisation is due to injury	Tick Yes or No
.,			



	If injury due to substance abuse/ alcohol consumption test 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 reason for not reporting to police	Open text
	SECTION D	- CLAIM DOCUMENTS SUBMITTED - CHECK L	IST
India	cate which supporting documents are	e submitted	
	SECTION E	- DETAILS IN CASE OF NON NETWORK HOSPIT	AL
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 like City Corporation/Municipality	As allocated by the City Corporation / Municipality
d)	Hospital PAN	Enter the Permanent Account Number	As allocated 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
	SEC	TION J - DECLARATION BY THE HOSPITAL	
Rea	d declaration carefully and mention o	date (in dd-mm-yy format), place (open text) an	d sign with stamp.



POLICY DECLARATION FORM

		Date:
Name	of the Hospital :	
Addres	ss:	
PATIEN	NT NAME (BLOCK LETTERS): AGE/SEX : AGE/SEX :	
Mobile	e No of Patient:	
Date o	of Admission: Date of Discharge:	
	Undertaking by the Patient regarding Heath Insurance Policy	
	्रात्यसाह प्रभू साथ नवसाना ग्लेशिया है संबंध में रोगी द्वारा शपथ-पत्र))	
	I have not declared about any health insurance policy, at the time of Hospital admission.	
	(मैं सुचित करता हूं कि अस्पताल में उपचार के दौरान मेरे पास कोई भी स्वास्थ्य बीमा पॉलिसी नहीं है ।	
	Signature: Name of the Patient/Patient's atte	_
	Name of the Patient/Patient's atte	nuant (मराज पर्राचान)
_		
	I have declared about the health insurance policy, at the time of Hospital admission. (मैं सुचित करता हूं कि अस्पताल में उपचार के दौरान मेरे पास स्वास्थ्य बीमा पॉलिसी है,	
	(म सुनित करता हूं कि अस्पताल में उपवार के दौरान मेर पास स्वास्थ्य बामा पालिसा है,	
	Signature: Name of the Patient/Patient's atte	
	Name of the Fatient/Fatient's atte	nuant (नराज का नान)
	Undertaking by the Hospital	
Dasad	an maticat understelling beginstell dealers that patients with the many to annual and the transfer	ن د ر جہ سیمر
Basea	l on patient undertaking hospital declare that patient: (रोगी के उपक्रम के आधार पर हम उस रोगी की घं	॥भणा करत ह)
•	Patient did not declare any health insurance coverage, at the time of hospital admission.	Hence we will bill
	the patient as per our rack rates. We may or may not consider discount for all such undert	
	कवरेज नहीं है, अस्पताल में भर्ती के समय । इसलिए हम मरीज को अपनी रैक दरों के अनुसार बिल देंगे। हम ऐसे सभी उप विचार कर भी सकते हैं और नहीं भी।)	क्रमा क लिए छूट पर
•	Patient declared health insurance coverage, at the time of hospital admission. But out of o	
	opting for reimbursement/ cash paying mode As insured is already covered under TPA so	•
	we are network provider, hence we agree to bill this patient as per PHS or insurer agreed (whichever is less). The benefit of discount as per MOU will also be given to this patient. (3)	
	(Whichever is less). The benefit of discount as per MOO will also be given to this patient. (बीमा कवरेज है, अस्पताल में भर्ती के समय । लेकिन वह अपनी मर्जी से रीड्रंबससमेंट/नकद भुगतान मोड का विकल्प चुन र	
	व्यक्ति पहले से ही टीपीए सर्विसिंग के अंतर्गत कवर है जिसके लिए हम नेटवर्क प्रदाता हैं, इसलिए हम इस मरीज को पीएचए	रस या बीमाकर्ता द्वारा
	सहमत दर सूची (जो भी कम हो) के अनुसार बिल देने के लिए सहमत हैं। एमओयू के अनुसार छूट का लाभ भी इस मरीज क	ो दिया जायेगा.)
Signati	ure:	
Name	of the Hospital Representative & Hospital Seal	