FORM 2: CLAIM FORM
ICICI Lombard

CLAIM FORM - PART A (TO BE FILLED IN BY INSURED)

INSURANCE DETAILS

Policy Number	Choose Policy	HRID	
PHS ID		Name of Proposer	
Proposer Address			
Name of Claimant		Relation to proposer	Choose Relation
Date of Birth		Age	Address
Gender	Choose Gender	Occupation	
Telephone Number		Mobile Number	
Claim Type	Choose Type	Office Email	

INSURANCE HISTORY

Date of commencement of first Insurance for the person	
Are you presently covered with any other Mediclaim / Health Insurance?	Select Coverage Status
If Yes, give details - Company / Policy No / Sum Insured (Attach Policy copies)	

PRIMARY INSURED'S BANK ACCOUNT PARTICULARS

PAN		Account Number		IFSC Code	
Bank Name				Branch	

HOSPITALIZATION DETAILS

Name of the Hospital where admitted				Room Type	Select Type
Past Hospitalisation	Select	Month/Year		Diagnosis	
Hospitallisation due to:	Select			Details	
Date of Injury / Disease first detected / LMP				How it occured	
Medico legal				Reported to Police	
Is claim is for Domiciliary Hospitalisation?				Select	

EXPENSES AND BILLING DETAILS			
Pre-hospitalisation Expenses		Hospitalisation Expenses	
Post-hospitalisation Expenses		Health-Check up Cost	
Ambulance Charges		Others	
Details of Lumpsum / cash benefit claimed			
Hospital Daily Cash		Surgical Cash	
Critical Illness benefit		Convalescence	
Pre / Post hosp lumpsum benefit		Others	

#	Bill Number	Date	Issued By	Towards	Amount
1					
2					
3					
4					
5					
6					
7					

DETAILS OF CLAIM DOCUMENTS SUBMITTED - CHECK LIST					
Claim Form Duly signed	Select	Pre-hosp Bills	Select	Nos.	
Copy of the claim intimation	Select	Post-hosp Bills	Select	Nos.	
Hospital Discharge Summary	Select	Investigation Reports	Select		
Operation Theatre Notes	Select	Doctor request for investigation	Select		
Hospital Main Bill	Select	ECG	Select		
Hospital Break-up Bill	Select	Pharmacy Bills	Select		
Hospital Bill Payment Receipt	Select	MLC Report & Police FIR	Select		
Doctor's Prescriptions	Select	Any other, please specify	Select		

Place

Date

Signature of the Insured

ICICI Lombard
Nibhaye Vaade

Part - B (To be filled by Treating Doctor/ Hospital only)

B1. Details of the Hospital/ Nursing home in which treatment was taken

Name of the Hospital/ Nursing home:
Address:
City: State:
Pincode: Telephone no.: Mobile no.:
ROHINI ID: Type of Hospital: Network ☐ Non Network ☐. If Non Network, provide below details
Registration No. with State Code: PAN: Number of Inpatient beds:
Facilities available in the hospital: OT: Y N ICU: Y N

B2. Details of the attending Medical Practitioner/ Doctor/ Treating Physician or Surgeon

Name:
Qualification: Registration no:
Telephone no.: Mobile no.:

B3. Details of the patient admitted

Name of the patient:
IP Registration no.: Gender: M F Age: Years Months Date of Birth: D D M M Y Y Y Y
Date of Admission: D D / M M / Y Y Y Y Time: H H : M M Date of Discharge: D D / M M / Y Y Y Y Time: H H : M M
Type of Admission: Emergency ☐ Planned ☐ Day Care ☐ Maternity ☐
Type of Treatment: Surgical Procedure ☐ Multiple Surgical Procedure ☐ Medical Treatment ☐
If Maternity, Date of Delivery: D D / M M / Y Y Y Y Gravida Status: G ☐ P ☐ A ☐ L ☐
Premature Baby: Yes ☐ No ☐
Status at time of discharge: Discharge to home ☐ Discharge to another hospital ☐ Deceased ☐
Total claimed amount: ₹

B4. Details of the procedure

Pre-authorization obtained: Yes ☐ No ☐ If yes, Pre-authorization No.:
If authorization by network hospital not obtained, give reason:
Date of injury sustained or disease/ illness first detected: D D / M M / Y Y Y Y
If Injury, give cause: Self inflicted ☐ Road traffic accident ☐ Substance abuse/Alcohol consumption ☐ Others
If Medico legal: Yes ☐ No ☐ Reported to police: Yes ☐ No ☐ MLC Report & Police FIR attached: Yes ☐ No ☐ (If yes, attach report)
FIR no. If not reported to Police, give reason:
If injury due to substance abuse/alcohol consumption, test conducted to establish this: Yes ☐ No ☐ (If yes, attach report)

B5. This section is mandatory only **if your health policy is not provided by your employer**

A) Diagnosis (ICD 10 Code primary & additional dignosis)	
i) Primary diagnosis (with ICD 10 code)	
ii) Additional diagnosis (with ICD 10 code)	
iii) Procedure diagnosis (with ICD 10 PCS code)	
B) Nature of surgery/ treatment given for present ailment	
C) Date of first consultation (Prior to hospitalization)	
D) Presenting complaints of the patient during admission	
E) Past medical history of the patient along with duration of illness (If yes, attach first & all past consultation paper)	
F) Was the patient under influence of alcohol during admission	
G) Whether the present treatment ailment is a complication of pre-existing disease ?	
i) If yes, please specify the disease (or) complication of any previous surgery done ?	
ii) If yes, please specify the details	
H) Whether the disease/ disorder is congenital in nature ?	
I) Number of in-patient beds in the hospital (including ICU)	

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 belief. If we have made any false or untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited.

Registration No. of Hospital
(Rubber stamp of the hospital)

Date: D D / M M / Y Y Y Y

Doctor's Seal and Signature

As per the policy Terms and Conditions, the Company reserves its right to have the Insured examined by a doctor appointed by it for verification of diagnosis.