Medi Assist

# REIMBURSEMENT CLAIM FORM

**TO BE FILLED BY THE INSURED**

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

**(To be Filled in block letters)**

SECTION A

## DETAILS OF PRIMARY INSURED:

a) Policy No.: b) Sl. No/ Certificate no.

c) Company / TPA ID (MA ID)No:

d) Name: SURNAME FIRST NAME MIDDLE NAME

e)Address:

City: State:

Pin Code Phone No: Email ID:

SECTION B

## DETAILS OF INSURANCE HISTORY:

a) Currently covered by any other Mediclaim / Health Insurance: Yes No b) Date of commencement of first Insurance without break: D D M M Y Y Y Y

c) If yes, company name: Policy No.

Sum insured (Rs.) d) Have you been hospitalized in the last four years since inception of the contract? Yes No Date: M M Y Y

Diagnosis: e) Previously covered by any other Mediclaim /Health insurance : : Yes No

f) If yes, company name:

SECTION C

## DETAILS OF INSURED PERSON HOSPITALIZED:

a) Name: SURNAME FIRST NAME MIDDLE NAME

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)

f) Occupation Service Self Employed Home Maker Student Retired Other (Please Specify)

g) Address (if diffrent from above) :

City: State:

Pin Code Phone No: Email ID:

SECTION D

## 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

c) Hospitalization due to: Injury Illness Maternity d) Date of injury / Date Disease first detected /Date of Delivery: D D M M Y Y Y Y

e) Date of Admission: D D M M Y Y f) Time H H M H g) Date of Discharge: D D M M Y Y h) Time: H H : M H

I) If injury give cause: Self inflicted Road Traffic Accident 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:

SECTION E

## DETAILS OF CLAIM:

a) Details of the Treatment expenses claimed

I. Pre -hospitalization expenses Rs. ii. Hospitalization expenses Rs.

iii. Post-hospitalization expenses Rs. iv. Health-Check up cost: Rs.

v. Ambulance Charges: Rs. vi. Others (code): Rs.

Total Rs.

vii. Pre -hospitalization period: days viii. Post -hospitalization period: days

b) Claim for Domiciliary Hospitalization: Yes No (If yes, provide details in annexure)

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: Rs.

Total Rs.

**Claim Documents Submitted - Check List:**

- 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
- Doctors request for investigation
- Investigation Reports (Including CT / MRI / USG / HPE)
- Doctors Prescriptions
- Others

SECTION F

## DETAILS OF BILLS ENCLOSED:

| Sl. No. | Bill No. | Date | Issued by | Towards | Amount (Rs) |
|---|---|---|---|---|---|
| 1. | | D D M M Y Y | | Hospital main Bill | |
| 2. | | D D M M Y Y | | Pre-hospitalization Bills: Nos | |
| 3. | | D D M M Y Y | | Post-hospitalization Bills: Nos | |
| 4. | | D D M M Y Y | | Pharmacy Bills | |
| 5. | | D D M M Y Y | | | |
| 6. | | D D M M Y Y | | | |
| 7. | | D D M M Y Y | | | |
| 8. | | D D M M Y Y | | | |
| 9. | | D D M M Y Y | | | |
| 10. | | D D M M Y Y | | | |

SECTION G

## DETAILS OF PRIMARY INSURED'S BANK ACCOUNT:

a) PAN: b) Account Number:

c) Bank Name and Branch:

d) Cheque / DD Payable details: e) IFSC Code:

SECTION H

## DECLARATION BY THE INSURED:

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 M Y Y Y Y Place: Signature of the Insured

(IMPORTANT: PLEASE TURN OVER)

| GUIDANCE FOR 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) Sl. No/ Certificate No. | Enter the social Insurance number or the certificate number of social health insurance scheme | As allotted by the organization |
| c) Company TPA ID No. | Enter the TPA ID No. | Licence number as allotted by IRDA 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 |
| **SECTION B -DETAILS OF INSURANCE HISTORY** | | |
| a) Currently covered by any other Mediclaim / Health Insurance? | Indicate whether currently 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-forrmat |
| c) 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 |
| d) 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 |
| 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 organization in full |
| **SECTION C -DETAILS OF INSURED PERSON HOSPITALIZED** | | |
| 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 |
| h) Phone No | Enter the phone number of patient | Include STD code with telephone number |
| 1) E-mail ID | Enter e-mail address of patient | Complete e-mail address |
| **SECTION D - DETAILS OF HOSPITALIZATION** | | |
| 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) Hospitalization due to | indicate reason of hospitalization | Tick the right option |
| d) Date of injury/Date 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 |
| g) Date of discharge | Enter date of discharge | Use dd-mm-yy format |
| h) Time | Enter time of discharge | Use hh-mm- format |
| l) 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 Medicene | Enter the system of medicine followed in treating the patient | Open Text |
| **SECTION E - DETAILS OF CLAIM** | | |
| 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 benifit claimed | Enter the amount claimed as lump sum / cash benefit | In rupees (Do not enter paise values) |
| d) Claim documents Submitted-Check List | indicate which supporting documents are submitted | Tick the right option |
| **SECTION F - DETAILS OF BILLS ENCLOSED** | | |
| Indicate which bills are enclosed with the amount in rupees | | |
| **SECTION G - DETAILS OF PRIMARY INSURED's BANK ACCOUNT** | | |
| 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 |
| c) 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 |
| c) IFSC Code | Enter the IFSC code of the Bank branch | IFSC code of the Bank branch in full |
| **SECTION H - DECLARATION BY THE INSURED** | | |
| Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign. | | |

# 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)**

SECTION A

## DETAILS OF HOSPITAL

a) Name of the hospital:

a) Hospital ID:

c) Type of Hospital: Network : ☐ Non Network : ☐ (if non network fill section E)

c) Name of the treating doctor: SURNAME FIRST NAME MIDDLE NAME

e) Qualification: f) Registration No. with State Code: g) Phone No.

SECTION B

## DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient: SURNAME FIRST NAME MIDDLE NAME

b) IP Registration Number: c) Gender: Male ☐ Female ☐ d) Age: Years YY Months MM e) Date of birth: DD MM YY

f) Date of Admission: DD MM YY g) Time: HH MM h) Date of Discharge: DD MM YY i) Time: HH MM

j) Type of Admission: Emergency ☐ Planned ☐ Day Care ☐ Maternity ☐ k) If Maternity i) Date of Delivery: DD MM YY ii) Gravida Status: :

l) Status at time of discharge: Discharge to home ☐ Discharge to another hospital ☐ Deceased ☐ m) Total claimed amount

SECTION C

## DETAILS OF AILMENT DIAGNOSED (PRIMARY)

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

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 ☐ 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 iv. Reported to Police ☐ Yes ☐ No

v. FIR No. vi. If not reported to police give reason:

SECTION D

## CLAIM DOCUMENTS SUBMITTED - CHECK LIST

- ☐ Claim Form duly signed
- ☐ Original Pre-authorization request
- ☐ Copy of the Pre-authorization approval letter
- ☐ Copy of Photo ID Card of patient Verified by hospital
- ☐ Hospital Discharge summary
- ☐ Operation Theatre Notes
- ☐ Hospital main bill
- ☐ Hospital break-up bill
- ☐ Investigation reports
- ☐ CT/MR/USG/HPE investigation reports
- ☐ Doctor's reference slip for investigation
- ☐ ECG
- ☐ Pharmacy bills
- ☐ MLC reports & Police FIR
- ☐ Original death summary from hospital where applicable
- ☐ Any other, please specify

SECTION E

## 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. c) Registration No. with State Code:

d) Hospital PAN: e) Number of inpatient beds f) Facilities available in the hospital i. OT ☐ Yes ☐ No ii. ICU ☐ Yes ☐ No

iii. Others:

SECTION F

## DECLARATION BY THE HOSPITAL

**(PLEASE READ VERY CAREFULLY)**

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.

Date: DD MM YY

Place:

Signature and Seal of the Hospital Authority:

| GUIDANCE FOR FILLING CLAIM FORM - PART B (To be filled in by the 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 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 |
| **SECTION 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 |
| ii. 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 |
| 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 |
| e) If authorization by network hospital not obtained, give reason | Enter reason for not obtaining pre-authorization number | Open text |
| 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 authorities |
| If not reported to police, give reason | Enter reason for not reporting to police | Open text |
| **SECTION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST** | | |
| Indicate which supporting documents are submitted | | |
| **SECTION E - DETAILS IN CASE OF NON NETWORK HOSPITAL** | | |
| 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 |
| **SECTION F - DECLARATION BY THE HOSPITAL** | | |
| Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign. and stamp | | |

# Documents Information – All in Original Required

- ✓ Claim Form (As attached) – Please ensure mandatory information is captured :
- ✓ MediAssist ID Card / MAID Number of the Patient.
- ✓ Name of Corporate
- ✓ Employee Name & Employee Code
- ✓ Phone Number
- ✓ Email Id : (Official and Personal)
- ✓ Patient Relationship to Policy Holder
- ✓ Form B to be filled by hospital
  Discharge Summary from Hospital (On Hospital Letter Head – Stamped and Signed)
- ✓ Doctor's First Prescription/ Casualty Card / OPD Card, Advising Hospitalization
- ✓ All investigation Reports & Lab Reports
- ✓ Radiology Films – Xray / Ultrasound / CT Scan / MRI (if Done)
- ✓ Hospital Bills (Final with Detailed Break Up)
- ✓ Pharmacy & Other Investigation Bills with Doctor's Prescription
- ✓ Proper numbered payment receipt with Stamp and Signature
- ✓ Cancelled Cheque Leaf of the Employee
- ✓ Patient valid Government ID proof scan copy
- ✓ Employee valid Government ID proof scan copy
- ✓ Total No of Pages submitted : _____
- ✓ Date of Submission : _____(If there is delay in submission need justification letter to be attached)
- ✓ Claimants can submit bills related to the hospitalization that are incurred by them 30 days prior to and 60 days post hospitalization.