

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)

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	DATA ELEMENT	OR FILLING CLAIM FORM - PART A (To be filled in by the insured DESCRIPTION	FORMAT
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a)	Policy No.	Enter the policy number	As allotted by the Insurance Company
	·	Enter the social Insurance number or the certificate number of	
b)	SI. No/ Certificate No.	social health insurance scheme	As allotted by the organization Licence number as allotted by IRDA and printed
)	Company TPA ID No.	Enter the TPA ID No.	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	1
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
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
9)	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
,		TION C -DETAILS OF INSURED PERSON HOSPITALIZED	realite of the organization in fair
1)	Name	Enter the full name of the patient	Surname, First name, Middle name
))	Gender	Indicate Gender of the patient	Tick Male or Female
		Enter age of the patient	Number of years and months
;) d)	Age 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
_			
)	Occupation	indicate occupation of patient	Tick the right option. If others, please specify.
1) 1)	Address Phone No	Enter the full postal address	Include Street, City and Pin code
_		Enter the phone number of patient	Include STD code with telephone number
)	E-mail ID	Enter e-mail address of patient	Complete e-mail address
,	N	SECTION D - DETAILS OF HOSPITALIZATION	I N
a)	Name of Hospital where admitted	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
(t)	Hospitalization due to Date of injury/Date Disease first detected / Date of	indicate reason of hospitalization	
_	Delivery	Enter the relevant date	Use dd-mm-yy format
e)	Date of admission	Enter date of admission	Use dd-mm-yy format
)	Time	Enter time of admission	Use hh-mm- format
J)	Date of discharge	Enter date of discharge	Use dd-mm-yy format
1)	Time	Enter time of discharge	Use hh-mm- format
)	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
	System of Medicene	Enter the system of medicine followed in treating the patient	Open Text
)		SECTION E - DETAILS OF CLAIM	
)			
	Details of Treatment Expenses	Enter the amount claimed as treatment Expenses	In rupees (Do not enter paise values)
a)	Details of Treatment Expenses Claim for Domiciliary Hospitalization	Enter the amount claimed as treatment Expenses indicate whether claim is for domiciliary hospitalization	Tick Yes or No
a) o)	Claim for Domiciliary Hospitalization Details of Lump sum/ Cash benifit claimed	·	. , , , , ,
a) o)	Claim for Domiciliary Hospitalization	indicate whether claim is for domiciliary hospitalization	Tick Yes or No
a) o) c)	Claim for Domiciliary Hospitalization Details of Lump sum/ Cash benifit claimed	indicate whether claim is for domiciliary hospitalization Enter the amount claimed as lump sum / cash benefit	Tick Yes or No In rupees (Do not enter paise values)
a) o) :)	Claim for Domiciliary Hospitalization Details of Lump sum/ Cash benifit claimed	indicate whether claim is for domiciliary hospitalization Enter the amount claimed as lump sum / cash benefit indicate which supporting documents are submitted	Tick Yes or No In rupees (Do not enter paise values)
a) o) c) d)	Claim for Domiciliary Hospitalization Details of Lump sum/ Cash benifit claimed Claim documents Submitted-Check List icate which bills are enclosed with the amount in rupees	indicate whether claim is for domiciliary hospitalization Enter the amount claimed as lump sum / cash benefit indicate which supporting documents are submitted	Tick Yes or No In rupees (Do not enter paise values)
a) o) c) d)	Claim for Domiciliary Hospitalization Details of Lump sum/ Cash benifit claimed Claim documents Submitted-Check List icate which bills are enclosed with the amount in rupees	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	Tick Yes or No In rupees (Do not enter paise values)
a) c) d) ndi	Claim for Domiciliary Hospitalization Details of Lump sum/ Cash benifit claimed Claim documents Submitted-Check List icate which bills are enclosed with the amount in rupees	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 ON G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT	Tick Yes or No In rupees (Do not enter paise values) Tick the right option
(i) (a) (b) (d) (d) (d) (a) (b)	Claim for Domiciliary Hospitalization Details of Lump sum/ Cash benifit claimed Claim documents Submitted-Check List icate which bills are enclosed with the amount in rupees SECTION	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 ON G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT Enter the permanent account number	Tick Yes or No In rupees (Do not enter paise values) Tick the right option As allotted by the Income Tax Department
a) b) d) ndi	Claim for Domiciliary Hospitalization Details of Lump sum/ Cash benifit claimed Claim documents Submitted-Check List icate which bills are enclosed with the amount in rupees SECTION PAN Account Number	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 ON 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	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
a) i) ii) iii) ndi a) ii) iii)	Claim for Domiciliary Hospitalization Details of Lump sum/ Cash benifit claimed Claim documents Submitted-Check List icate which bills are enclosed with the amount in rupees SECTIC PAN Account Number Bank Name and Branch	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 ON 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	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

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 ease include the original preauthorization request form in lieu of PART A

(To be Filled in block letters)

DETAILS OF HOSPITAL	zation request form in lieu of PART A
a) Name of the hospital: a) Hospital ID: c) Type of Hospital: c) Name of the treating doctor: s U R N A M E F I R e) Qualification: f) Registration No. with State Code:	Network : Non Network : (if non network fill section E) ISTNAME MIDDDLE NAME g) Phone No. 9) Phone No.
DETAILS OF THE PATIENT ADMITTED	
a) Name of the Patient: b) IP Registration Number: c) Gender: Male Female f) Date of Admission: D M M Y Y g) Time: H M M J j) Type of Admission: Emergency Planned Day Care Maternity k) If Material I) Status at time of discharge: Discharge to home Discharge to another hospital Deceased DETAILS OF AILMENT DIAGNOSED (PRIMARY)	d) Age: Years Y Y Months M M e) Date of birth: D D M M Y Y h) Date of Discharge: D D M M Y Y i) Time: H H M M rmity i) Date of Delivery: D D M M Y Y ii) Gravida Status: :
a) ICD 40 Codes	100.40.000
a) ICD 10 Codes Description I. Primary Diagnosis	b) ICD 10 PCS Description 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 I	
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 v. FIR No. vi. If not reported to police give reason:	If Yes, attach reports) iii. If Medico legal: Yes No iv. Reported to Police Yes No
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
ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF	PF NON-NETWORK HOSPITAL)
a) Address of the Hospital City: Pin Code: b) Phone No. d) Hospital PAN: iii. Others:	State: C) Registration No. with State Code: No ii. ICU Yes No
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 belie our right to claim under this claim shall be forfeited.	(PLEASE READ VERY CAREFULLY) f. If we have made any false or untrue statement, suppression or concealment of any material fact,
•	
Date: D D M M Y Y Place: Signature and Seal of the Ho	C C C C C C C C C C C C C C C C C C C

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
	SEC	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
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)
,		I C - DETAILS OF AILMENT DIAGNOSED (PRIMARY)	
a)	ICD 10 Code	,	
۵,	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	·
	Co-morbidities	<u> </u>	Standard Format and Open text
- 1.		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	Indicate whether test conducted	Tick Yes or No
	conducted to establish this	Indicate whether injury is medico legal	Tick Yes or No
	Medico Legal Reported to Police	Indicate whether injury is medico legal 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
			· · · · · · · · · · · · · · · · · · ·
Indica	ate which supporting documents are submitted	TION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST	
HUIU		ION E - DETAILS IN CASE OF NON NETWORK HOSPITA	.I
۵)		Enter the full postal address	Include Street, City and Pin Code
a) h)	Address Phone No.	Enter the full postal address Enter the phone number of hospital	Include Street, City and Pin Code Include STD code with telephone number
b)		Enter the phone number of nospital Enter the registration number of the Hospital obtained from local body	·
c)	Registration No. with State Code	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	
Rea	d 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.