Claim Form



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

SECTION A	A –	DET	AIL	S OF	PR	IMA	ARY	IN:	SUF	RED)											
a) Policy No				b) S	SI. N	lo/ (Cer	tific	ate	No	:											
c) Company / TPA ID No																						
d) Name																						
e) Address																						
Phone no	Со	de								N	/lob	ile										
Email ID																						
SECTION B	- D	ETA	ILS	OF II	งรเ	JRA	NC	EΗ	IST	OR	Υ											
a) Currently covered by any other mediclaim health	h in	sura	nce							Y	ΈS		N	0								
b) Date of commencement of first insurance without	ut b	reak								D	1 C	VI I	VI	Υ	Υ	Υ	Υ					
c) If Yes, Company Name																						
Policy No.																						
Sum Insured										F	ls.											
d) Have you been hospitalized in the last four years	s sir	nce i	nce	ption	of	the	cor	ntra	ct	Y	'ES		N	0	D	D	M	M	Υ	Υ	Υ	Υ
Diagnosis																						
e) Previously covered by any other Mediclaim/Hea	lth i	nsur	and	е						Y	'ES		N	0								
f) If yes, Company Name																						
SECTION C - DET.	AIL	S OF	IN	SURI	ED I	PER	SO	NΗ	ios	PIT	ALI	SEI)									
a) Name																						
b) Relationship (Self/spouse/Child/Father/Mother/O	Othe	er)																				
c) Date of Birth				d) A	٩ge							n	nths	s/yr	s							
e) Address (If different than above																						
Phone no	Со	de								N	Лob	ile										
Email ID																						
f) Gender Male Female	g)	Осс	upa	tion	Se	rvic	e/S	elf	emp	olo	/ed/	Но	me	mal	ker/	/Stu	ıder	nt/R	etire	ed/C	Othe	ers
h)Telephone				i) N	lobi	le N	lo															
j) E-mail ID, if																						
SECTION	D -	DET	ΔII	S OF	нс	SPI	ΙΤΔ	LIS	ΔΤΙ	ON												
a) Name of the Hospital where admitted																						
b) Room Category occupied	Da	ıycaı	e/S	ingle	Ос	cup	and	cy/T	win	Sh	narir	ng/	3 о	r m	ore	be	ds p	oer	rooi	n		
c) Hospitallisation due to	IIIr	ness	/ Inj	jury /	Ma	iteri	nity															
d) Date of Injury/ Date of disease first detected/ Date of delivery																						
e) Date of admission) D	M	M	Y	YY	/ Y	/														
f) Time	F	Н	M	M																		
g) Date of discharge) D	M	M	Y Y	YY	/ Y	/														
h) Time	F	Н	M	M		-	,															
i) If injury, give cause	Se	lf Int	flict	ed/Ro	oad	Tra	ffic	Ac	cide	ent/	Sub	sta	nce	Ab	ous	e/A	lcoh	nol (Con	sun	npti	on
ii) If Medico legal		YE	s	N	Ю			ii) F	Repo	orte	ed to	ро	olic	e?			/ES		N	Э		
iii) MLC Report, & Police FIR attached?		YE	s [N	Ю			j) S	yste	em	of r	ned	icir	ne					nic/C			ne

alDetails of the treatment expenses claimed i) Prer-hospitalisation Expenses Rs. ii) Hospitalisation Expenses Rs. iii) Post-hospitalisation Expenses Rs. iv) Health-Check up Cost Rs. vi) Others (code) Rs. vii) Pre-hospitalisation Period Days viii) Pre-hospitalisation Period Rs. viii) Pre-hospitalisation Period Days viii) Post-hospitalisation Period A) Claim for Domiciliary Hospitalization D) Details of Lumpsum / cash benefit claimed: D) Hospital Daily Cash Rs. ii) Surgical Cash Rs. ii) Surgical Cash Rs. vi) Others Rs. vi) Others Rs. viii) Pre-hospitalisation Period A) Claim for Domiciliary Hospitalization D) Hospital Daily Cash Rs. vii) Post-hospitalisation Rs. viii) Post-hospitalisation Rs. vii) Others Rs. viii) Post-hospitalisation Rs. viii) Post-hospitalisation Rs. viii) Convalescence Rs. vi) Others Rs. viii) Post-hospitalisation Rs. viii) Others Rs. viii) Post-hospitalisation Rs. viii) Others Rs. viii) Other										SE	CTI	ON E -	DETAILS OF CL	.AIM		
iii) Post-hospitalisation Expenses Rs. iv) Health-Check up Cost Rs. vi) Ambulance Charges Rs. vi) Others (code) Rs Total Rs. vii) Pre-hospitalisation Period Days viii) Post-hospitalisation Period PYES NO (if yes, please provide details i9n annexure) b) Details of Lumpsum / cash benefit claimed: ii) Hospital Daily Cash Rs. ii) Surgical Cash Rs. vi) Convalescence Rs. vi) Others Rs. viii Others Rs. vi) Others Rs. vi) Others R	a)Det	ails of the treatme	nt	exp	ens	ses	clai	me	d							
Ambulance Charges	i) Pre	-hospitalisation Ex	фе	nse	s	R	s.						ii) Hospitalisati	ion Expenses	Rs	
Total Rs	iii) Pc	st-hospitalisation	Exp	pen	ses	R	s						iv) Health-Che	ck up Cost	Rs	
vii) Pre-hospitalisation Period Days viii) Post -hospitalisation Period Days viii) Post -hospitalisation Period Days viii) Post -hospitalisation Period Days VES NO (if yes, please provide details i9n annexure) Press of the provided Action of t	v) An	nbulance Charges				R	s.						vi) Others (co	de)	Rs _	
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Claim for Domiciliary Hospitalization	vii) P⊦	re-hospitalisation [Per	iod		D	ays	;					viii) Post -hosp	oitalisation Period		
b) Details of Lumpsum / cash benefit claimed: ii) Hospital Daily Cash Rs. iii) Critical Illness Benefit Rs. iv) Convalescence Rs. vi) Others Rs. vii) Others Rs. vii) Others Rs. vii) Others Rs. vii) Others Poparation Threater Notes ECG Operation Threater Notes ECG Doctor's Request for Investigation Investigation Reports (Including CT, MRI/USG/HPE) Doctor's Prescription. Others Others SECTION - F DETAILS OF BILLS ENCLOSED Sno Bill No Date Issued By Towards Amount (Rs) SECTION - F DETAILS OF BILLS ENCLOSED Sno Bill No Date Issued By Towards Amount (Rs) SECTION - G DETAILS OF BILLS ENCLOSED Sno D M M V V Y V V V V V V V V V V V V V V V	a) Cla	· aim for Domiciliary	, Ho	gso	itali		-									
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iii) Critical Illness Benefit Rs. iv) Convalescence Rs	-	·													Rs	
V) Pre/Post hospitalisation lumpsum benefit: Claim Documents Submitted - Check List: Duly filled and signed Claim Form Copy of intimation letter, if any Hospital Main Bill Hospital Bill Payment Receipt Hospital Bill Payment Receipt Hospital Discharge Summary Pharmacy Bill SECTION - F DETAILS OF BILLS ENCLOSED Sno Bill No Date Issued By Towards Amount (Rs) SECTION - F DETAILS OF PRIMARY INSURED'S BANK ACCOUNT BY Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y	-		it													
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Duly filled and signed Claim Form Copy of intimation letter, if any Hospital Main Bill Hospital Bill Payment Receipt Hospital Bill Payment Receipt Hospital Discharge Summary Pharmacy Bill SECTION - F DETAILS OF BILLS ENCLOSED Sno Bill No Date Issued By Towards Amount (Rs) SECTION - BILLS PAY A STORMARY INSURED'S BANK ACCOUNT SECTION - G DETAILS OF PRIMARY INSURED'S BANK ACCOUNT SECTION - G DETAILS OF PRIMARY INSURED SANK ACCOUNT SPAN D D M M Y Y Y Y Y D D D M		•	1011			n	S						vi) Others		ns	
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Hospital Bill Payment Receipt Hospital Discharge Summary Pharmacy Bill SECTION - F DETAILS OF BILLS ENCLOSED						,							Doctor's F	Request for Invest	igation	
Hospital Discharge Summary Pharmacy Bill				_									O		uding CT,	MRI/USG/HPE)
SECTION - F DETAILS OF BILLS ENCLOSED														•		
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SECTION - G DETAILS OF PRIMARY INSURED'S BANK ACCOUNT D D M M Y Y Y Y Y	SIIO	DIII INO	+	D	D	M		1	Y	Y	Y		issued by	Towar	us	Amount (ns)
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SECTION - G DETAILS OF PRIMARY INSURED'S BANK ACCOUNT D D M M Y Y Y Y Y				D	D	M	M	Υ	Υ	Υ	Υ					
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SECTION – G DETAILS OF PRIMARY INSURED'S BANK ACCOUNT B) PAN			+	\vdash	\vdash	+	_	-	-	+	+					
SECTION - G DETAILS OF PRIMARY INSURED'S BANK ACCOUNT a) PAN				-		+	+	Υ	Υ	Υ	Υ					
SECTION - G DETAILS OF PRIMARY INSURED'S BANK ACCOUNT a) PAN				D	D	M	М	Υ	Υ	Υ	Υ					
SECTION – G DETAILS OF PRIMARY INSURED'S BANK ACCOUNT b) Account Number c) Bank Name/ Branch d) Payable details: Cheque/ DD e) IFSC Code e) *please attach a cancelled cheque pertaining to the same *please attach a cancelled cheque pertaining to the same Note:			_	-		+	+	<u> </u>	+	+						
b) Account Number				D	D	M	M	Υ	Υ	Υ	Υ					
b) Bank Name/ Branch d) Payable details: Cheque/ DD e) *please attach a cancelled cheque pertaining to the same *please attach a cancelled cheque pertaining to the same *please attach a cancelled cheque pertaining to the same Note:					SE	СТІ	ON	- 0	3 DI	EΤΑ	ILS	OF PR	MARY INSURE	D'S BANK ACCO	UNT	
d) Payable details: Cheque/ DD	a) PA	N											b) Account Nu	mber		
f) MICR No *please attach a cancelled cheque pertaining to the same Note:	c) Ba	nk Name/ Branch_											•			
Note:	•															-
	-												*please atta	ch a cancelled ch	eque perf	aining to the same
account details. In an event Insured person bears expenses for treatment please provide account details of Insured Persons in th	It is a	greed that the Poli														
		, , , , , , , , , , , , , , , , , , ,	. р.		0			.90		. 07.	p 0					
above format along with proof or incurring such expenses.								SE	СТІ	ON	Н-	DECLA	RATION BY TH	E INSURED		
SECTION H - DECLARATION BY THE INSURED	made this c neces this c	e any false or untru claim, my right to ssary medical infor laim is made. I hero	e si cla ma eby	tate aim atior / de	me rei n/c cla	ent, mbi doci re tl	sup urse ume nat l	pre eme ents ha	ssiont frove i	on o sha m a ncli	or co all be any h udec	ncealm forfei ospital all the	nent of any mate ted. I also conso / Medical Practit bills / receipts fo	rial fact with resp ent & authorize T ioner who has att	ect to que PA / insu ended on	stions asked in relation to rance company, to see the person against whon
SECTION H – DECLARATION BY THE INSURED I hereby declare that the information furnished in this claim form is true & correct to the best of my knowledge and belief. If I hav made any false or untrue statement, suppression or concealment of any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent & authorize TPA / insurance company, to see necessary medical information / documents from any hospital / Medical Practitioner who has attended on the person against whore 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.	any s	uppiementary clair	m e	хсе	pt 1	ine	pre/	pos	st-h	osp	oitali	ation	iaim, if any.			

GUIDANCE FOR FI	LLING CLAIM FORM – PART A (To be filled	d in by the insured)
DATA ELEMENT	DESCRIPTION	FORMAT
	SECTION A - DETAILS OF PRMARY 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	As allotted by the organizationcertificate number of social health insurance scheme
c) Company TPA ID No.	Enter the TPA ID No.	License number as allotted by IRDA and
2, 23, 23, 1		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
	ECTION B - DETAILS OF INSURANCE HISTOR	
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	Enter the date of commencement of	Use dd-mm-yy format
Insurance without break	first insurance	oco da min yy format
c) Company Name	Enter the full name of the insurance	Name of the organization in full
5	company	A . II
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	Indicate whether hospitalized in	Tick Yes or No
the last 4 years	the last 4 years	
Date	Enter the date of hospitalization	Use mm-yy format
Diagnosis	Enter the diagnosis details	Open Text
e) Previously Covered by any other	Indicate whether previously covered by	Tick Yes or No
Mediclaim/ Health Insurance?	another Mediclaim / Health Insurance Enter the full name of the insurance	Name of the organization in full
f) Company Name	company\	Name of the organization in full
SECTIO	N C - DETAILS OF INSURED PERSON HOSPIT	TALIZED
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	Tick the right option. If others, please
f) Occupation	policyholder	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
i) 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
I) 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	Tick Yes or No
i) Contain of Madiain a	Police FIR attached	On an Tout
j) System of Medicine	Enter the system of medicine followed in treating the patient	Open Text
	SECTION E - DETAILS OF CLIAM	
a) Details of Treatment Expenses	Enter the amount claimed as	In rupees (Do not enter paise values)
	treatment expenses	
b) Claim for Domiciliary Hospitalization	Indicate whether claim is for domiciliary hospitalization	Tick Yes or No
c) Details of Lump sum / cash benefit claimed	Enter the amount claimed as lump sum /	In rupees (Do not enter paise values)
d) Claim Documents Submitted-Check List	Indicate which supporting documents	Tick the right option
	are submitted	
1	SECTION F - DETAILS OF BILLS ENCLOSED	FUDGO
lm=!!==+	which bills are enclosed with the amounts in	
		ACCOUNT
SECTION	G - DETAILS OF PRIMARY INSURED'S BANK	
a) PAN	G - DETAILS OF PRIMARY INSURED'S BANK A Enter the permanent account number	As allotted by the Income Tax department
a) PAN b) Account Number	G - DETAILS OF PRIMARY INSURED'S BANK A Enter the permanent account number Enter the bank account number	As allotted by the Income Tax department As allotted by the bank
a) PAN b) Account Number c) Bank Name and Branch	G - DETAILS OF PRIMARY INSURED'S BANK A Enter the permanent account number	As allotted by the Income Tax department As allotted by the bank Name of the Bank in full
a) PAN b) Account Number	G - DETAILS OF PRIMARY INSURED'S BANK A Enter the permanent account number Enter the bank account number Enter the bank name along with the branch	As allotted by the Income Tax department As allotted by the bank
a) PAN b) Account Number c) Bank Name and Branch d) Cheque/ DD payable details e) IFSC Code	G - DETAILS OF PRIMARY INSURED'S BANK A 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 made out to Enter the IFSC code of the bank branch	As allotted by the Income Tax department As allotted by the bank Name of the Bank in full Name of the individual/ organization in full IFSC code of the bank branch in full
section a) PAN b) Account Number c) Bank Name and Branch d) Cheque/ DD payable details e) IFSC Code	G - DETAILS OF PRIMARY INSURED'S BANK A 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 made out to	As allotted by the Income Tax department As allotted by the bank Name of the Bank in full Name of the individual/ organization in full IFSC code of the bank branch in full

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 preauthorisation request form in lieu of PART A

	SECTION A	A – DETAILS OF HOSPITAL													
a) Name of the Hospital whe	ere treated		b) Hospital ID												
c) Type of Hospital	Ne	twork	Non Network (If non network fill form section E)												
d) Name of the treating Doct	tor		(ii non network iii form section L)												
e) Qualification		egistration No with state Cod	le l												
g) Phone No:		ogistration ito with state ood													
	SECTION P. DI	ETAILS OF PATIENT ADMITT	ED												
	SECTION B - DE	TAILS OF PATIENT ADMITT	ED												
a) Name of the patient															
b) IP Registration Number															
c) Gender Male Fer	male d) A	ge Y Y M M	e)Date of Birth												
f) Date of Admission	D M M Y Y Y Y		g) Time of Admission H H M M												
h) Date of Discharge	D M M Y Y Y		i) Time of Discharge H H M M												
j) Type of Admission	Emergency/Planned/Day	care/Maternity	k) If Maternity												
,	D M M Y Y Y Y		ii) Gravida Status												
I) Status at time of discharge	 Discharged to Home, Discharged to another Home 	penital Deceased	Total Claimed Amount Rs H H M M												
		•													
		OF AILMENTS DIAGNISED (PRIMARY)												
a) ICD 10 Code	Primary Diagnosis	Additional Diagnosis	Co-morbidities												
Details of	Diagnosis	Diagnosis	Co-morbidities												
b) ICD 10 PCS	Procedure 1	Procedure 2	Procedure 3												
d) Pre-authorization	Y N	e) Pre-authorization	No												
obtained		•													
f) If authorization by															
network hospital not obtained, give reason															
g) Hospitalisation	Y N	i) If was give cause													
due to Injury	1	i) ii yes, give cause													
Self inflicted?	Y N	Road Traffic Accident	Y N												
Substance Abuse / Alcoho	ol Consumption		Y N												
	·	on, Test Conducted to establi	sh this:												
(If yes, attach reports	YN	v) FIR No													
iii) Medico Legal	Y N		vi) If not reported to Policy give reasons												
iv) Reported to Policy	Y		moy give reasons												
IV) Reported to Folicy		OCUMENTO CURMITTED C	HECKLIST.												
		OCUMENTS SUBMITTED - C													
Claim form duly filled		Investigation													
Original Pre authoriza	tion Request	CT/MRI/USG/I	HPE investigation Report												
Copy of Pre-authoriza	tion approval Letter	Doctor's refer	ence slip for Investigation												
Copy of photo ID card	d of patient verified by Hosp	ital ECG													
Hospital Discharge Su	ummary	Pharmacy Bill	s												
Operation Theatre No	•	MLC Report &													
	100														
Hospital Main Bill			Original death summary from hospital where applica												
Hospital break up Bill		Any other, PI	specify												
SEC	CTION E -ADDITIONAL DE	TAILS IN CASE OF NON NET	WORK HOSPITAL												
a) Address of the Hospital															
b) Phone NO:		c) Registration no with Sta	ite Code												
		_													
d) Hospital PAN		e) No of In-patient Beds													
f) Facilities available in Hos	spital:														
i) OT Y	N	ii) ICU Y	N												
iii) Others															

SECTION F - DECLARATION BY 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.

|--|

Place_____

Signature and seal of the Hospital Authority

	FILLING CLAIM FORM – PART B (To be filled	in by the hospital)							
DATA	DESCRIPTION	FORMAT							
	SECTION A - DETAILS OF HOSPITAL								
a) Name of Hospital	Enter the name of hospital	Name of 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	Tick the right option							
c) Type of Hospital	network 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 qualifications of the treating doctor	Abbreviations of educational qualification							
,	Enter the registration number of the doctor	As allocated by the Medical Council							
f) Registration No. with State Code	along with the state code	of India							
g) Phone No.	Enter the phone number of doctor	Include STD code with telephone numb							
	'	'							
	ECTION B - DETAILS OF THE PATIENT ADMITT								
n) Name of Patient	Enter the name of hospital	Name of hospital in full							
o) IP Registration Number	Enter insurance provider registration	As allotted by the insurance provider							
	number								
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 Admission	Enter date of admission	Use dd-mm-yy format							
) Time	Enter time of admission	Use hh:mm format							
) Date of Discharge	Enter date of discharge	Use dd-mm-yy format							
) Time	Enter time of discharge	Use hh:mm format							
Type of Admission	Indicate type of admission of patient	Tick the right option							
**	maioute type of autilission of patient	nox the right option							
) If Maternity	Enter Data of Delivery if west with	Llos del nom us format							
Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format							
Gravida Status	Enter Gravida status if maternity	Use standard format							
x) Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option							
SECT	ON C - DETAILS OF AILMENT DIAGNOSED (PR	IMARY)							
) ICD 10 Code									
Primary Diagnosis	Enter the ICD 10 Code and description	Standard Format and Open text							
Tilliary Diagnosis	of the primary diagnosis	Standard Format and Open text							
Additional Diagnosis	Enter the ICD 10 Code and description	Standard Format and Open text							
Additional Diagnosis	of the additional diagnosis	Standard Format and Open text							
Co-morbidities	Enter the ICD 10 Code and description	Standard Format and Open text							
	of the co-morbidities	Standard Format and Open text							
o) ICD 10 PCS									
Procedure 1	Enter the ICD 10 PCS and description	Standard Format and Open text							
110004410 1	of the first procedure	Standard Format and Opon toxt							
Procedure 2	Enter the ICD 10 PCS and description	Standard Format and Open text							
	of the second procedure								
Procedure 3	Enter the ICD 10 PCS and description	Standard Format and Open text							
	of the third procedure								
Details of Procedure	Enter the details of the procedure	Open text							
e) Present Ailment is a Complication	Indicate whether present ailment is a	Tick Yes or No							
of PED	complication of some pre- existing disease								
d) Pre-authorization obtained	Indicate whether pre-authorization obtained	Tick Yes or No							
e) Pre-authorization Number	Enter pre-authorization number	As allotted by TPA							
) If authorization by network hospital	Enter reason for not obtaining	Open text							
not obtained, give reason	pre-authorization number	Open text							
g) Hospitalization due to injury	Indicate if hospitalization is due to injury	Tick Yes or No							
Cause	Indicate cause of injury	Tick the right option							
	Indicate cause of injury Indicate whether test conducted	Tick Yes or No							
If injury due to substance									
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							
SECT	ION D - CLAIM DOCUMENTS SUBMITTED-CHE	CKLIST							
ndicate which supporting documents are		O. 101							
•									
	ON E - DETAILS IN CASE OF NON NETWORK H								
) Address	Enter the full postal address	Include Street, City and Pin Code							
) Phone No.	Enter the phone number of hospital	Include STD code with telephone numb							
Registration No.	Enter the registration number of patient	As allocated by the Hospital							
i) PAN	Enter the permanent account number	As allotted by the Income Tax departmen							
Number of Inpatient Beds	Enter the number of inpatient beds	Digits							
	·	•							
) Facilities available in the hospital	Indicate facilities available in the hospital	Tick the right option. If others, please specify							
	SECTION F - DECLARATION BY THE INSURED								
load doctoration corefully and montion de	ate (in dd:mm:yy format), place (open text) and s	sign.							
read declaration carefully and mention da									
	SECTION G - DECLARATION BY THE HOSPITA	L							

$\begin{tabular}{ll} \textbf{PART C}\\ \end{tabular} \begin{tabular}{ll} \textbf{(To be filled ONLY for re-imbursement under wellness benefit of Product Name policy)} \end{tabular}$

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Signature of the Policyholder

CHECK LIST OF ENCLOSURES FOR SUBMISSION OF CLAIM

- Duly filled and signed Re-imbursement Form.
- Original payment Receipt of the hospital bill.

CHECK LIST OF ENCLOSURES FOR SUBMISSION OF CLAIM

Note:

- 1. When original bills, receipts, prescriptions, reports and other documents are submitted to the other insurer or to the reimbursement provider, verified photocopies attested by such other organisation/provider have to be submitted.
- 2. If original bills, receipts, prescriptions, reports and other documents are submitted to Us and Insured Person requires same for claiming from other organisation/provider, then on request from the Insured Person We will provide attested copies of the bills and other documents submitted by the Insured Person.

In-patient Treatment / Day Care Procedures

- Duly filled and signed Claim Form.
- Photocopy of ID card / Photocopy of current year policy.
- Original Detailed Discharge Summary with date of admission & discharge, clinical history, past history / procedure details/ Day care summary from the hospital.
- Original consolidated hospital bill with break up of each Item, duly signed by the insured.
- Original payment Receipt of the hospital bill.
- First Consultation letter and subsequent Prescriptions.
- Original bills, original payment receipts and Reports for investigation.
- Original medicine bills and receipts with corresponding Prescriptions.
- Original invoice/Sticker of implants/bills for Implants (viz. Stent /PHS Mesh/ IOL etc.) with original payment receipts.

Road Traffic Accident

In addition to the In-patient Treatment documents:

- Copy of the First Information Report from Police Department / Copy of the Medico-Legal Certificate.
 - In Non Medico legal cases
- Treating Doctor's Certificate giving details of injuries (How, when and where injury sustained)
 In Accidental Death cases
- Copy of Post Mortem Report & Death Certificate (If conducted)

For Death Cases

In addition to the In-patient Treatment documents:

- Original Death Summary from the hospital.
- Copy of the Death certificate from treating doctor or the hospital authority.
- Copy of the Legal heir certificate, if the claim is for the death of the principle insured.

Pre and Post-hospitalisation expenses

- Duly filled and signed Claim Form.
- Photocopy of ID card / Photocopy of current year policy.
- Original Medicine bills, original payment receipt with prescriptions.
- Original Investigations bills, original payment receipt with prescriptions and report.
- Original Consultation bills, original payment receipt with prescription.
- Copy of the Discharge Summary of the main claim.

Organ Donation/Transplantation

In addition to the documents of general hospitalization

- Organ Function test / blood test proving organ failure.
- Treatment Certificate issued by the Transplant Surgeon of the hospital concerned.

Ambulance Benefit

- Duly filled and signed Claim Form.
- Photocopy of ID card / Photocopy of current year policy.
- Original Bill with Original Payment Receipt.
- Treating Doctor's consultation prescription indicating Emergency Hospitalization.

Customer Identification Procedure (as per KYC norms of IRDA)												
Please submit the following documents in case of claim an	nount exceeds Rs. 100,000											
Legal name and any other names used (Any one of the mentioned documents)	Passport/ PAN Card/ Voter's Identity Card/ Driving License/ Letter from a recognized public authority or public servant verifying the identity and residence of the customer											
Proof of Residence (Any one of the mentioned documents)	Telephone bill/ Bank account statement/ Letter from any recognized public authority/ Electricity bill/ Ration card											

For more information; Email us at customersupport@tata-aig.com or visit www.tataaiginsurance.in Contact us on our 24 hour Toll Free Helpline at 1800 266 7780 or 1800 22 9966 (only for senior citizen policy holders) Insurance is the subject matter of the solicitation

Tata AIG General Insurance Company Limited