

HEALTH CLAIM FORM

CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT - PART A TO BE FILLED IN BY THE INSURED

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

(To be filled in block letters)

DETAILS OF PRIMAR	RY INSURE):																								
a) Policy No:													b) SI. N	lo./Ce	rtifica	te No:										
c) Company/TPA ID No:		jHH	╗	7	╦	$\dashv \vdash$	┧┼┼	╗	Ħ۴			\neg	,								لـــار					
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DETAILS OF INSURA																										4
a) Currently covered by a	any other Me	diclaim/	Health	insura	nce:		_ <u>Y</u>	es	ЩМ	0	b) Date (of comm	enceme	nt of fi	irstin	surance	witho	ut br	reak: D	D	М	М	Υ	Υ	_	
c) If yes, company name:	: <u>_</u>			<u>_</u> L					$\bigsqcup \bigsqcup$		Poli	y No.	$\sqcup \sqcup$	Ш				_ _		ШL		ШL	<u>_</u> L	اللا		U
Sum Insured (Rs.)						d	I) Have y	oubee	nhosp	italized	in the la	st four y	ears sin	ce ince	eption	of the	contra	ct _	Yes	No	Date:	М	М	Υ	Υ	ř
Diagnosis:													e) Pı	reviou	sly cov	ered b	y any o	ther	Mediclaim/Hea	alth Insu	ırance:		Yes		No	SECTIONS
f) If yes, Company Name:	:																									Ž
DETAILS OF INSURE	D PERSON	HOSPI	TALIZI	ED:																						
a) Name:	SU	RIN	А	МЕ				F	I F	S	Т	N A	МЕ			М			LE	N A	М	Е				7
b) Gender:	Male	Fe	male [╡		c) Age:	: vears	Y	Y	М	М] (b	Date of E	3irth:	D [М	1	YY							_
e) Relationship to Prima] Se		— ر د	pouse		Child	٦٣	Fathe	r ∺‴	 Mot		Othe	'		ے اease :	pecify	 v)								
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DETAILS OF HOSPITA	ALIZATION																									
a) Name of Hospital whe	ere Admitted	l: [
b) Room Category occup	oied:	Day care	· 🗌		Singl	e occup	ancy [Twinsh	naring (301	more b	eds pe	er roor	n 🗌										
c) Hospitalization due to	o: Injury	· 🔲	Ilne	ess	7	Mate	ernity	7		d) D	ate of in	ury/Date	Diseas	se first	dete	ted/D	ate of I	Deliv	ery D D	M	1	Υ	Υ			
e) Date of Addmission:	D D		М)	Y	f) 1	Γime: 📙	Н	: 1	1 M	() Date o	f Discha	arge: [D [М	4	YY	h) Time	 e: H	Н	: M	М		Ü
i) If injury give cause:	Self infl	icted	<u> </u>	L Ro	ad Tra	ffic Acci	<u> </u>	┽╴		⊐∟ Substa	nce Abu				tion	╡	ـــاكـــــــا ا (i	—l lf Med	dico legal:	Yes	H	No.				_
ii) Reported to police:	Ye	-	No				port & F	⊥ Police F			Yes		No			 i) S√s	tem of				ш					2
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DECLAR	ΙΛΟΙΤΔΩ	RV THE I	MISHIRED:

I hereby declare that the information furnished in this claim is true & correct to the best of my knowledge and belief. If I have 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 forfieted. I also consent & authorise 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 will not be making any suplementary claim except the pre/post-hospitalization claim, if any

that will not be m	naking any suplementary claim except ti	e pre/post-hospitalization claim, if any	
Date:	DD MM YY	Place	Signature of the Insured
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GUIDAN	CE FOR FILLING CLAIM FORM - PART A (To be filled in by the ins	sured)
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 of the certificate number of social health insurance scheme	As allotted by the organization
c) Company TPA ID No.	Enter the TPA ID No.	License number as allotted by IRDA and printed in TP/ 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 Medicliam / 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 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	Inrupees
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	User mm-yy format
Diagnosis	Enter the diagnosis details	OpenText
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
i) E-mail ID	Enter e-mail address of patient	Complete e-mail address
N. 60 % 1.1	SECTION D - DETAILS OF HOSPITALIZATION	T 10 10 10 10 10 10
a) Name of Hospital where Insured	Enter the name of hospital	Name of hospital in full
b) Room category occupied c) Hospitalization due to	Indicate the room category occupied Indicate reason of hospitalization	Tick the right option 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 in 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 Medicine	Enter the system of medicine followed in treating the patient	OpenText
	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 benefit claimed	Enter the amount claimed as lump sum /cash benefit	In rupees (Do not enter paise values)
	Indicate which supporting documents are submitted	Tick the right option
d) Claim Documents Submitted-Check List		
	SECTION F - DETAILS OF BILLS ENCLOSED	
Indicate which bills are enclosed with the amounts in rupees	SECTION F - DETAILS OF BILLS ENCLOSED	
Indicate which bills are enclosed with the amounts in rupees	SECTION F - DETAILS OF BILLS ENCLOSED SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT	As allotted by the Income Tay department
Indicate which bills are enclosed with the amounts in rupees a) PAN	SECTION F - DETAILS OF BILLS ENCLOSED SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT Enter the permanent account number	As allotted by the income Tax department As allotted by the bank
Indicate which bills are enclosed with the amounts in rupees a) PAN b) Account Number	SECTION F - DETAILS OF BILLS ENCLOSED SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT Enter the permanent account number Enter the bank account number	As allotted by the bank
Indicate which bills are enclosed with the amounts in rupees a) PAN	SECTION F - DETAILS OF BILLS ENCLOSED SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT Enter the permanent account number Enter the bank account number Enter bank name along with the branch Enter the name of beneficiary the cheque/DD should be	<u> </u>
Indicate which bills are enclosed with the amounts in rupees a) PAN b) Account Number c) Bank Name and Branch	SECTION F - DETAILS OF BILLS ENCLOSED SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT Enter the permanent account number Enter the bank account number Enter bank name along with the branch	As allotted by the bank Name of the bank in full