



CLAIM FORM - PART A

Important instructions for completing the form

- ▶ To Be Filled In By The Insured
- ▶ Form to be filled in block letters
- ▶ The issue of this Form is not to be taken as an admission of liability.

Details Of Primary Insured

Policy no.	Sl. no./ Certificate no.	
_____	_____	
Company/TPA ID No.		

Name		

Address		

City	State	Pincode
_____	_____	_____
Phone No.	Email ID	
_____	_____	

Details Of Insurance History

Currently covered by any other Mediciam/ Health Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of commencement of first insurance without break _____	
If yes, Please provide details Company Name	
Policy no.	Sum Assured
_____	_____
Have you been hospitalized in last four years since inception of the contract? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date	Diagnosis
_____	_____
Previously covered by any other Mediciam / Health Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Company Name	

Details Of Insured Person Hospitalised

Name



Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Third Gender	
Date of birth	____ ____ ____ ____ ____ ____ ____ ____	Age	____ ____ ____ In Years	
Relationship to Primary Insured				
<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Father	<input type="checkbox"/> Mother
<input type="checkbox"/> Other (Please Specify)	_____			
Occupation				
<input type="checkbox"/> Service	<input type="checkbox"/> Self Employed	<input type="checkbox"/> Homemaker	<input type="checkbox"/> Student	
<input type="checkbox"/> Retired	<input type="checkbox"/> Other (Please Specify) _____			
Address (if different from above)				
City	State	Pincode		
Phone No.	Email ID			

Details Of Hospitalisation

Name of Hospital where admitted			
Room Category Occupied			
<input type="checkbox"/> Day Care	<input type="checkbox"/> Single Occupancy	<input type="checkbox"/> Twin Sharing	<input type="checkbox"/> 3 or more beds per room
Hospitalization due to/ अस्पताल में भर्ती होने के कारण			
<input type="checkbox"/> Injury	<input type="checkbox"/> Illness	<input type="checkbox"/> Maternity	
Date of Injury/ Date Disease first detected/ Date of Delivery			
Date of admission		Date of discharge	
Time		Time	
If Injury, give cause			
<input type="checkbox"/> Self Inflicted	<input type="checkbox"/> Road Traffic Accident	<input type="checkbox"/> Substance Abuse/ Alcohol Consumption	
If Medico-Legal		Reported to Police	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
MLC Report & Police FIR Attached/ एमएलसी रिपोर्ट एवं पुलिस प्राथमिकी संलग्न है			
<input type="checkbox"/> Yes	<input type="checkbox"/> No		
System of Medicine/ चिकित्सा प्रणाली			

**Details Of Claim**

Details of the treatment expenses claimed	
Pre-hospitalization Expenses ₹	Hospitalization Expenses ₹
Post-hospitalization Expenses ₹	Health-Checkup Cost ₹
Ambulance Charges ₹	Others (code) ₹
Total ₹	
Pre-hospitalization Period Days	Post-hospitalization Period: Days Days

Claim for Domiciliary Hospitalization Yes No
If yes, provide details in annexure

Details of Lump sum/Cash benefit claimed	
Hospital Daily Cash ₹	Surgical Cash ₹
Critical Illness benefit ₹	Convalescence ₹
Pre/Post Hospitalization Lump sum benefit ₹	Others ₹
Total/ कुल ₹	

Claim Documents Submitted - Check List

<input type="checkbox"/> Claim Form Duly Signed	<input type="checkbox"/> Operation Theatre Notes
<input type="checkbox"/> Copy of the Claim Intimation (if any)	<input type="checkbox"/> ECG
<input type="checkbox"/> Hospital Main Bill	<input type="checkbox"/> Doctor's Request for Investigation
<input type="checkbox"/> Hospital Break-up Bill	<input type="checkbox"/> Investigation Reports (Including CT/ MRI/ USG/ HPE)
<input type="checkbox"/> Hospital Bill Payment Receipt	<input type="checkbox"/> Doctor's Prescriptions
<input type="checkbox"/> Hospital Discharge Summary	<input type="checkbox"/> Others
<input type="checkbox"/> Pharmacy Bill	

Details Of Bills Enclosed

Sl. no	Bill no.	Date	Issued by	Towards	Amount (₹)
1.		DD/MM/YYYY		Hospital Main Bill	
2.		DD/MM/YYYY		Pre-hospitalization Bills: _____ Nos.	



Sl. no	Bill no.	Date	Issued by	Towards	Amount (₹)
3.		DD/MM/YYYY		Pre-hospitalization Bills: _____ Nos.	
4.		DD/MM/YYYY		Pharmacy Bills/ फार्मसी बिल	
5.		DD/MM/YYYY			
6.		DD/MM/YYYY			
7.		DD/MM/YYYY			
8.		DD/MM/YYYY			
9.		DD/MM/YYYY			
10.		DD/MM/YYYY			

Details Of Primary Insured's Bank Accounts

PAN	Account Number
Bank Name	
Bank Branch	
Cheque/ DD Payable Details	IFSC Code

Declaration By The Insured

I hereby declare that the information furnished in this claim form is true and 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 forfeited. I also consent and 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 and that I will not be making any supplementary claim except the pre/ post-hospitalization claim, If any.

Signature of Insured _____

Date Place 

**Guidance For Filling Claim Form - Part A** (To Be Filled In By The Insured)

Data Element	Description	Format
Section A - Details of the 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 Organisation
c) Company TPA ID No.	Enter the TPA ID No.	License number, as allotted by the IRDA and printed in TPA documents
d) Name	Enter the full name of the Policy Holder	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	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-YYYY 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 assured	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 DD-MM-YYYY 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-YYYY format
e) Relationship to Primary Insured	Indicate relationship of patient with Policy Holder	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



Data Element	Description	Format
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-YYYY format
e) Date of admission	Enter the date of admission	Use DD-MM-YYYY format
f) Time	Enter the time of admission	Use HH:MM format
g) Date of discharge	Enter date of discharge	Use DD-MM-YYYY format
h) Time	Enter the time of discharge	Use HH:MM format
i) If Injury, give cause	Indicate cause 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 Medicine	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 benefit claimed	Enter the amount claimed as Lump sum/ Cash benefit	In rupees (Do not enter paise values)
d) Claim Document Submitted-Check List	Indicate which supporting documents are submitted	Tick the right option

Section F - Details of Bill Enclosed		
Indicate which bills are enclosed with the amounts in rupees		

Section G - Details of Primary Insured's Bank Accounts		
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
d) 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
e) 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-YYYY format), place (open text) and sign.		

**CLAIM FORM - PART B****Important instructions for completing the form**

- ▶ To be filled in by the hospital
- ▶ Form to be filled in block letters
- ▶ 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

Details Of Hospital

Name of the Hospital		
Hospital ID		
Type of Hospital <input type="checkbox"/> Network <input type="checkbox"/> Non-Network (If non-network, fill section E)		
Name of the Treating Doctor		
Qualification	Registration No. with State Code	Phone No.

Details Of The Patient Admitted

Name of the Patient		
IP Registration Number		
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Age ____ Years ____ Months	Date of Birth DD / MM / YYYY
Date of Admission Time/ समय	Date of Discharge Time/ समय	
Type of Admission <input type="checkbox"/> Emergency <input type="checkbox"/> Planned <input type="checkbox"/> Daycare <input type="checkbox"/> Maternity		
If Maternity Date of Delivery <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		Gravida Status _____
Status at time of discharge <input type="checkbox"/> Discharge to home <input type="checkbox"/> Discharge to another hospital <input type="checkbox"/> Deceased		
Total claimed amount ₹		

Details Of Ailment Diagnosed (Primary)

ICD 10 Codes
Primary Diagnosis Description
Additional Dignosis Description



Co-morbidities Description
Co-morbidities Description
ICD 10 PCS
Procedure 1 Description
Procedure 2 Description
Procedure 3 Description
Details of Procedure
Pre-authorization obtained <input type="checkbox"/> Yes <input type="checkbox"/> No
Pre-authorization Number
If authorization by network hospital not obtained, give reason
Hospitalization due to injury <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, give cause <input type="checkbox"/> Self Inflicted <input type="checkbox"/> Road traffic accident <input type="checkbox"/> Substance abuse/ alcohol consumption
If injury due to Substance Abuse / Alcohol Consumption, Test Conducted to establish this <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, attach report)
If Medico-Legal <input type="checkbox"/> Yes <input type="checkbox"/> No
Reported to Police <input type="checkbox"/> Yes <input type="checkbox"/> No
FIR No <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
If not reported to Police, give reason

Claim Documents Submitted - Check List

<input type="checkbox"/> Claim Form Duly Signed	<input type="checkbox"/> Investigation Reports
<input type="checkbox"/> Original Pre-authorization request	<input type="checkbox"/> CT / MRI / USG / HPE Investigation Reports
<input type="checkbox"/> Copy of the Pre-authorization Approval Letter	<input type="checkbox"/> Doctor's Reference Slip for Investigation ECG
<input type="checkbox"/> Copy of Photo ID Card of Patient Verified by Hospital	<input type="checkbox"/> Pharmacy Bill
<input type="checkbox"/> Hospital Discharge Summary	<input type="checkbox"/> MLC Reports & Police FIR
<input type="checkbox"/> Operation Theatre Notes	<input type="checkbox"/> Original Death Summary from Hospital Where Applicable
<input type="checkbox"/> Hospital Main Bill	<input type="checkbox"/> Any other, Please Specify
<input type="checkbox"/> Hospital Break-up Bill	



Details In Case Of Non Network Hospital (Only Fill In Case Of Non-network Hospital)

Address of the Hospital

City

State

Pincode

Phone No.

Registration No. with State Code

Hospital PAN

Number of inpatient beds

Facilities available in the hospital

OT Yes No

ICU Yes No

Others _____

Declaration By The Hospital

We hereby declare that the information furnished in this claim form is true and 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 _____

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 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-network hospital	Tick the right option
d) Name of the 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 Number 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 the doctor	Include STD code with telephone number

Section B - Details of Patient Admitted		
a) Name of Patient	Enter the name of hospital	Name of hospital in full
b) IP Registration Number	Enter insurance provider's registration number	As allotted by the insurance provider
c) Gender	Indicate gender of the Patient	Tick 'Male' or 'Female'
d) Age	Enter the age of Patient	Number of years and months
e) Date of Birth	Enter the Date of Birth	Use DD-MM-YYYY format
f) Date of Admission	Enter the Date of Admission	Use DD-MM-YYYY format
g) Time	Enter the time of Admission	Use HH-MM format
h) Date of Discharge	Enter the Date of Discharge	Use DD-MM-YYYY format
i) Time	Enter the time of Discharge	Use HH-MM format
j) Type of Admission	Indicate type of admission of patient	Tick the right option
If Maternity,		
Date of Delivery	Enter the Date of Delivery, if maternity	Use DD-MM-YYYY format
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 & Open text
Additional Diagnosis	Enter the ICD 10 Code and description of the Additional Diagnosis	Standard format & Open text
Co-morbidities	Enter the ICD 10 Code and description of the Co-morbidities	Standard format & Open text



Data Element	Description	Format
Section C - Details of Ailment Diagnosed (Primary)		
b) ICD 10 PCS		
Procedure 1	Enter the ICD 10 PCS and description of the First Procedure	Standard format & Open text
Procedure 2	Enter the ICD 10 PCS and description of the Second Procedure	Standard format & Open text
Procedure 3	Enter the ICD 10 PCS and description of the Third Procedure	Standard format & Open text
Details of Procedure	Enter the details of the procedure	Open text
c) Pre-authorisation obtained	Indicate whether Pre-authorisation obtained	Tick 'Yes' or 'No'
d) Pre-authorisation number	Enter the Pre-authorisation number	As allotted by the TPA
e) If authorisation by network hospital not obtained, give reason	Enter reason for not obtaining Pre-authorisation number	Open text
f) Hospitalisation due to injury	Indicate if hospitalisation 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 Checklist

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 doctor along with state code	As allotted by the Medical Council of India
d) Hospital PAN	Enter the Permanent Account Number	As allotted 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-YYYY format) and Place (open text), along with Sign and Stamp.