

CHECK LIST OF ENCLOSURES FOR SUBMISSION OF CLAIMS

[Please tick (✓) the appropriate box]

D. L. Gilladia, Claim Farms	Description of magnitude whom payment is
Duly filled in Claim Form	Revenue Stamp on receipts where payment is above Rs.5000/-and stamp & signature of hospital.
Photocopy / of Mediassist ID card Mediassist ID	
no	First consultation letter for the presenting complaints.
Whether intimation given to TPA or HR within 72 hours or not. (Please Attached Mail Print of	
Intimation)	Bank Details(copy of cancelled cheque)
If not, declaration for delay in intimation	Follow-up advice or line of treatment after discharge from the hospital/treating Doctor
General:	discharge from the hospital/freating Doctor
General:	
Original copy of consolidated bill on pre-printed	For Death Cases:
stationery with serial number of hospital, with detail	Attested copy of death summary in pre-printed
break-ups cost wise and quantity wise as below	stationery of hospital signed by the consultant with
☐ Break-up of laboratory charges	hospital stamp and registration number of the hospital
☐ Disposals Medicines	Attested copy death certificate from competent
Medicines used in OT	authority
Injections	Legal heir certificate (in case of death of the
Professional / Consultancy charges	main member)
Nursing charges	For Maternity Cases:
Details for equipment charges (if any)	Original copy of treating doctor certificate
Room rent – break-up with number of days	regarding obstetric history (Gravida, Para, Living
Original copy of the receipt of payment	children, Abortions, Death)
	2. Ultra Sound Report (USG Report)
All original prescriptions for the Medical bills attached	For Accidental Cases:
All the Original Investigation Reports with	Attested copy of MLC report
requisition slips	Attested copy of FIR
Original Pathological and Medical investigation,	Original copy of treating doctor's certificate with
X-ray reports with bills	circumstances and injuries sustained due to RTA
Original Discharge summary in pre-printed	Original copy of treating doctor's certificate for
stationery of hospital duly signed by the consultant	any evidence of influence of alcohol / other narcotics
with hospital stamp and registration number of the	substance during the accident
hospital	Attested copy of post mortem report (in case of
CURRENT YEAR HOSPITAL	death)
CURRENT YEAR HOSPITAL REGISTRATION CERTIFICATE. (mandatory)	Death summary from the hospital & death
If hospitalization is for 2 days then declaration	certificate from Municipal Corporation.
from hospital authorities stating time of Admission &	For Some Special Cases:
Discharge (24 Hrs. criteria applied.)	In case of Cataract-Lens sticker with tax invoice
If claimed amount is more than Rs.100000,	& A Scan Report
require the photo id proof & address proof of the	In case of Surgery- Implant stickers with tax
patient.	invoice
	In case of heart related treatment- stent sticker
	with tax invoice
a	

CLAIM FORM - PART A' to 'CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT - PART A 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)

(To	he	Fill	led	in	blo	ck	lett	erel	۱

DETAILS OF PRIMARY INSURED;					
a) Policy No.: b) Sl. No/ Certificate no.					
c) Company/ TPA ID No:					
Name: SURNAME FIRST NAME NAME.					
e) Address:					
City: State: State:					
Pin Code Phone No: Email ID:					
DETAILS OF INSURANCE HISTORY:					
a) Currently covered by any other Mediclaim / Health Insurance: Yes No b) Date of commencement of first Insurance without break: DD D M M YYYYY					
c) If yes, company name:					
Sum insured (Rs.)					
Diagnosis: e) Previously covered by any other Mediclaim /Health insurance ::					
) If yes, company name:					
DETAILS OF INSURED PERSON HOSPITALIZED: :					
NAME SURNAME NAME NAME NAME					
o) 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)					
Occupation Service Self Employed Home Maker Student Retired Other (Please Specify)					
) Address (if diffrent from above):					
City: State: Sta					
Pin Code Phone No: Phone No: Email ID:					
DETAILS OF HOSPITALIZATION: :					
)) Name of Hospital where Admited:					
) Room Calegory occupied: Day care Single occupancy Twin sharing 3 or more beds per room					
) 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 Y Y Y Y					
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					
) If injury give cause: Self inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption I) If Medico legal Yes No					
If injury give cause: Self inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption I) If Medico legal Yes No ii) Reported to Police III iii. MLC Report & Police FIR attached Yes No ii) System of Medicine:					
) If injury give cause: Self inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption I) If Medico legal Yes No i) Reported to Police III. MLC Report & Police FIR attached Yes No i) System of Medicine: DETAILS OF CLAIM:					
) If injury give cause: Self inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption I) If Medico legal Yes No i) Reported to Police iii. MLC Report & Police FIR attached Yes No i) System of Medicine: DETAILS OF CLAIM: Claim Documents Submitted - Check List:					
If injury give cause: Self inflicted					
If injury give cause: Self inflicted					
Off injury give cause: Self inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption I) If Medico legal Yes No OFFIRE TRAILS OF CLAIM: Details of the Treatment expenses claimed Pre -hospitalization expenses Rs.					
If injury give cause: Self inflicted					
If injury give cause: Self inflicted					
If injury give cause: Self inflicted					
If injury give cause: Self inflicted					
Off injury give cause: Self inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption I) If Medico legal Yes No Office No No No No No No No No No N					
If injury give cause: Self inflicted					
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If injury give cause: Self inflicted					
If injury give cause					
If injury give cause: Self Inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption I) If Medico legal Yes No No System of Medicine:					
If injury give cause:					
If injury give cause:					

SECTION

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	Y Y Y Pla	ace:	Signature of the Insured	

	DATA ELEMENT	DESCRIPTION	FORMAT
		SECTION A - DETAILS OF PRIMARY INSURED	it in the second
a)	Policy No.	Enter the policy number	As allotted by the Insurance Company
)	SI, No/ Certificate No.	Enter the social Insurance number or the certificate number of	As allotted by the oraganization
)	Company TPA ID No.	social health insurance scheme Enter the TPA ID No.	Licence number as allotted by IRDA and printe
96 86		• concentration of the control of th	in TPA documents.
)	Name	Enter the full name of the policyholder Enter the full postal address	Surname, First name, Middle name Include Street, City and Pin code
)	Address	SECTION B -DETAILS OF INSURANCE HISTORY	I module direct, only and i in code
)	Currently covered by any other Mediclaim / Health Insurance?	Indicate whether currently covered by another Mediclaim / Health Insurance	Tick Yes or No
)	Date of commencement of first Insurance without break	Enter the date of commencement of first Insurance	Use dd-mm-yy-forrmat
)	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
)	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
)	Previously covered by any other Mediclaim / Health	Indicate whether previously covered by another mediclaim / Health Insurance	Tick Yes or No
_	Insurance? Company Name	Enter the full name of the Insurance Company	Name of the organization in full
_		TION C -DETAILS OF INSURED PERSON HOSPITALIZED	reality of the organization in tall
		Enter the full name of the patient	Surname, First name, Middle name
	Name	Indicate Gender of the patient	Tick Male or Female
)	Gender	Enter age of the patient	Number of years and months
)	Age Date of Birth		Use dd-mm-yy format
10	Annual Control of the	Enter Date of Birth of patient Indicate relationship of patient with policyholder	Tick the right option, if others, please specify
)	Relationship to primary Insured		Tick the right option. If others, please specify.
	Occupation	indicate occupation of patient	Include Street, City and Pin code
)	Address	Enter the full postal address	Include STD code with telephone number
0	Phone No	Enter the phone number of patient	Complete e-mail address
)	E-mail ID	Enter e-mail address of patient SECTION D - DETAILS OF HOSPITALIZATION	Complete e-mail address
	Name of Laurital whose admited		Name of hospital in full
))	Name of Hospital where admited	Enter the name of hospital indicate the room category occupied	Tick the right option
	Room category occupied	indicate the room category occupied	Tick the right option
)	Hospitalization due to Date of injury/Date Disease first detected / Date of	Enter the relevant date	Use dd-mm-yy format
)	Delivery Date of admission	Enter date of admission	Use dd-mm-yy format
_	Time	Enter date 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
-	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
	System of Medicene	SECTION E - DETAILS OF CLAIM	
	Details of Treatment Expences	Enter the amount claimed as treatment expences	In rupees (Do not enter paise values)
)	Claim for Domiciliary Hospitalization	indicate whether claim is for domiciliary hospitalization	Tick Yes or No
,	Details of Lump sum/ Cash benifit claimed	Enter the amount claimed as lump sum / cash benefit	In rupees (Do not enter paise values)
)	Claim documents Submitted-Check List	indicate which supporting documents are submitted	Tick the right option
		SECTION F - DETAILS OF BILLS ENCLOSED	
di	cate which bills are enclosed with the amount in rupees		
	SECTION	ON G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT	
)	PAN	Enter the permanent account number	As allotted by the Income Tax Department
)	Account Number	Enter the Bank account number	As allotted by the Bank
)	Bank Name and Branch	Enter the Bank name along with the branch	Name of the Bank in full
`	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
1		Foto the IECC and of the Donk brough	IFSC code of the Bank branch in full
	IFSC Code	Enter the IFSC code of the Bank branch	IFSC code of the Bank branch 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
Please include the original preauthorization request form in lieu of PART A

(To be Filled in block letters)

DETAILS OF HOSPITAL	
a) Name of the hospital: a) Hospital ID: c) Type of Hospital: c) Name of the treating doctor: SURNAME f) Registration No. with State Code:	Network: Non Network: (if non network fill section E) SET NAME MIDDLE NAME 9) Phone No.
DETAILS OF THE DATIENT ADMITTED	
a) Name of the Patient:	
b) IP Registration Number: C) Gender: Male Female	d) Age: Years Y Y Months M M e) Date of birth: D D M M Y Y
f) Date of Admission: D D M M Y Y g) Time: H H M M	h) Date of Discharge: D D M M Y Y i) Time: H H M M M TO TO TO THE NEW Y Y ii) Date of Delivery: D D M M Y Y ii) Gravida Status: :
j) Type of Admission: Emergency Planned Day Care Maternity k) If Mater	ity i) Date of Delivery: D D M M Y Y ii) Gravida Status: .
1) Status at time of discharge: Discharge to home Discharge to another hospital Deceased [m) Total claimed amount
DETAILS OF AILMENT DIAGNOSED (PRIMARY)	
	b) ICD 10 PCS Description
a) ICD 10 Codes Description I. Primary Diagnosis	i. Procedure 1: Description
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 N	umber:
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, 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:	
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	NON-NETWORK HOSPITAL)
a) Address of the Hospital City: Pin Code: b) Phone No. d) Hospital PAN: iii, Others:	State:
DECLADATION BY THE HOSPITAL	(PLEASE READ VERY CAREFULLY)
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 belief, our right to claim under this claim shall be forfeited.	
Date: D D M M Y Y	SECTION
Place: Signature and Seal of the Hos	

	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
3/	SEC	TION B - DETAILS OF THE PATIENT ADMITTED	8
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
-))	Date of Admission	Enter date of admission	Use dd-mm-yy format
) g)	Time	Enter Time of admission	Use hh:mm format
y) h)	Date of Discharge	Enter the of admission Enter date of Discharge	Use dd-mm-yy format
85 00		Enter time of Discharge	Use hh:mm format
)	Time		
)	Type of Admission	Indicate type of admission of patient	Tick the right option
k)	If Maternity	Catas Data of Dallivan, if materials	Hoo did was the format
	Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format
878	Gravida Status	Enter Gravida status if maternity	Use standard format
)	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
)	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
:)	Pre-authorization obtained	Indicate whether pre-authorization obtained	Tick Yes or No
))	Pre-authorization Number	Enter pre-authorization number	As allotted by TPA
-	If authorization by network hospital not obtained, give reason	Enter reason for not obtaining pre-authorization number	Open text
:)		***	•
	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 authrities
	If not reported to police, give reason	Enter reason for not reporting to police	Open text
	SEC	TION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST	
ndica	te which supporting documents are submitted		
	CONTROL TO A CONTROL TO A CONTROL STATE OF A CONTROL OF	ION E - DETAILS IN CASE OF NON NETWORK HOSPITA	L
)	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 number
	AMERICANO. # 0 100 1001000 # 0	Enter the registration number of the Hospital obtained from local body	GC NGC 7000 PS 2500 PP 29 800000 A000
)	Registration No. with State Code	like City Corporation / Municipality	As allocated by the City Corporation / Municipa
)	Hospital PAN	Enter the permanent account number	As allocated by the Income Tax Department
,	Mark and the state of the state	Enter the number of inpatient beds	Digits
)	Number of Inpatient beds Facilities available in the hospital	Lines the number of impatient beds	Tick the right option. If others, please specify