<u>L</u>	IST OF DOCUMENTS REQUIRED FOR SETTLEMENT OF HOSPITALISATION CLAIMS
1.	FOR CLAIMING HOSPITALISATION EXPENSES
Α	CLAIM FORM – PART A: DULY COMPLETED BY THE INSURED ON THE PRESCRIBED FORMAT - ORIGINAL
В	CLAIM FORM – PART B: DULY COMPLETED AND SIGNED BY THE HOSPITAL AUTHORITIES - ORIGINAL
С	ADMISSION NOTES – CERTIFIED COPY
D	TPA ID CARD – XEROX COPY
Е	ANY OTHER ID PROOF LIKE VOTER ID/ DL/ PASSPORT ETC - COPY
F	ADDRESS PROOF - COPY
G	REFERRAL LETTER, IF ANY, TO HOSPITAL – CERTIFIED COPY
Н	DETAILED DISCHARGE SUMMARY - ORIGINAL
I	DEATH SUMMARY (INSTEAD OF Discharge Summary) IF PATIENT HAS PASSED AWAY DURING HOSPITALISATION - ORIGINAL
J	INVESTIGATION REPORTS - IN ORIGINAL – FOR INVESTIGATIONS DONE DURING HOSPITALISATION
К	HISTOPATHOLOGY REPORT, IF ANY, IN ORIGINAL
L	CERTIFIED COPY OF OPERATION THEATRE (OT) NOTES – WHERE SURGERY IS PERFORMED
М	MLC REPORT/ FIR FOR ACCIDENT CASE <mark>S – CERTIFIED COPY</mark>
Ν	STICKER FOR THE IMPLANTS USE <mark>D - ORIGINAL</mark>
0	SUPPPORTING INVOICE FOR THE IMPLANTS USED – CERTIFIED COPY
Р	HOSPITAL MAIN BILL - ORI <mark>GINAL</mark>
Q	BREAK-UP BILL FOR TH <mark>E HO</mark> SPITAL MAIN BILL - ORIGINAL
R	DETAILED BILL FOR TH <mark>E NO</mark> N-ADMISSIBLE AMOUNTS COLLECTED FROM THE PATIENT
S	RECEIPT FOR THE AM <mark>OUNT COLLECTED FROM THE PATIENT</mark>
Т	RECEIPT FOR THE CO-PAY COLLECTED FROM THE PATIENT
U	COPY OF THE PRE-AUTH DENIED LETTER, IF ANY, FOR CASHLESS DENIED
V	CONFIRMATION FROM THE HOSPITAL FOR NON-UTILISATION OF CASHLESS FACILITY, IF CASHLESS SANCTIONED
W	PRESCRIPTIONS FOR MEDICINES PURCHASED DURING HOSPITALISATION
Х	PHARMACY BILLS IN ORIGINAL FOR MEDICINES PURCHASED DURING HOSPITALISATION
Y	LIST OF BILLS SUBMITTED WITH THE AMOUNT UNDER EACH BILL
	DOCUMENTS FOR NATIONAL ELECTRONIC FUND TRANSFER (NEFT)
7	a. NEFT FORMAT GIVING DETAILS OF BANK ACCOUNT CLAIM AMOUNT TO BE TRANSFERRED
Z	b. A COPY OF THE PAGE OF BANK PASS BOOK CONTAINING A/C NUMBER & NAME/ ADDRESS OF A/C HOLDER.
	c. A CANCELLED CHEQUE FOR THE ABOVE ACCOUNT IN TO WHICH CLAIM AMOUNT HAS TO BE TRANSFERRED
AA	COVERING LETTER STATING YOUR COMPLETE CURRENT ADDRESS, CONTACT NUMBER AND THE LIST OF DOCUMENTS ATTACHED
AB	ANY OTHER DOCUMENT THAT THE CLAIM PROCESSING TEAM/ TPA REQUESTS
2. F	OR CLAIMING PRE-HOSPITALISATION EXPENSES
а	CLAIM FORM - PART A DULY COMPLETED AND SIGNED
b	OPD CONSULTATION PAPER, IF ANY – ORIGINAL
С	CONSULTATION BILL/ CASH RECEIPT, IF ANY
d	PRESCRIPTION FOR MEDICINES PURCHASED PRIOR TO HOSPITALISATION
е	PHARMACY CASH BILLS FOR MEDICINES PURCHASED PRIOR TO HOSPITALISATION
f	INVESTIGATION REPORTS - IN ORIGINAL - FOR INVESTIGATIONS DONE PRIOR TO ADMISION, IF ANY
g	CASH BILLS FOR THE INVESTIGATIONS DONE PRIOR TO HOSPITALISATION
h	REFERENCE LETTER FOR INVESTIGATION CONDUCTED PRIOR TO HOSPITALISATION

Page 1

i	DOCUMENTS FOR NATIONAL ELECTRONIC FUND TRANSFER (NEFT) AS IN ITEM 1 - 'Z' ABOVE
j	COVERING LETTER STATING YOUR COMPLETE CURRENT ADDRESS, CONTACT NUMBER & LIST OF DOCUMENTS ATTACHED
	OR CLAIMING POST-HOSPITALISATION EXPENSES
а	CLAIM FORM – PART A DULY COMPLETED AND SIGNED
b	OPD CONSULTATION PAPER, IF ANY – ORIGINAL
с	CONSULTATION BILL/ CASH RECEIPT, IF ANY
d	PRESCRIPTION FOR MEDICINES PURCHASED - POST-DISCHARGE
е	PHARMACY BILLS FOR MEDICINES PURCHASED - POST-DISCHARGE
f	INVESTIGATION REPORTS - IN ORIGINAL – FOR INVESTIGATIONS DONE - POST-DISCHARGE, IF ANY
g	CASH BILLS FOR THE INVESTIGATIONS DONE - POST-DISCHARGE
h	REFERENCE LETTER FOR INVESTIGATION CONDUCTED - POST-DISCHARGE
i	DOCUMENTS FOR NATIONAL ELECTRONIC FUND TRANSFER (NEFT) AS IN ITEM 1 - 'Z' ABOVE
j	COVERING LETTER STATING YOUR COMPLETE CURRENT ADDRESS, CONTACT NUMBER AND THE LIST OF DOCUMENTS ATTACHED
4. F	OR HOSPITALS CLAIMING CASHLESS HOSPIALISATION EXPENSES APPROVED
А	CLAIM FORM – PART A: DULY COMPLETED BY THE INSURED ON THE PRESCRIBED FORMAT - ORIGINAL
В	CLAIM FORM – PART B: DULY COMPLETED AND SIGNED BY THE HOSPITAL AUTHORITIES - ORIGINAL
С	ADMISSION NOTES – CERTIFIED COPY
D	TPA ID CARD – XEROX COPY
Е	ANY OTHER ID PROOF LIKE VOTER ID/ DL/ PASSPORT ETC - COPY
F	ADDRESS PROOF - CO <mark>PY</mark>
G	PRE-AUTHORISATION REQUEST IN ORIGINAL DULY SIGNED BY THE INSURED AND THE HOSPITAL
Н	PRE-AUTHORISATION APPROVAL LETTER COPY
I	REFERRAL LETTER, IF ANY, TO HOSPITAL – CERTIFIED COPY
J	DETAILED DISCHARGE SUMMARY - ORIGINAL
К	DEATH SUMMARY (INSTEAD OF Discharge Summary) IN CASE THE PATIENT HAS PASSED AWAY DURING HOSPITALISATION - ORIGINAL
L	INVESTIGATION REPORTS - IN ORIGINAL – FOR INVESTIGATIONS DONE DURING HOSPITALISATION
М	HISTOPATHOLOGY REPORT, IF ANY, IN ORIGINAL
Ν	CERTIFIED COPY OF OPERATION THEATRE (OT) NOTES – WHERE SURGERY IS PERFORMED
0	MLC REPORT/ FIR FOR ACCIDENT CASES – CERTIFIED COPY
Р	STICKER FOR THE IMPLANTS USED - ORIGINAL
Q	SUPPPORTING INVOICE FOR THE IMPLANTS USED – CERTIFIED COPY
R	HOSPITAL MAIN BILL - ORIGINAL
S	BREAK-UP BILL FOR THE HOSPITAL MAIN BILL - ORIGINAL
Т	DETAILED BILL FOR THE NON-ADMISSIBLE AMOUNTS COLLECTED FROM THE PATIENT
U	RECEIPT FOR THE AMOUNT COLLECTED FROM THE PATIENT FOR THE NON-ADMISSIBLE AMOUNTS
V	RECEIPT FOR THE CO-PAY COLLECTED FROM THE PATIENT
W	PRESCRIPTIONS FOR MEDICINES PURCHASED DURING HOSPITALISATION
Х	PHARMACY BILLS IN ORIGINAL FOR MEDICINES PURCHASED DURING HOSPITALISATION
Y	LIST OF BILLS SUBMITTED WITH THE AMOUNT UNDER EACH BILL
Z	ANY OTHER DOCUMENT THAT THE CLAIM PROCESSING TEAM/ TPA REQUESTS

NOTE: (1) YOU SHOULD SUBMIT THE ABOVE DOCUMENTS ALONG WITH A COVERING LETTER (2) IF YOU ARE SUBMITTING PRE &/OR POST-HOSPITALISATION CLAIMS SEPARATELY YOU SHOULD SUBMIT THE CLAIM FORM DULY COMPLETED (3) ALSO SUBMIT THIS CHECKLIST

 ${}^{\rm Page}Z$

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 liability

(To be Filled in block letters)

TAILS OF PRIMARY INSURED:									
Policy No.:									
Pin Code Phone No: Phone No: <td< td=""></td<>									
TAILS OF INSURANCE HISTORY:									
Currently covered by any other Mediclaim / Health Insurance: Yes No b) Date of commencement of first Insurance without break: D D M M Y Y Y Y									
f yes, company name:									
m insured (Rs.)									
agnosis: e) Previously covered by any other Mediclaim /Health insurance :: Yes No									
f yes, company name:									
TAILS OF INSURED PERSON HOSPITALIZED: :									
Name: SURNAME FIRST NAME MIDDLE NAME									
Gender Male Female c) Age years Y Y Months M d) Date of Birth D D M Y Y Y									
Relationship to Primary insured: Self Spouse Child Father Mother Other (Please Specify)									
Occupation Service Self Employed Home Maker Student Student Other (Please Specify)									
Address (if diffrent from above) :									
Pin Code Phone No: Email ID:									
TAILS OF HOSPITALIZATION: :									
Room Category 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									
Date of Admission: D M Y Y f) Time H H g) Date of Discharge: D M M Y Y h) Time: H H H g) Date of Discharge: D M M Y Y h) Time: H H III H III H III H III H III IIII IIII IIIIII IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII									
f injury give cause: Self inflicted 🗌 Road Traffic Accident 🗌 Substance Abuse / Alcohol Consumption 🗌 I) If Medico legal 🗌 Yes 🗌 No									
finjury give cause: Self inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption I) If Medico legal Yes No Reported to Police III. MLC Report & Police FIR attached Yes No j) System of Medicine:									
Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine:									
Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine: Interstand Stress Interstand Stress No j) System of Medicine: Interstand Stress Interstand Stress Rs. Interstand Stress Interstand Stress Interstand Stress Pre -hospitalization expenses Rs. Interstand Stress Interstand Stress Interstand Stress									
Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine: CTAILS OF CLAIM: Details of the Treatment expenses claimed Claim Documents Submitted - Check List: Pre -hospitalization expenses Rs. Iii. Hospitalization expenses Claim form duly signed Post-hospitalization expenses Rs. Iii. Hospitalization expenses Copy of the claim intimation, if any									
Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine: ETAILS OF CLAIM:									
Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine: Ctain Documents Submitted - Check List: Details of the Treatment expenses claimed Claim Documents Submitted - Check List: Pre -hospitalization expenses Rs. Claim form duly signed Post-hospitalization expenses Rs. Copy of the claim inimation, if any Ambulance Charges: Rs. Rs. Hospital Break-up Bill									
Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine: Ctain Documents Submitted - Check List: Ctain Documents Submitted - Check List: Details of the Treatment expenses Rs. Claim form duly signed Pre -hospitalization expenses Rs. Claim form duly signed Post-hospitalization expenses Rs. Copy of the claim intimation, if any Hospital Bill Hospital Bill Hospital Bill Total Rs. Hospital Bill Payment Receipt									
Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine: Ctain Documents Submitted - Check List: Details of the Treatment expenses claimed Claim Documents Submitted - Check List: Pre -hospitalization expenses Rs. Claim form duly signed Post-hospitalization expenses Rs. Copy of the claim intimation, if any Post-hospitalization expenses: Rs. Copy of the claim intimation, if any Image: Charges: Rs. Image: Charges: Rs. Image: Charges: Rs. Image: Charges: Rs. Image: Charges: Rs. Image: Charges: Rs. Image: Charges: Rs. Image: Charges: Rs. Image: Charges: Rs. Image: Charges: Rs. Image: Charges:									
Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine: Ctain Documents Submitted - Check List: Ctain form duly signed Claim form duly signed Pre -hospitalization expenses Rs. Claim form duly signed Post-hospitalization expenses Rs. Copy of the claim intimation, if any Hospitalization expenses Rs. Hospitalization expenses Pre -hospitalization expenses Rs. Hospital Bill Hospitalization priod: days Hospitalization priod: days									
Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine: CTAILS OF CLAIM:									
Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine: CTAILS OF CLAIM: Claim Documents Submitted - Check List: Details of the Treatment expenses claimed Claim form duly signed Pre -hospitalization expenses Rs. Claim form duly signed Post-hospitalization expenses Rs. Claim form duly signed Post-hospitalization expenses Rs. Copy of the claim inimation, if any Hospital Dialy cosh: Rs. Hospital Bill Payment Receipt Pre -hospitalization period: days Viii. Post -hospitalization period: days Details of Lump sum / cash benefit claimed: Operation Theater Notes Pre is Surgical Cash: Rs. Arbulance hospital Daily cash: Rs. Ii. Surgical Cash: Rs. ECG Critical linese benefit: Ps Ii. Surgical Cash: Rs. ECG									
Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine: ETALLS OF CLAIM:									
Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine: ETALLS OF CLAIM: Details of the Treatment expenses claimed iii. Hospitalization expenses Rs. Icaim form duly signed Copy of the claim intimation, if any Hospital Main Bill Hospital Bill Payment Receipt Hospital Isation period: days Itotal Rs. Itotal Interstructure Itotal Interstructure Itopital Discharge Summary Pharmacy Bill Operation Theater Notes ECG Operation Theater Notes ECG Octor's request for investigation Investigation Reports (Including CT If MRI Payment Receipt Investigation Lump sum benefit: Rs. Itotal Rs. Itotal Rs. Itotal Rs. Itotal Rs. Itotal Rs. Itotal Itotal Rs. Itotal Itotal Rs. Itotal 									
Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine: ETALLS OF CLAIM: Details of the Treatment expenses claimed Claim Documents Submitted - Check List: Pre -hospitalization expenses Rs. II. Hospitalization expenses Rs. III. Hospitalization expenses Claim Documents Submitted - Check List: Post-hospitalization expenses Rs. III. Hospitalization expenses Rs. IIII. Hospitalization expenses Copy of the claim intimation, if any Hospitalization expenses Rs. IIII. Hospitalization expenses Rs. IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII									
Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine: TAILS OF CLAIM: Claim Documents Submitted - Check List: Details of the Treatment expenses claimed Claim Documents Submitted - Check List: Pre -hospitalization expenses Rs. Claim form duly signed Post-hospitalization expenses Rs. Claim form duly signed Ambulance Charges: Rs. Claim Jonet Submitted - Check List: Pre -hospitalization period: days VI. Others (code): Rs. Otal Rs. Hospital Main Bil Pre -hospitalization period: days VII. Post -hospitalization period: days Claim for Domiciliary Hospitalization: Yes No (If yes, provide details in annexure) Details of Lump sum / cash benefit: Rs. II. Surgical Cash: Rs. ECG Octor's request for investigation iv. Convalescence: Rs. Doctor's request for investigation Pre/Post hospitalization Lump sum benefit: Rs. II. Surgical Cash: Rs. Doctor's request for investigation Pre/Post hospitalization Lump sum benefit: Rs. II. Surgical Cash: Rs. Doctor's request for investig									
Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine: CTAILS OF CLAIM: Claim Documents Submitted - Check List: Details of the Treatment expenses claimed Claim form duly signed Pre -hospitalization expenses Rs. Claim form duly signed Post-hospitalization expenses Rs. Claim form duly signed Ambulance Charges: Rs. Claim form duly signed Pre -hospitalization period: days VI. Others (code): Rs. Pre -hospitalization period: days VIII. Post-hospitalization period: days Hospital Bill Payment Receipt Pre -hospitalization: Yes No (If yes, provide details in annexure) Pharmacy Bill Hospital Discharge Summary Details of Lump sum / cash benefit claimed: Iii. Surgical Cash: Rs. ECG Doctor's request for investigation Pre/Post hospitalization Lump sum benefit: Rs. Iii. Surgical Cash: Rs. Image: Claim Structure Struct									
Reported to Police iii. MLC Report & Police FIR attached yes No j) System of Medicine: TAILS OF CLAIM: Claim form duly signed Claim form duly signed Claim form duly signed Pre-hospitalization expenses Rs. Claim form duly signed Copy of the claim intimation, if any Pre-hospitalization expenses Rs. Claim form duly signed Copy of the claim intimation, if any Hospital Station expenses Rs. Copy of the claim intimation, if any Hospital Main Bill Pre-hospitalization period: days Intol Rs. Copy of the claim intimation, if any Pre-hospitalization period: days Intol No Hospital Bill Hospital Bill Pre-hospitalization period: days Intol No (If yes, provide details in annexure) Pharmacy Bill Details of Lump sum / cash benefit claimed: Intol Intol Intol Pre-mospitalization									
Reported to Police ii. MLC Report & Police FIR attached Yes No j) System of Medicine: TALLS OF CLAIM: Claim Documents Submitted - Check List: Claim form duly signed Claim form duly signed Pre -hospitalization expenses Rs. ii. Hospitalization expenses Rs. Claim form duly signed Pre-hospitalization expenses Rs. iii. Hospitalization expenses Rs. Copy of the claim intimation, if any Hospital Nambulance Charges: Rs. iv. Health-Check up cost: Rs. Copy of the claim intimation, if any Pre -hospitalization expenses Rs. iv. Health-Check up cost: Rs. Copy of the claim intimation, if any Hospital Discharge Summary Hospital Bill Payment Receipt Hospital Bill Payment Receipt Hospital Discharge Summary Pre -hospitalization period: days iv. (If yes, provide details in annexure) Poperation Theater Notes ECG Details of Lump sum / cash benefit claimed: iv. Convalescence: Rs. ECG Doctor's request for investigation Investigation Lump sum benefit: Rs. iv. Convalescence: Rs. ECG Doctor's Prescriptions Doctor's Prescriptions Doctor's Prescriptions Doctor's Prescriptions D									
Reported to Police iii. MLC Report & Police FIR attached yes No j) System of Medicine: TAILS OF CLAIM: Claim form duly signed Claim form duly signed Claim form duly signed Pre-hospitalization expenses Rs. Claim form duly signed Copy of the claim intimation, if any Pre-hospitalization expenses Rs. Claim form duly signed Copy of the claim intimation, if any Hospital Station expenses Rs. Copy of the claim intimation, if any Hospital Main Bill Pre-hospitalization period: days Intol Rs. Copy of the claim intimation, if any Pre-hospitalization period: days Intol No Hospital Bill Hospital Bill Pre-hospitalization period: days Intol No (If yes, provide details in annexure) Pharmacy Bill Details of Lump sum / cash benefit claimed: Intol Intol Intol Pre-mospitalization									
Reported to Police iii. MLC Report & Police FR attached Yes No j) System of Medicine: TALLS OF CLAM: Details of the Treatment expenses claimed Claim form duly signed Claim form duly signed Pre -hospitalization expenses Rs. Claim form duly signed Copy of the claim intimation, if any Pre-hospitalization expenses Rs. Copy of the claim intimation, if any Hospital Bill Pre-hospitalization expenses Rs. Copy of the claim intimation, if any Hospital Bill Pre-hospitalization expenses Rs. Copy of the claim intimation, if any Hospital Bill Pre-hospitalization expenses Rs. Copy of the claim intimation, if any Hospital Bill Payment Receipt Pre-hospitalization period: days Viii. Post-hospitalization period: days Pharmacy Bill Claim for Doniciliary Hospitalization: Yes No (If yes, provide details in annexure) Pharmacy Bill Details of Lump sum / cash benefit: Rs. Convalescence: Rs. Color's request for investigation finestigation Reports (Including CT / MRI / USG / HPE); Dodor's request for investigation finestigation Reports (Including CT / MRI / USG / HPE); Pre/Post hospitalization Lump sum benefit: Rs.									
Reported to Police ii. MLC Report & Police FIR attached Yes No j) System of Medicine: CTALES OF CLAM:									
Reported to Police ii. MLC Report & Police FIR attached Yes No j) System of Medicine: CTALES OF CLAM:									
Reported to Police iii. MLC Report & Police FIR attached yes No j) System of Medicine: TALES OF CLAM:									
Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine: TALLS OF CLAIM: Claim Documents Submitted - Check List: Claim form duly signed Copy of the claim intrinsion, if any Pre-hospitalization expenses Rs. III. Hospitalization expenses Rs. Claim form duly signed Pre-hospitalization expenses Rs. III. Hospitalization expenses Rs. Claim form duly signed Pre-hospitalization expenses Rs. III. Hospital Bit Hospital Bit Hospital Bit Pre-hospitalization period: days VII. Pre-hospitalization period: days Hospital Bit Pre-hospitalization period: days VII. Prest-hospitalization period: days Hospital Bit Objection for Moniciliary Hospital Discharge Summary Pharmacy Bit Hospital Discharge Summary Pharmacy Bit Objection form fit claimed: Ves No If yes, provide details in annexure) Dockor's request for investigation Objection form fit claimed: No Convalescence: Rs. Dockor's request for investigation Critical lliness benefit: Rs. III. Or Mark Amount (Rs) Mount (Rs) Pre-hospitalization Lump sum ben									
Appoind to Police ii. MLC Report & Police FIR attached yes j) System of Medicine: TAILS OF CLAM:									

DECLARATION BY THE INSURED:

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.

SECTION H

Date	DD	MM	YYYY	Place:

Signature of the Insured

	DATA ELEMENT	DESCRIPTION	FORMAT
	1	SECTION A - DETAILS OF PRIMARY INSURED	
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
		social health insurance scheme	Licence number as allotted by IRDA and printer
c)	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
a)	Currently covered by any other Mediclaim / Health	SECTION B -DETAILS OF INSURANCE HISTORY Indicate whether currently covered by another Mediclaim /	1
a)	Insurance?	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
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 mm-yy format
	Diagnosis	Enter the diagnosis details	Open Text
e)	Previously covered by any other Mediclaim / Health	Indicate whether previously covered by another mediclaim /	Tick Yes or No
	Insurance? Company Name	Health Insurance Enter the full name of the Insurance Company	Name of the organization in full
)		TION C -DETAILS OF INSURED PERSON HOSPITALIZED	Name of the organization in full
		Enter the full name of the patient	Surnama Eirat nama Middla nama
1)	Name Gender	Indicate Gender of the patient	Surname, First name, Middle name Tick Male or Female
) \			
;) I)	Age Date of Birth	Enter age of the patient	Number of years and months
)		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.
)	Address	Enter the full postal address	Include Street, City and Pin code
ı)	Phone No	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
		SECTION D - DETAILS OF HOSPITALIZATION	1
a)	Name of Hospital where admited	Enter the name of hospital	Name of hospital in full
)	Room category occupied	indicate the room category occupied	Tick the right option
-) -)	Hospitalization due to	indicate reason of hospitalization	Tick the right option
4)	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
)	Time	Enter time of admission	Use hh-mm- format
J)	Date of discharge	Enter date of discharge	Use dd-mm-yy format
ı)	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	
ı)	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	
ndic	ate which bills are enclosed with the amount in rupees		
		N G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT	
ı)	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
;)		Enter the name of the beneficiary the cheque / DD should be	
-	Cheque/ DD navable details		
2) 2) 2)	Cheque/ DD payable details IFSC Code	made out to Enter the IFSC code of the Bank branch	Name of the individual / organization in full IFSC code of the Bank branch in full

CLAIM FORM - PART B TO BE FILLED IN BY THE HOSPITA	L.
The issue of this Form is not to be taken as an adm Please include the original preauthorization request fo	ission of liability (To be Filled in block letters)
a) Name of the hospital:	
a) Hospital ID:	Non Network : (if non network fill section E)
c) Name of the treating doctor:	
e) Qualification: f) Registration No. with State Code:	g) Phone No.
DETAILS OF THE PATIENT ADMITTED	
a) Name of the Patient:	
b) IP Registration Number:	Y Months M e) Date of birth: 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	
j) Type of Admission: Emergency Planned Day Care Maternity k) If Maternity i) Date of Deliver	ery: D D M M Y Y ii) Gravida Status: .
I) Status at time of discharge: Discharge to home Discharge to another hospital Deceased	m) Total claimed amount
DETAILS OF AILMENT DIAGNOSED (PRIMARY)	
a) ICD 10 Codes Description b)	ICD 10 PCS Description
I. Primary Diagnosis	
ii. Additional Diagnosis:	
iii. Co-morbidities:	
iv. Co-morbidities:	۲
c) Pre-authorization obtained:	
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
	iii. If Medico legal: Yes No iv. Reported to Police Yes No
CLAIM DOCUMENTS SUBMITTED - CHECK LIST	
Claim Form duly signed	n reports
	G/HPE investigation reports erence slip for investigation
Copy of the resolution additionation approvalence Copy of Photo ID Card of patient Verified by hospital	erence silp for investigation
Hospital Discharge summary Pharmacy b	bills
	s & Police FIR ath summary from hospital where applicable
	please specify
ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK H	HOSPITAL)
a) Address of the Hospital	
Pin Code: b) Phone No	c) Registration No. with State Code:
	vailable in the hospital i. OT Yes No ii. ICU Yes No
iii. Others:	
DECLARATION BY THE HOSPITAL	(PLEASE READ VERY CAREFULLY)
	<u> </u>
our right to claim under this claim shall be forfeited.	
Date: DD MM YYY	
Place: Signature and Seal of the Hospital Authority:	

Signature	and	Seal	of the	Hospital	Authorit

	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 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										
	Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format								
	. Gravida Status	Enter Gravida status if maternity	Use standard format								
I)	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	(
u)		Enter the ICD 10 Code and description of the primary diagnosis									
	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								
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								
	If injury due to substance abuse/alcohol consumption test conducted to establish this Medico Legal	Indicate whether test conducted Indicate whether injury is medico legal	Tick Yes or No Tick Yes or No								
	If injury due to substance abuse/alcohol consumption test conducted to establish this Medico Legal Reported to Police	Indicate whether test conducted Indicate whether injury is medico legal Indicate whether police report was filed	Tick Yes or No Tick Yes or No Tick Yes or No								
	If injury due to substance abuse/alcohol consumption test conducted to establish this Medico Legal Reported to Police FIR No.	Indicate whether test conducted Indicate whether injury is medico legal Indicate whether police report was filed Enter first information report number	Tick Yes or No Tick Yes or No Tick Yes or No As issued by police authrities								
	If injury due to substance abuse/alcohol consumption test conducted to establish this Medico Legal Reported to Police FIR No. If not reported to police, give reason	Indicate whether test conducted Indicate whether injury is medico legal Indicate whether police report was filed Enter first information report number Enter reason for not reporting to police	Tick Yes or No Tick Yes or No Tick Yes or No As issued by police authrities Open text								
	If injury due to substance abuse/alcohol consumption test conducted to establish this Medico Legal Reported to Police FIR No. If not reported to police, give reason SEC	Indicate whether test conducted Indicate whether injury is medico legal Indicate whether police report was filed Enter first information report number	Tick Yes or No Tick Yes or No Tick Yes or No As issued by police authrities Open text								
Indica	If injury due to substance abuse/alcohol consumption test conducted to establish this Medico Legal Reported to Police FIR No. If not reported to police, give reason SEC ate which supporting documents are submitted	Indicate whether test conducted Indicate whether injury is medico legal Indicate whether police report was filed Enter first information report number Enter reason for not reporting to police TION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST	Tick Yes or No Tick Yes or No Tick Yes or No As issued by police authrities Open text								
Indica	If injury due to substance abuse/alcohol consumption test conducted to establish this Medico Legal Reported to Police FIR No. If not reported to police, give reason SEC ate which supporting documents are submitted	Indicate whether test conducted Indicate whether injury is medico legal Indicate whether police report was filed Enter first information report number Enter reason for not reporting to police	Tick Yes or No Tick Yes or No Tick Yes or No As issued by police authrities Open text								
Indica a)	If injury due to substance abuse/alcohol consumption test conducted to establish this Medico Legal Reported to Police FIR No. If not reported to police, give reason SEC ate which supporting documents are submitted	Indicate whether test conducted Indicate whether injury is medico legal Indicate whether police report was filed Enter first information report number Enter reason for not reporting to police TION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST	Tick Yes or No Tick Yes or No Tick Yes or No As issued by police authrities Open text								
	If injury due to substance abuse/alcohol consumption test conducted to establish this Medico Legal Reported to Police FIR No. If not reported to police, give reason SEC ate which supporting documents are submitted SECT	Indicate whether test conducted Indicate whether injury is medico legal Indicate whether police report was filed Enter first information report number Enter reason for not reporting to police TION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST ION E - DETAILS IN CASE OF NON NETWORK HOSPITA	Tick Yes or No Tick Yes or No Tick Yes or No As issued by police authrities Open text L								
a)	If injury due to substance abuse/alcohol consumption test conducted to establish this Medico Legal Reported to Police FIR No. If not reported to police, give reason SEC ate which supporting documents are submitted SECT Address	Indicate whether test conducted Indicate whether injury is medico legal Indicate whether police report was filed Enter first information report number Enter reason for not reporting to police TION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST ION E - DETAILS IN CASE OF NON NETWORK HOSPITA Enter the full postal address Enter the phone number of hospital Enter the registration number of the Hospital obtained from local body	Tick Yes or No Tick Yes or No Tick Yes or No As issued by police authrities Open text L Include Street, City and Pin Code Include STD code with telephone number								
a) b) c)	If injury due to substance abuse/alcohol consumption test conducted to establish this Medico Legal Reported to Police FIR No. If not reported to police, give reason SEC ate which supporting documents are submitted SECT Address Phone No. Registration No. with State Code	Indicate whether test conducted Indicate whether injury is medico legal Indicate whether police report was filed Enter first information report number Enter reason for not reporting to police TION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST ION E - DETAILS IN CASE OF NON NETWORK HOSPITA Enter the full postal address Enter the phone number of hospital Enter the registration number of the Hospital obtained from local body like City Corporation / Municipality	Tick Yes or No Tick Yes or No Tick Yes or No As issued by police authrities Open text L Include Street, City and Pin Code Include STD code with telephone number As allocated by the City Corporation / Municipality								
a) b) c) d)	If injury due to substance abuse/alcohol consumption test conducted to establish this Medico Legal Reported to Police FIR No. If not reported to police, give reason SEC ate which supporting documents are submitted SECT Address Phone No. Registration No. with State Code Hospital PAN	Indicate whether test conducted Indicate whether injury is medico legal Indicate whether police report was filed Enter first information report number Enter reason for not reporting to police TION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST ION E - DETAILS IN CASE OF NON NETWORK HOSPITA Enter the full postal address Enter the phone number of hospital Enter the registration number of the Hospital obtained from local body like City Corporation / Municipality Enter the permanent account number	Tick Yes or No Tick Yes or No Tick Yes or No As issued by police authrities Open text Include Street, City and Pin Code Include STD code with telephone number As allocated by the City Corporation / Municipality As allocated by the Income Tax Department								
a) b) c) d) e)	If injury due to substance abuse/alcohol consumption test conducted to establish this Medico Legal Reported to Police FIR No. If not reported to police, give reason SEC ate which supporting documents are submitted SECT Address Phone No. Registration No. with State Code Hospital PAN Number of Inpatient beds	Indicate whether test conducted Indicate whether injury is medico legal Indicate whether police report was filed Enter first information report number Enter reason for not reporting to police TION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST ION E - DETAILS IN CASE OF NON NETWORK HOSPITA Enter the full postal address Enter the phone number of hospital Enter the registration number of the Hospital obtained from local body like City Corporation / Municipality Enter the pumment account number Enter the number of inpatient beds	Tick Yes or No Tick Yes or No Tick Yes or No As issued by police authrities Open text Include Street, City and Pin Code Include STD code with telephone number As allocated by the City Corporation / Municipality As allocated by the Income Tax Department Digits								
a) b) c) d)	If injury due to substance abuse/alcohol consumption test conducted to establish this Medico Legal Reported to Police FIR No. If not reported to police, give reason SEC ate which supporting documents are submitted SECT Address Phone No. Registration No. with State Code Hospital PAN	Indicate whether test conducted Indicate whether injury is medico legal Indicate whether police report was filed Enter first information report number Enter reason for not reporting to police TION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST ION E - DETAILS IN CASE OF NON NETWORK HOSPITA Enter the full postal address Enter the phone number of hospital Enter the registration number of the Hospital obtained from local body like City Corporation / Municipality Enter the permanent account number	Tick Yes or No Tick Yes or No Tick Yes or No As issued by police authrities Open text Include Street, City and Pin Code Include STD code with telephone number As allocated by the City Corporation / Municipality As allocated by the Income Tax Department								

ELECTRONIC CLEARING SERVICE (CREDIT CLEARING) MANDATE FORM

	For Claim under Policy No																							
1.	(A) (CARD	HOL	DER'S	NAN	/IE																		
	(B) A	ADDR	ESS																					
																							$ \rightarrow $	
	(C) 1	TELEP	HON	IE / M	OBIL	E N	o:		1							1								
	(D) I	E-MA	IL ID	:	.				_															
2.	ТТК	ID N	0				-							-			-							
3.	PAR A.	TICU BAN		OF BA	ANK	ACC	OUN	Т																
	А.	DAN																					Т	
	В.			NAME											1					11				
	Б.	DNAI	NCH																	Т				
										I					I									
	C.	ADD	RESS																	1	Τ		Т	
																					1		+	
	D.	9 DIG	іт сс	DDE NU	JMBE	RO	F THE	BAN	K &	BRAN	NCH.	APPE	ARI	NG O	N TH	IE N	IICR C	HEQ	JE IS	SUEE) BY	THE	BAN	к
	E.	ACCO	DUN.	Τ ΤΥΡΕ	E (SA	VIN	GS AG	co	UNT	/ CU	IRRE	NT A		DUN	T)									
	F.	ACCO	DUN.	Τ Νυν	1BER	(AS	SAPP	EAR	ING	ON	THE	CHE	QUE	Е ВО	OK)									
	G.	BAN	< AC	COUN	т нс	DLDE	ER NA	ME																
4.	DAT	E OF	EFFE	CT:																				
																			_					
							DRMA					1ENT	IH	KOU	GH	KIG	SOR	NEF	I					
5.	IFSC		E (IN	IDIAN	FINA	ANC	IAL S'	/STE	MC	ODE)									_				1
				1														1						
6.	NEF	T CO	DE (N		NAL	ELE	CTRO	NIC	FUN	IDS -	TRAI	NSFE	R C	ODE))									

By submission of the above, I authorise M/s Vidal Health TPA Private Ltd (formerly known as TTK Healthcare TPA Pvt Ltd) / the Insurance Company to settle the claim under reference through direct payment by ECS. I hereby declare & confirm that the particulars given above are correct and complete. I agree that I shall not hold the TPA/ Insurance Company responsible for delay or non-receipt of payment for any reason whatsoever after issue of instructions for transfer of payment by Insurer/ TPA based on the above.

Date: Place: