

CLAIM FORM - PART A

TO BE FILLED IN BY THE INSURED

The issue of theis form is not to be taken as admission of liability

(To be filled in block letters)

| DETAILS OF PRIMARY INSURED | | | | | | | | | | |
|--|---|--|--|---------------|---|--|--|-------------------|---------|---------------------------------------|
| a) Policy no: | | b) SI. No/ Certificate N | lo: | | | | |] _ | | |
| c) Company/ TPA ID No: | |] | | | | | | | | |
| d) Name: | | | | | | | | | | |
| e) Address: | | | | | | | | | | |
| | | | | | | | | | | |
| City: | | State: | | | | П | | | Т | |
| Pin Code: Phone No: | | | Email ID: | | | | | | | |
| DETAILS OF INSURANCE HISTORY | | | <u>-</u> | | | | | | | |
| a) Currently covered by any other Mediclaim/ Health Insurance: | b) Date of commenc | ement of first insurance withou | ut break: | | | | | | | |
| c) If yes, company name: | Policy No: | | | | | | | | |] , |
| Sum Insured (·): d) Have you been hospitalize | zed in the last four years | since inception of the contract | ? Yes No | Date: | | | | | | |
| Diagnosis: | | e) F | Previously covered by any oth | er Mediclaim/ | / Health In: | surance | : | | Yes | No |
| f) If yes, Company Name : | | | | | | | | | | |
| DETAILS OF INSURED PERSON HOSPITALIZED | <u> </u> | | | | | | | | | |
| a) Name : | | | | | | Π | Т | | | |
| b) Gender : Male Female c) Age: years months | d) [| Date of Birth: | | Ti Ti | | | | | | |
| e) Relatuionship to Primary Insured: Self Spouse Child Father | = | | (Please specify) | _ | | | | | | |
| f) Occupation: Service Self Employed Homemaker Student | Retired | = = | (Please specify) | | | | | | | |
| g) Address (if different from above): | | | , , , , , , , , , , , , , , , , , , , | TT | T | П | Т | П | Т | |
| g) , seesee (ii umoroiti ii viii uuotto). | | | | + | + | \forall | + | \forall | + | ++ |
| City | | State: | + + + + | + | + | 十 | + | + | + | ┿┿. |
| City: | | | moil ID: | | | | | | | |
| Pin Code: Phone No: Phone No: | | <u> </u> | Email ID: | | | | | | | |
| DETAILS OF HOSPITALIZATION | | | | | _ | | _ | | _ | |
| a) Name of Hospital where Admitted: | | | <u> </u> | \dashv | | ш | | | | |
| b) Room category occupied: Day Care Single occupancy | Twin sharing | | 3 or more beds per room | | _ | | _ | _ | | |
| c) Hospitalization due to: Injury Illness Maternity | d) Dat | te of injury/ Date Disease first | detected/ Date of Delivery: | + | _ | Ш | ⊨ | Щ | _ | 8 |
| e) Date of Admission: f) Time: | | g) Date of Discharge: | ╇ | Щ | ╡ , | h) Time | : ∟ | | : L | |
| i) If injury, give cause: Self inflicted Road Traffic Accident | Substance abus | se / Alcohol Consumption | i. If Medic | co Legal: | Yes | N | 0 | | | |
| E December 1 March 1 March 1 March 2 M | | | | | | | | | | |
| ii. Reported to police: Yes No iii. MLC Report & Police FIR attached: | Yes No | j) System of medicine | e: | | | | | | | |
| ii. Reported to police: Yes No iii. MLC Report & Police FIR attached: DETAILS OF CLAIM | Yes No | j) System of medicine | e: | | | | | | | |
| | Yes No | j) System of medicine | e: [| CI | laim Docu | ıments | Submitte | d- Chec | k List: | |
| DETAILS OF CLAIM a) Details of treatment expenses claimed | Yes No | j) System of medicine | e: | CI | _ | | Submitte | | k List: | |
| a) Details of treatment expenses claimed i. Pre Hospitalization Expenses ii. Ho | | j) System of medicine | | CI | Claim | FormDu | | | | |
| DETAILS OF CLAIM a) Details of treatment expenses claimed i. Pre Hospitalization Expenses iii. Post Hospitalization Expenses iv. H | ospitalization Expenses | j) System of medicine | | CI | Claim | FormDu | uly signed | | | |
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| d) Cheque/ DD Payable details: | | | | | | e) IFSC Cod | de: | | | | | | | | \Box | | | 工 | G |
|---|---|-------------------------|----------------------------|--|------------------|----------------------|-----------|---------------|---------------|---------------|----------------------|------------|----------|---------|-----------|------------|---------|----|-----|
| DECLARATION BY THE INSURED | | | | | | | | | | | | | | | | | | | _ |
| I hereby declare that the information for | | | | | | | | | | | | | | | | | | | - 1 |
| claim, my right to claim reimbursemer made. I hereby declare that I have inc | | | | | | | | | | itioner | who has at | ended on | 1 the pe | rson a | gainst wh | nom this o | laim is | | 2 |
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| Date: | | Place: | | | | Signature | of the in | sured: | | | | | | | | | | ╝ | |
| | | | | | | _ | | | | | | | _ | _ | | | | | |
| | DATA ELEMENT | | GUID | ANCE FOR FILLING CLAIM | | | the ins | ured) | | _ | | | | | | | | | |
| | DATA ELEMENT | | | SECTION A - DE | | RIPTION | | | | | | | | FOI | RMAT | | | | |
| a) Policy No. | | | | Enter the policy number | TAILS OF FRIE | IART INSURED | | | | Δς | allotted b | v the in | suran | | mnany | | | | |
| b) SI. No/ Certificate No. | | | | Enter the social insurance | e number or the | e certificate number | r of soc | ial healt | h | $\overline{}$ | allotted b | | | | прапу | | | | _ |
| b) of Nor Octanicate No. | | | | insurance scheme | | | | | | _ | | | | | DDA | | die TD | | |
| c) Company TPA ID No. | | | | Enter the TPA ID No | | | | | | | ense num uments. | ber as a | allotted | ı by ı | RDA an | ia printe | ain ip | 'A | |
| d) Name | | | | Enter the full name of the | policyholder | | | | | Sur | name, Fi | rst name | e, Mid | dle n | ame | | | | |
| e) Address | | | | Enter the full postal addre | | | | | | Incl | ude Stre | et, City a | and Pi | n Co | de | | | | |
| | | | | SECTION B - DET | TAILS OF INSUR | RANCE HISTORY | | | | _ | | | | | | | | | |
| a) Currently covered by any other Med | | ice? | | Indicate whether currently | covered by ar | nother Mediclaim / I | Health | Insurano | ce | Ticl | k Yes or I | 10 | | | | | | | |
| , , , , , , , , , , , , , , , , , , , |) Date of Commencement of first Insurance without break | | | | | t insurance | | | | Use | e dd-mm- | yy forma | at | = | | | | | |
| c) Company Name Policy No. | | | Enter the full name of the | insurance con | npany | | | | $\overline{}$ | ne of the | | | | | | | | _ | |
| Sum Insured | | Enter the policy number | | | | | | $\overline{}$ | allotted b | y the ins | suranc | e co | mpany | | | | | | |
| d) Have you been Hospitalized in the la | last 4 years since incer | otion of the contra | ct? | Enter the total sum insure Indicate whether hospital | | | | | | _ | upees k Yes or I | Vn. | | — | | | | | |
| Date | | | | Enter the date of hospital | | - youro | | | | + | mm-yy f | | | _ | | | | | _ |
| Diagnosis | | | | Enter the diagnosis detail | ls | | | | | $\overline{}$ | en Text | | | | | | | | |
| e) Previously Covered by any other Me | ediclaim/ Health Insura | nce? | | Indicate whether previous | sly covered by a | another Mediclaim | / Healtl | h Insurai | nce | Ticl | k Yes or I | No | | | | | | | |
| f) Company Name | | | | Enter the full name of the | insurance con | nany | | | | Nar | me of the | organiz | ration | in full | | | | | |
| | | | | SECTION C - DETAILS | | · · | ED | | | | | organiz | 41.011 | | | | | | |
| a) Name | | | | Enter the full name of the | patient | | | | | Sur | name, Fi | rst name | e, Mid | dle n | ame | | | | |
| b) Gender | | | | Indicate Gender of the pa | ntient | | | | | Ticl | k Male or | Female | 3 | | | | | | |
| c) Age d) Date of Birth | | | | Enter age of the patient | | | | | | - | mber of y | | | ths | | | | | |
| e) Relationship to primary Insured | | | | Enter Date of Birth of pati Indicate relationship of pa | | ryholder | | | | - | dd-mm- k the righ | - | | ore r | nlease s | enecify | | | |
| f) Occupation | | | | Indicate occupation of pa | | synoidei | | | | $\overline{}$ | k the righ | | | | | | | | _ |
| g) Address | | | | Enter the full postal addre | | | | | | $\overline{}$ | ude Stre | | | | | | | | |
| h) Phone No | | | | Enter the phone number | of patient | | | | | Incl | ude STD | code w | ith tel | ephor | ne numb | ber | | | |
| i) E-mail ID | | | | Enter e-mail address of p | | | | | | Cor | nplete e- | mail add | dress | | | | | | |
| a) Name of Hospital where admitted | | | | SECTION D - DI | | PITALIZATION | | | | N. | | -14-1 1- | £.11 | | | | — | | _ |
| b) Room category occupied | | | | Enter the name of hospital Indicate the room categorian | | | | | | $\overline{}$ | me of hos | | | | | | | | _ |
| c) Hospitalization due to | | | | Indicate reason of hospita | | | | | | $\overline{}$ | k the righ | | | | | | | | _ |
| d) Date of Injury/Date Disease first det | tected/ Date of Delivery | у | | Enter the relevant date | | | | | | $\overline{}$ | dd-mm- | | | | | | | | |
| e) Date of admission | | | | Enter date of admission | | | | | | Use | dd-mm- | yy forma | at | | | | | | |
| f) Time g) Date of discharge | | | | Enter time of admission | | | | | | $\overline{}$ | hh:mm | | _ | | | | | | |
| h) Time | | | | Enter date of discharge | | | | | | $\overline{}$ | dd-mm- hh:mm | | at | | — | — | — | | |
| i) If Injury give cause | | | | Enter time of discharge Indicate cause of injury | | | | | | - | k the righ | | | | | | | | _ |
| If Medico legal | | | | Indicate whether injury is | medico legal | | | | | _ | k Yes or I | | _ | _ | | | | | _ |
| Reported to Police | | | | Indicate whether police re | eport was filed | | | | | Ticl | k Yes or I | Vo | | | | | | | |
| MLC Report & Police FIR attached | | | | Indicate whether MLC rep | oort and Police | FIR attached | | | | Ticl | k Yes or I | 10 | | | | | | | |
| j) System of Medicine | | | | Enter the system of medi | cine followed in | | nt | | | Ope | en Text | | | | | | | | |
| a) Details of Treatment Expenses | | | | Enter the amount claimed | | | | | | ln r | upees (D | o not on | tor no | ico v | alues) | | | | |
| b) Claim for Domiciliary Hospitalization | 1 | | | Indicate whether claim is | | | | | | $\overline{}$ | Yes or I | | ет ра | ise v | alues) | | | | |
| c) Details of Lump sum/ cash benefit c | claimed | | | Enter the amount claimed | | | | | | $\overline{}$ | upees (D | | iter pa | ise v | alues) | | | | |
| d) Claim Documents Submitted-Check | List | | | Indicate which supporting | | | | | | Ticl | k the righ | option | | | | | | | |
| Indicate which hills are analoged | the amounts in sunce | | | SECTION F - D | ETAILS OF BILL | S ENCLOSED | | | | | | | | | | | | | |
| Indicate which bills are enclosed with t | ne amounts in rupees | | | SECTION G - DETAILS OF | DDIMARY INC. | IDED'S DANK ACCO | TINT | | | | | | | | | | | | |
| a) PAN | | | | Enter the permanent acco | | MED 3 BANK ACCC | JONI | | | Δο | allotted b | v the In | come | Tay | denartm | nent | | | |
| b) Account Number | | | | Enter the bank account n | | | | | | $\overline{}$ | allotted b | | | | .oparull | -OIR | | | |
| c) Bank Name and Branch | | | | Enter the bank name alor | | nch | | | | _ | ne of the | | | | | | | | _ |
| d) Cheque/ DD payable details | | | | Enter the name of the ber | neficiary the ch | eque/ DD should be | e made | e out to | | Nar | ne of the | individu | ual/ or | ganiz | ation in | full | | | |
| e) IFSC Code | | | | Enter the IFSC code of th | | | | | | IFS | C code o | f the ba | nk bra | ınch i | n full | | | | |
| Read declaration carefully and mention | n date (in dd:mm:vv fo | rmat), place (oner | text) and sign | SECTION H - DE | CLAKATION BY | I HE INSURED | | | | | | — | — | | — | — | — | | |
| | | . ,,, c.225 (oper | , oigii. | | | | | | | | | | | | | | | | |



CLAIM FORM - PART B

TO BE FILLED IN BY THE HOSPITAL

The issue of theis form is not to be taken as admission of liability

Please include the original preauthorization request form in lieu of PART A

| DETAILS OF HOSPITAL | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|-------------|--------------|----------|-----------|-------------------|------------|-----------|--------|---------------|-----------------------------|---|--|---|--|--------|-------------|-------------|---------------|------------|----------|---------|-----------|--------------|------------------------------|---|---|---|-------------|----------|---------|----------|-----------|----------|----------|----------|
| a) Name of the Hospital: | Г | Т | T | Т | $\overline{\Box}$ | T | T | T | T | T | T | T | Ī | П | | | T | T | Т | П | | П | T | T | T | T | Т | Т | Т | T | T | T | T | | П |
| c) Hospital ID: | | Ť | Ī | | $\overline{\Box}$ | Ī | Ī | Ī | | (|) Type | of Hos | pital: | | | Net | work | Ī | Non N | letwork | | 1 | | | | (if n | on ne | twork, | fill Se | ction E |) | | | | |
| d) Name of the treating doo | tor: | | T | | \Box | Ī | \Box | ੂ | \Box | | | | | | | | Ī | Ī | | | | Ī | | | | | Γ | | | | | L | | | |
| e) Qualification: | | | | | | _ | \Box | | f) | Regis | tration | No. wit | h state | code: | | | | Τ | | | | 1 | g) Pi | none N | o. 🗀 | | Π | | Ι | Ι | Τ | T | | | |
| DETAILS OF PATIENT AD | MITTED | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a) Name of Patient: | | | | | \Box | Ī | I | | \Box | | | | | | | | | T | | | | | | | | | | | Π | | | \Box | | | |
| b) IP Registration No.: | | П | | | \coprod | \Box | | | c) Gende | er: | Male | |] F | emale | | | d) A | e: yea | ırs | | n | onths | Τ | e) I | Date of | Birth: | | | Τ |] | | 工 |] | | |
| f) Date of Admission: | | | | |] [| \Box | | , | g) Time: | | Ι |] : | | | | | h) Date | of Disch | harge: | | | Ī | \top | | | |] | | i) Ti | me: | | \Box |] : | | |
| j) Type of Admission: Er | nergency | | | Planned | | | Day Ca | are | M | laterni | y 🗌 | | | k) If I | Mater | nity: | i. E | ate of [| Delivery | | | ΙĒ | T | | | |] | | ii. G | ravida | Statu | 3: | | | |
| I) Status at time of discharg | e: | Disc | nargeo | to hom | , 🔲 | | Dis | schar | rged to ar | nother | hospita | al |] | Dece | ased | | | | | | | | | | m) To | otal cla | imed a | amoun | tΩ | | Τ | 工 | | | |
| DETAILS OF AILMENT DI | AGNOSE | (PRIM | ARY) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a) | | | ICD 1 |) Codes | | | | | | De | scriptio | on | | | | b) | | | | | | ICD : | 0 PCS | | | | | | | | Descri | otion | | | |
| i. Primary Diagnosis : | | | | | \Box | | F | | | | | | | | | i. P | rocedur | 1: | | | | | | | | | | | | | | | | | |
| | _ | | | | | | Ļ | _ | | | | | | | | | | | | _ | | | | | | _ | Ļ | | | | | _ | | | |
| ii. Additional Diagnosis : | | | | | $\perp \perp$ | | ŀ | _ | | | | | | | | ii. F | rocedu | e 2 : | | L | | | | | | _ | H | | | | | | | | |
| | | _ | _ | _ | т т | \neg | F | _ | | | | | | _ | l | | | | | | | | _ | _ | _ | ٦. | H | | | | | _ | | | |
| iii. Co-morbidities : | ш | | | | | | ┝ | — | | | | | | \dashv | | íii. | Procedu | re 3 : | | ш | _ | ш | | _ | | | \vdash | | | | | — | | | |
| iv. Co-morbidities : | | Т | Т | Т | П | \neg | F | = | | | | | | ᆿ | | jv | Details o | f Proce | edure : | | | | | | | | _ | | | | | = | | | |
| co morbiditos . | | _ | | | — | _ | ļ | _ | | | | | | | | 14. | _ 0 (1110) | | | | | | | | | | | | | | | _ | | | |
| c) Pre authorization obtaine | d: | | | | | | Ē | | Yes | No | | | d) F | re-auth | orizat | ion nun | nber: | I | I | | | | Ī | Ī | Ī | Ī | Ī | Ī | Ī | | | | | | |
| e) If authorization by netwo | rk hospita | not obt | ained, | give rea | son: | | Ē | = | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| f) Hospitalization due to inju | ıry: | Y | es | No | | i. | If yes, o | give (| cause | | | Self i | nflicted | | | Road | Traffic | Accider | nt 🗀 |] | | | | Substa | nce ab | use / a | lcohol | consu | mptio | n | Ī | | | | |
| ii. If injurydue to Substance | abuse / al | cohol co | nsum | tion, Te | t Conduc | ted to | establis | sh thi | is: | | | | Yes | | No | (if | yes, att | ach rep | orts) | iii. I | f Med | ico Lega | | Ye | s [| No | | iv. | Repo | rted to | Police | | Yes | | No |
| v. FIR No. | | | | | П | | | | | vi. If n | ot repo | rted to | police, | give rea | ason: | | | | | | | | | | | | | | | | | | | | |
| CLAIM DOCUMENTS SUE | MITTED - | CHECK | LIST | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Claim Form | duly sign | ed | | | | | | | | | | | | | | | Inve | tigation | n reports | ; | | | | | | | | | | | | | | | |
| Original Pre | -authoriza | tion req | uest | | | | | | | | | | | | | | CT/ | //RI/ US | SG/ HPE | / Invest | tigatio | n reports | | | | | | | | | | | | | |
| Copy of the | Pre-autho | rization | appro | al letter | | | | | | | | | | | | | Doct | or's refe | erance s | lip | | | | | | | | | | | | | | | |
| Copy of ph | oto ID can | of patie | nt ver | fied by I | ospital | | | | | | | | | | | | ECG | | | | | | | | | | | | | | | | | | |
| Hospital dis | charge su | mmary | | | | | | | | | | | | | | | Phar | macy b | ills | | | | | | | | | | | | | | | | |
| Oparation 1 | heatre No | tes | | | | | | | | | | | | | | | MLC | report | & Police | FIR | | | | | | | | | | | | | | | |
| Hospital ma | ain bill | | | | | | | | | | | | | | | | Origi | nal dea | th sumn | nary fro | m ho | pital, wh | ere app | olicable | | | | | | | | | | | |
| Hospital bre | eak-up bill | | | | | | | | | | | | | | | | Any | other, p | lease s | ecify | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | I | | | | | | | | | | | | | | | | _ | | | |
| DETAILS IN CASE OF NO | N NETWO | RK HO | PITA | (ONLY | FILL IN (| CASE | OF NO | N NE | TWORK | HOS | PITAL) | _ | _ | | | _ | _ | _ | _ | _ | | _ | _ | _ | _ | _ | _ | _ | _ | _ | _ | = | _ | _ | _ |
| a) Address of the hospital: | \vdash | 4 | 4 | <u> </u> | ₩ | ᆜ | 븢 | 븍 | \Rightarrow | + | + | <u> </u> | <u> </u> | Щ | | | 4 | + | + | _ | | Щ | + | <u> </u> | + | <u> </u> | 누 | <u> </u> | ¥ | Ļ | + | 누 | <u> </u> | <u> </u> | _ |
| | 느 | | <u> </u> | <u> </u> | | ᆜ | <u> </u> | ᆜ | | <u> </u> | <u> </u> | <u> </u> | <u> </u> | Щ | _ | Щ | | <u> </u> | <u> </u> | <u> </u> | | Щ | + | <u> </u> | | <u> </u> | 누 | <u> </u> | Ļ | Ļ | <u> </u> | 누 | <u> </u> | 느 | <u> </u> |
| Ci | ty: | 4 | <u> </u> | <u> </u> | ᆜ | _ | Д | | — | | + | <u> </u> | <u> </u> | Н | | | St | ate: | <u> </u> | Ļ | | | | | | | | 뉴 | Ļ | Ļ | + | 누 | <u> </u> | <u> </u> | <u> </u> |
| Pi | n Code: | 4 | 4 | <u> </u> | 屵 | ᆜ | _ | b) |) Phone N | No: | | | | Ц | | | 4 | | | J | | C | Regist | tration | No. wit | n State | Code | Ļ | <u> </u> | | | 느 | <u> </u> | 느 | 뉴 |
| d) Hospital PAN | \perp | <u> </u> | <u> </u> | | <u>Ш</u> | | ᆜ | _ | <u></u> | e |) Numb | ber of i | npatien | t beds | | | | f) l | Facilities | availal | ble in | the hosp | tal: | i. 0 | T: | Yes | <u>L</u> | No | | | ii. ICL | <u>:L</u> | Yes | | No |
| iii. Others: | | | | | | | | _ | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | OSPITAL | | | | | _ | | _ | | | | | | | | | | | | | | | | | | | | | | | (Pleas | e read | very | carefu | lly) |
| DECLARATION BY THE H | | | | | | n ie tri | | rrect | to the be | st of o | ır know | /ledge a | and bel | ief. If we | e have | made | any fals | e or uni | true stat | ement, | suppr | ess or co | ncealm | ent of a | anu ma | terial fa | act, ou | ır right | to cla | im und | ler this | claim | shall b | е | |
| We hereby declare that | the inform | ation fur | nished | in this C | laim Forn | 11 13 11 1 | ne & coi | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | the inform | ation fur | nished | in this C | laim Forr. | 11 15 (11 | ue & coi | | | | | | | | | | | | | | | | | | | | | | | | | | | | - |
| We hereby declare that forfeited. | the inform | ation fur | nished | in this C | laim Forn | | ue & coi | | .5 0.0 06 | | | | | | | | | | | | | Г | | | | | | | | | | — | | | 1 |
| We hereby declare that | the inform | ation fur | nished | in this C | laim Forn | | ue & coi | | | | | | | | | | | | | | | Γ | | | | | | | | | | _ | | | |
| We hereby declare that forfeited. | the inform | ation fur | nished | in this C | laim Forn | | ue & coi | | .5 4.0 00 | | | | | | | | | | Signa | ture of | the in | sured: | | | | | | | | | | | | | |
| We hereby declare that forfeited. | the inform | ation fur | nished | in this C | laim Forn | | ue & coi | | .5 4.0 00 | | | | | | | | | | Signa | ture of | the in | sured: | | | | | | | | | | | | | |
| We hereby declare that forfeited. | the inform | ation fur | nished | in this C |] | | ue & coi | | | JIDAN | CE FO | OR FILI | LING (| CLAIM I | FORM | 1 – PA | RT B (1 | o be f | Signa | | | | | | | | | | | | | _ | | | |
| We hereby declare that forfeited. | the inform | | | in this C |] | | ue & coi | | | JIDAN | CE FO | PR FILI | | | | D | ESCRIP | TION | illed in | | | | | | | | | | | FORM | AT | | | | |
| We hereby declare that forfeited. Date: Place: | the inform | | | <u>T</u> |] | | Lue & coi | | | Ţ | | | SEC. | TION A | | D | | TION | illed in | | | | | | | | | | | FORM | AT | | | | |
| We hereby declare that forfeited. | the inform | | | <u>T</u> |] | | ue & coi | | | En | ter the | name (| SEC [*] | FION A | | D | ESCRIP | TION | illed in | | | | | | me of h | | | | | ORM | AT | | | | |
| We hereby declare that forfeited. Date: | the inform | | | <u>T</u> |] | | ue & coi | | | En En | ter the | name o | SEC [*] of hosp | rion A ital | - DE | DITAILS | OF HO | TION | illed in | | | | | As | allocate | ed by t | he TP | | | FORM | AT | | | | |
| We hereby declare that forfeited. Date: Place: Place: a) Name of Hospital b) Hospital ID | | | | <u>T</u> |] | | ue & coi | | | En En | ter the ter ID n | name on the number whether | SEC [*] of hosp of hos | FION A | - DE | Di TAILS | OF HO | TION | illed in | | | | | As Tic | | ed by t ght opt | he TP. ion | | | FORM | AT | | | | |
| We hereby declare that forfeited. Date: Place: Place: Place: a) Name of Hospital ID c) Type of Hospital ID d) Name of treating dd e) Qualification | octor | DAT | | <u>T</u> |] | | Lue & coi | | | En En Inc | ter the ter ID n icate w ter the | name on the name of the name o | SECTOR HOSPING OF HOSPING HOSP | rION A ital pital | non ne | D TAILS | OF HO | TION | illed in | | | | | As Tic Na | allocati k the ri | ed by t ght opt loctor i | he TP. ion n full | A | | | | | | | |
| We hereby declare that forfeited. Date: | octor | DAT | | <u>T</u> |] | | Lue & coi | | | En En Ind En En | ter the ter ID n licate w ter the ter the | name on the number of the there of the the name of the qualific or registra | SECTOR HOSPING OF HOSPING OF THE ITEM ACTIONS ACTION OF THE ITEM ACTIO | rion A ital pital rork or r reating of the tr | non ne | Dirails | OF HO | TION | illed in | by the | | | | As Tic Na Abl As | allocate k the rig me of co breviati allocate | ed by t ght opt loctor i ons of ed by t | he TP. ion n full educa he Me | A tional | qualifi | cation | s | | | | |
| We hereby declare that forfeited. Date: Place: Pla | octor | DAT | | <u>T</u> | lalaim Forr | | Lue & coi | | | En En Ind En En | ter the ter ID n licate w ter the ter the ter the ter the | name of number of the there of the there of the there of the the there of the | SECTOR HOSP of hosp of hos In network the transfer of the tran | rion A ital pital vork or r reating of the tr imber o | non ne | DirAILS | OF HO | TION SPITA | illed in | by the | | | | As Tic Na Abl As | allocate k the rig me of co previati | ed by t ght opt loctor i ons of ed by t | he TP. ion n full educa he Me | A tional | qualifi | cation | s | | | | |

| C) Gender | Enter insurance provider registration number ndicate Gender of the patient Enter date of admission Enter time of admission Enter time of admission Enter time of discharge Indicate type of admission of patient Enter Date of Delivery if maternity Enter Gravida status if maternity Indicate status of patient at time of discharge | As allotted by the insurance provider Tick Male or Female Number of years and months Use dd-mm-yy format Use hh:mm format Use dh-mm-yy format Use hh:mm format Tick the right option Use dd-mm-yy format Use dd-mm-yy format |
|--|--|--|
| d) Age | Enter age of the patient Enter date of admission Enter time of admission Enter date of discharge Enter time of discharge Indicate type of admission of patient Enter Date of Delivery if maternity Enter Gravida status if maternity | Number of years and months Use dd-mm-yy format Use hh:mm format Use dd-mm-yy format Use hh:mm format Tick the right option Use dd-mm-yy format |
| e) Date of Admission E f) Time E g) Date of Discharge h) Time E li) Type of Admission In me Date of Discharge in f) Time E li) Type of Admission In Maternity Date of Delivery Gravida Status E li k) Status at time of discharge | Enter date of admission Enter time of admission Enter date of discharge Enter time of discharge Indicate type of admission of patient Enter Date of Delivery if maternity Enter Gravida status if maternity | Use dd-mm-yy format Use hh:mm format Use dd-mm-yy format Use hh:mm format Tick the right option Use dd-mm-yy format |
| f) Time E g) Date of Discharge E h) Time E i) Type of Admission In j) If Maternity Date of Delivery Gravida Status E k) Status at time of discharge In | Enter time of admission Enter date of discharge Enter time of discharge Indicate type of admission of patient Enter Date of Delivery if maternity Enter Gravida status if maternity | Use hh:mm format Use dd-mm-yy format Use hh:mm format Tick the right option Use dd-mm-yy format |
| 9) Date of Discharge h) Time Ei 1) Type of Admission In 1) If Maternity Date of Delivery Gravida Status k) Status at time of discharge In | Enter date of discharge Enter time of discharge Indicate type of admission of patient Enter Date of Delivery if maternity Enter Gravida slatus if maternity | Use dd-mm-yy format Use hh:mm format Tick the right option Use dd-mm-yy format |
| h) Time | Enter time of discharge Indicate type of admission of patient Enter Date of Delivery if maternity Enter Gravida status if maternity | Use hh:mm format Tick the right option Use dd-mm-yy format |
| i) Type of Admission In j) If Maternity E Date of Delivery E Gravida Status E k) Status at time of discharge In | ndicate type of admission of patient Enter Date of Delivery if maternity Enter Gravida status if maternity | Tick the right option Use dd-mm-yy format |
| j) if Maternity Date of Delivery Gravida Status E) k) Status at time of discharge | Enter Date of Delivery if maternity Enter Gravida status if maternity | Use dd-mm-yy format |
| Date of Delivery Gravida Status E k) Status at time of discharge In | Enter Gravida status if maternity | · · |
| Gravida Status E k) Status at time of discharge In | Enter Gravida status if maternity | · · |
| Gravida Status E. k.) Status at time of discharge In | Enter Gravida status if maternity | · · |
| · | ndicate status of nations at time of discharge | 403C Stanuaru ronnat |
| | nuicate status or patient at tille of discipline | Tick the right option |
| a) ICD 10 Code | SECTION C - DETAILS OF AILMENT DIAGNOSED (PRIMARY) | 3 - 1 |
| a) IOD TO CODE | | |
| Primary Diagnosis | Enter the ICD 10 Code and description of the primary diagnosis | Standard Format and Open text |
| Additional Discourse | Enter the ICD 10 Code and description of the primary diagnosis | Standard Format and Open text |
| 0 | Enter the ICD 10 Code and description of the additional diagnosis | Standard Format and Open text |
| b) ICD 10 PCS | Enter the ICD TO Code and description of the co-morbidities | Standard Format and Open text |
| Procedure 1 | Table the ICD 40 DCC and description of the first according | Standard Format and Open text |
| Proceedings 0 | Enter the ICD 10 PCS and description of the first procedure | ' |
| December 2 | Enter the ICD 10 PCS and description of the second procedure | Standard Format and Open text |
| Details of Presenture | Enter the ICD 10 PCS and description of the third procedure | Standard Format and Open text |
| c) Pro authorization obtained | Enter the details of the procedure | Open text |
| d) Dro outhorization Number | ndicate whether pre-authorization obtained | Tick Yes or No |
| C | Enter pre-authorization number | As allotted by TPA |
| A Harristination during the house | Enter reason for not obtaining pre-authorization number | Open text |
| | ndicate if hospitalization is due to injury | Tick Yes or No |
| | ndicate cause of injury | Tick the right option |
| If injury due to substance abuse/alcohol consumption, test conducted to establish this In | ndicate whether test conducted | Tick Yes or No |
| Medico Legal In | ndicate whether injury is medico legal | Tick Yes or No |
| Reported To Police | ndicate 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 |
| <u> </u> | SECTION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST | |
| 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) Dhara Na | Enter the phone number of hospital | Include STD code with telephone number |
| a) Paristantian Na with Otata Onda | Enter the registration number of the doctor along with the state code | As allocated by the Medical Council of India |
| d) Hospital PAN | Enter the permanent account number | As allotted by the Income Tax department |
| a) Number of Innations Dada | Enter the number of inpatient beds | Digits |
| C Continue and the boundary | · | Tick the right option. If others, please specify |
| y street | ndicate facilities available in the hospital SECTION F - DECLARATION BY THE INSURED | Trox the right option. If others, please specify |
| Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign | | |