CLAIM FORM

CLAIM FORM – PART A TO BE FILLED IN BY THE INSURED

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

SECTION A – DETAILS OF PRIMARY INSURED									
, ,				b) Sl. No/ Certificate No:					
c) Company/ TPA ID No									
d) Name									
e) Address (with city, State & Pincode Phone no)								
Email ID									
Linding		SECTION B- DETA	ILS OF I	NSU	RANCE HISTORY	,			
a) Currently covered by any other r	nediclaim hea	alth insurance			YES / NO				
b) Date of commencement of first ins					DD/MM/YYYY				
c) If Yes, Company Name									
Policy No.									
Sum Insured					Rs.				
d) Have you been hospitalized in the last four years since inception of the					YES / NO	Date: MI	<i>1</i> /VVV	v	
contract					123/110	Date. Wil	V1/1 1 1	<u>'</u>	
Diagnosis									
e) Previously covered by any other Me	ediclaim/Heal	th insurance			YES / NO				
f) If yes, Company Name									
N. Marian	SECI	ION C- DETAILS OF	· INSUK	ED P	ERSON HOSPITA	ILISED			
a) Name b) Relationship to Primary Insured							ı		
(Self/spouse/Child/Father/Mother/Otl	ner)			c) Date of Birth			d) Age	mths/yrs	
	/								
e) Address (If different than above)									
f) Condor		Male / Female		راي	Occupation	Service/Self e	mplo	yed/Home	maker/ /student/
f) Gender Male / Female				gj	Оссирации	Retired/ Othe	rs		
h)Telephone No				i) N	Nobile No				
j) E-mail ID, if any									
		SECTION D- DET	AILS OF	HOS	SPITALISATION				
a) Name of the Hospital where admitted			_	1-1					
b) Room Category occupied					ingle Occupancy	// I win Sharing/	3 or n	nore beds	per room
c) Hospitalization due to			_		jury / Maternity				
d) Date of Injury/ Date of disease first detected/ Date of delivery			DD/M DD/M						
e) Date of admission			HH/M		111				
f) Time			1		/VV				
g) Date of discharge h) Time			DD/MM/YYYY HH/MM						
i) If injury, give cause			<u> </u>	Self Inflicted/Road Traffic Accident/ Substance Abuse/ Alcohol Consumpti					
i) If Medico legal		YES / NO		Reported to police?				YES / NO	
				· · ·			Allopathic/Other systems of		
iii) MLC Report, & Police FIR attached? YES / NO			J) Syst) System of medicine medicine					
SECTION E- DETAILS OF CLAIM									
a) Details of the treatment expense	es claimed								
i) Pre-hospitalisation Expenses	Rs.			ii) Hospitalisation Expenses				Rs.	
iii) Post-hospitalisation Expenses	Rs.			iv) Health-Check up Cost			Rs.		
v) Ambulance Charges	Rs.			vi) Others (code)				Rs	
<u> </u>					To	tal		Rs.	
vii) Pre-hospitalisation Period Days				viii) Post -hospitalisation Period					
b) Claim for Domiciliary Hospitaliza	ation	YES / NO (i	if yes. nl		provide details			1	
c) Details of Lumpsum / cash benefit		27.12) , P		,	<i>y</i> :			
i). Hospital Daily Cash	Rs.			ii) Surgical Cash Rs.			Rs.	Rs.	
iii) Critical Illness Benefit	Rs.				iv) Convalescence Rs.				

Claim Documents Submitted- Check List:	vi) Others Rs.							
Claim Documents Submitted Check List.	1							
Duly filled and signed Claim Form	Copy of intimation letter, if any							
Hospital Main Bill	Hospital Break Up bill							
Hospital Bill Payment Receipt	Hospital Discharge Summary							
Pharmacy Bill	Operation Threater Notes							
□ ECG	Doctor's Request for Investigation							
Investigation Reports (Including CT, MRI/USG/HPE)	Doctor's Prescription.							
Others								
SECTION – F DETAILS OF BILLS	ENCLOSED							
Sno Bill No Date Issued By Towards	Amount (Rs)							
D D M M Y Y								
SECTION – G DETAILS OF PRIMARY INSURED'S BANK ACCOUNT								
a) PAN b) Account Number								
<u> </u>	d) Payable details: Cheque/ DD e) *please attach a cancelled							
	cheque pertaining to the same							
	*please attach a cancelled cheque pertaining to the same							
Note:								
It is agreed that the Policyholder/Claimant will intimate in writing to TATA- AIG General Insurance Co. Ltd. about any change in bank account details. In an event Insured person bears expenses for treatment please provide account details of Insured Persons in the above format along with proof of								
incurring such expenses.								
SECTION H – DECLARATION BY THE INSURED								
I hereby declare that the information furnished in this claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact with respect to questions asked in relation to this claim, my right to claim								
reimbursement shall be 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: Place Signature	of Insured							

	GUIDANCE FOR FILLING CLAIM FORM – PART A (To be filled in by the insured)						
	DATA ELEMENT	DESCRIPTION	FORMAT				
SECTION A - DETAILS OF PRIMARY INSURED							
a)	Policy No.	Enter the policy number	As allotted by the insurance company				
b)	SI. No/ Certificate No.	Enter the social insurance number or the certificate number of	As allotted by the organization				
c)	Company TPA ID No.	Enter the TPA ID No	License number as allotted by IRDA and printed 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				
SECTION B - DETAILS OF INSURANCE HISTORY							
a)	Currently covered by any other Mediclaim / Health Insurance?	Indicate whether currently covered by another Mediclaim / Health Insurance	Tick Yes or No				
b)	Date of Commencement of first Insurance without	Enter the date of commencement of first insurance	Use dd-mm-yy format				
c)	Company Name	Enter the full name of the insurance company	Name of the organization in full				

	Policy No.	Enter the policy number	As allotted by the insurance company
	Sum Insured	Enter the total sum insured as per the policy	In rupees
d)	Have you been Hospitalized in the last 4 years	Indicate whether hospitalized in the last 4 years	Tick Yes or No
_	Date	Enter the date of hospitalization	Use mm-yy format
	Diagnosis	Enter the diagnosis details	Open Text
5)	Previously Covered by any other Mediclaim/ Health Insurance?	Indicate whether previously covered by another Mediclaim / Health Insurance	Tick Yes or No
)	Company Name	Enter the full name of the insurance company	Name of the organization in full
	SECTIO	N C - DETAILS OF INSURED PERSON HOSPITALIZED	
)	Name	Enter the full name of the patient	Surname, First name, Middle name
)	Gender	Indicate Gender of the patient	Tick Male or Female
:)	Age	Enter age of the patient	Number of years and months
i)	Date of Birth	Enter Date of Birth of patient	Use dd-mm-yy format
)	Relationship to primary Insured	Indicate relationship of patient with policyholder	Tick the right option. If others, please
)	Occupation	Indicate occupation of patient	Tick the right option. If others, please
()	Address	Enter the full postal address	Include Street, City and Pin Code
1)	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)	Name of Hospital where admitted	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
l)	Date of Injury/Date Disease first detected/ Date of Delivery	Enter the relevant date	Use dd-mm-yy format
2)	Date of admission	Enter date of admission	Use dd-mm-yy format
)	Time	Enter time of admission	Use hh:mm format
()	Date of discharge	Enter date of discharge	Use dd-mm-yy format
1)	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 Medicine	Enter the system of medicine followed in treating the	Open Text
ст	ION E – DETAILS OF CLIAM		
a)	Details of Treatment Expenses	Enter the amount claimed as treatment expenses	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 benefit claimed	Enter the amount claimed as lump sum/ cash benefit	In rupees (Do not enter paise values)
d)	Claim Documents Submitted-Check List	Indicate which supporting documents are submitted	Tick the right option
		SECTION F - DETAILS OF BILLS ENCLOSED	
ndi	cate which bills are enclosed with the amounts in rupee	es	
_		G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT	1
1)	PAN	Enter the permanent account number	As allotted by the Income Tax departmen
)	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
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 fu
2)	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 preauthorisation request form in lieu of PART A

SECTION A – DETAILS OF HOSPITAL

O Name of the treating Doctor SECTION B Defaults of Parallel Decade Section S Defaults of Parallel Decade Section S	a) Name of the Hospital where treated					b) Hospital ID					
SECTION Procedure Section Procedure Section Procedure Section Procedure Section Sectio	c) Type of Hospital			Net	work		Non Network (If non network fill form section E)				
Name of the patient SECTION B - DETAILS OF PATIENT ADMITTED		ating Doctor							1		
a) Name of the patient b) IP Registration Number	e) Qualification								g) Phone No		
District		1	SEG	TION B	- DETAILS	S OF PATIENT ADM	NITTE)			
e) Date of Birth Date of Admission DDAMM/YYY Date of Admission DDAMM/YYY Difference of DDAMM/YY DDAMM/YY DDAMM/YY DDAMM/YY DDAMM/YY DDAMM/YY DDAMM/YY DAMM/YY DDAMM/YY DDAMM/YY DAMM/YY DAMM/Y DAMM/YY DAMM/	patient					b) IP Registration	Num	ber			
f) Date of Admission DDMMMYYYY Date of Discharge DMMMYYYY Disper of Admission DDMMMYYYY Disper of Admission DDMMMYYYY Disper of Discharge Discharge Discharge Discharge DMMMYYY Disper of Discharge Discharge	c) Gender	Male/ Fem	Male/ Female			d) Age				YY/MM	
Display Disp	,										
Diginal of Admission Emergency/Planned/Daycare/Maternity EDMM/YYY I) Date of Diginal of Declared to Home Discharged to Another Hospital Declared of Declared of Declared of Admission Discharged to Another Hospital Declared of Dec	f) Date of Admission	DD/MM/YY	ΥY			<u> </u>				HH/MM	
Dollway	h) Date of Discharge				· ·	-ge			HH/MM		
Dollwary Dollwary Dollwary Dollwary Dollwary Doceased	" "	Emergency	//Planned/Dayo	are/Mat	ernity	k) If Maternity					
Discharged to another Hospital Commorbidities	/					ii) Gravida Status					
SECTION C - DETAILS OF ALIMENTS DIAGNISED (PRIMARY) a) ICD 10 Code Primary Diagnosis Details of Procedure/s done b) ICD 10 PCS Procedure 1 Procedure 2 Procedure 3 Diagnosis Procedure 2 Procedure 3 Procedure 3 Procedure 3 Procedure 4 Procedure 5 Procedure 5 Procedure 6 Procedure 6 Procedure 6 Procedure 7 Procedure 6 Procedure 9 Procedure 9 Procedure	,	Discharged		spital		Total Claimed An	nount		Rs		
a) ICD 10 Code Primary Additional Diagnosis Di	0	Deceased	SECTION (DETA	II S OF AII	MENTS DIACNISE	D (DD	IMADV)			
Details of Procedure/s done Diagnosis					ILS OF All		אץ) ע.	IIVIAKY)	Co		
Details of Procedure/s done b) ICD to PCS	a) ICD 10 Code										
b) ICD to PCS	<u>. </u>		Diagnos	<u> </u>	I	2.46110313	1		orbidities	ı	
d) Pre-authorization obtained	Details of Procedure/s	done									
d) Pre-authorization obtained	b) ICD 10 PCS		Procedu	e 1		Procedure 2			Procedure 3		
f) If authorization by network hospital not obtained, give reason g) Hospitalisation due to Injury Self inflicted? YES / NO Road Traffic Accident YES / NO Substance Abuse / Alcohol Consumption YES / NO ii) If yes, give cause Substance Abuse / Alcohol Consumption YES / NO iii) If Injury due to Substance abuse / alcohol consumption, Test Conducted to establish this: V/N (if yes, attach reports V/S / NO V) FIR No V) FIR No VIS / NO V) FIR No SECTION D - CLAIM DOCUMENTS SUBMITTED - CHECKLIST Claim form duly filled and signed Investigation reports Copy of Pre-authorization Request Copy of Pre-authorization approval Letter Copy of Pre-authorization approval Letter Copy of Pre-authorization approval Letter Copy of photo ID card of patient verified by Hospital Copy of photo ID card of patient verified by Hos	•	n obtained					horiza	tion No		ı	
g) Hospitalisation due to Injury Self inflicted? VES / NO Road Traffic Accident YES / NO Substance Abuse / Alcohol Consumption YES / NO Ii) If yes, give cause Substance Abuse / Alcohol Consumption YES / NO Substance Abuse / Alcohol Consumption YES / NO VES / NO V	/		ital not obtain		reason	2,			1		
Self inflicted? YES / NO Road Traffic Accident YES / NO Substance Abuse / Alcohol Consumption, Test Conducted to establish this: iv) Reported to Policy YES / NO y) FIR No iii) Medico Legal YES / NO iii) finjury due to Substance abuse / alcohol consumption, Test Conducted to establish this: iv) Reported to Policy YES / NO iv) If not reported to Policy YES / NO iv) FIR No	g) Hospitalisation due to			i) If yes, give	i) If yes, give cause						
ii) If Injury due to Substance abuse / alcohol consumption, Test Conducted to reports V/N (If yes, attach reports iii) Medico Legal YES / NO v) FIR No v) FIR No v) FIR No v) FIR No SECTION D - CLAIM DOCUMENTS SUBMITTED - CHECKLIST Claim form duly filled and signed Claim form duly filled and signed Copy of Pre-authorization Request Copy of Pre-authorization approval Letter Doctor's reference slip for Investigation Report Copy of photo ID card of patient verified by Hospital Hospital Discharge Summary Pharmacy Bills Original death summary from hospital where applicable Hospital Main Bill Original death summary from hospital where applicable Hospital break up Bill Any other, PI specify SECTION E - DETAILS IN CASE OF NON NETWORK HOSPITAL Address of the Hospital Address of the Hospital Address of the Hospital No of In-patient Beds Fig. Facilities available in Hospital Others SECTION F - DECLARATION BY HOSPITAL We hereby declare that the information furnished in this Claim Form is true & 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)				YES / NO			I YES/NO				
iv) Reported to Policy YES / NO v) FIR No vi) If not reported to Policy give reasons SECTION D - CLAIM DOCUMENTS SUBMITTED - CHECKLIST Claim form duly filled and signed Investigation reports Original Pre authorization Request CT/MRI/USG/HPE investigation Report Copy of Pre-authorization approval Letter Doctor's reference slip for Investigation Copy of photo ID card of patient verified by Hospital ECG Hospital Discharge Summary Pharmacy Bills Operation Theatre Notes MLC Report & Police FIR Hospital Main Bill Original death summary from hospital where applicable Hospital break up Bill Any other, PI specify SECTION E - DETAILS IN CASE OF NON NETWORK HOSPITAL Address of the Hospital D) Phone NO: Registration no with State Code d) Hospital PAN No of In-patient Beds f) Facilities available in Hospital OT Y/N ii) ICU Y/N We hereby declare that the information furnished in this Claim Form is true & 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	alcohol consumption, Test Conducted to			iii) Medico Le							
SECTION D - CLAIM DOCUMENTS SUBMITTED - CHECKLIST				v) FIR No							
Claim form duly filled and signed						VITILITIE					
□ Claim form duly filled and signed □ Investigation reports □ Original Pre authorization Request □ CT/MRI/USG/HPE investigation Report □ Copy of Pre-authorization approval Letter □ Doctor's reference slip for Investigation □ Copy of photo ID card of patient verified by Hospital □ ECG □ Hospital Discharge Summary □ Pharmacy Bills □ Operation Theatre Notes □ MLC Report & Police FIR □ Hospital Main Bill □ Original death summary from hospital where applicable □ Hospital break up Bill □ Any other, PI specify SECTION E – DETAILS IN CASE OF NON NETWORK HOSPITAL a) Address of the Hospital □ Do Phone NO: c) Registration no with State Code □ d) Hospital PAN e) No of In-patient Beds □ F Facilities available in Hospital □ OT □ Y/N □ II □ ICU □ Y/N III Others SECTION F – DECLARATION BY HOSPITAL We hereby declare that the information furnished in this Claim Form is true & 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)											
Original Pre authorization Request Copy of Pre-authorization approval Letter Doctor's reference slip for Investigation Copy of photo ID card of patient verified by Hospital Hospital Discharge Summary Pharmacy Bills Operation Theatre Notes Hospital Main Bill Original death summary from hospital where applicable Hospital break up Bill Any other, Pl specify SECTION E − DETAILS IN CASE OF NON NETWORK HOSPITAL A) Address of the Hospital C) Registration no with State Code (d) Hospital PAN (e) No of In-patient Beds (f) Facilities available in Hospital i) OT Y/N iii) Others SECTION F − DECLARATION BY HOSPITAL We hereby declare that the information furnished in this Claim Form is true & 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)	SECTION D – CLAIM DOCUMENTS SUBMITTED - CHECKLIST										
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Operation Theatre Notes MLC Report & Police FIR				☐ Ph	Pharmacy Bills						
Hospital Main Bill Hospital break up Bill SECTION E – DETAILS IN CASE OF NON NETWORK HOSPITAL a) Address of the Hospital b) Phone NO: c) Registration no with State Code d) Hospital PAN e) No of In-patient Beds f) Facilities available in Hospital i) OT Y/N ii) ICU Y/N iii) Others SECTION F – DECLARATION BY HOSPITAL We hereby declare that the information furnished in this Claim Form is true & 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)							ca FIR				
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Date: Signature and seal of the Hospital Authority GUIDANCE FOR FILLING CLAIM FORM – PART B (To be filled in by the hospital)	,			in this C	laim Form	n is true & correct	o the	best of ou			
GUIDANCE FOR FILLING CLAIM FORM – PART B (To be filled in by the hospital)											
DATA DESCRIPTION FORMAT			GUIDAN	CE FOR	FILLING C			o be fille	d in by the hos	pital)	
	DATA DESCRIPTION FORMAT										

a) Name of Hospital Enter the name of hospital Section N - DETAILS OF 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 treating doctor Enter the name of the treating doctor Name of doctor in full e) Qualification Enter the name of the treating doctor Abbreviations of educa f) Registration No. with State Code Enter the path of the treating doctor Abbreviations of educa f) Registration No. with State Code Enter the path of the treating doctor Abbreviations of educa f) Registration No. with State Code Enter the phone number of doctor Include STD code with the state code g) Phone No. Enter the phone number of doctor Include STD code with the SECTION B - DETAILS OF THE PATIENT a) Name of Patient Enter the name of hospital Name of hospital in full b) IP Registration Number Enter the name of hospital Name of hospital in full d) Age Enter age of the patient Tick Male or Female e) Date of Admission Enter age of the patient Number of years and m e) Date of Admission Enter date of admission Use dd-mm-yy format f) Time Enter time of admission Use dd-mm-yy format h) Time Enter time of discharge Use dd-mm-yy format h) Time Enter time of discharge Use dd-mm-yy format h) Time Enter time of discharge Use dd-mm-yy format h) Time Enter time of discharge Use dd-mm-yy format Cravida Status Enter Gravida status if maternity Use dd-mm-yy format k) Status at time of discharge Indicate status of patient at time of discharge Use himm format k) Status at time of discharge Indicate status of patient at time of the primary Date of Delivery Enter Date of Delivery if maternity Use dd-mm-yy format carvida Status Enter Gravida status if maternity Use dd-mm-yy format convention Enter the ICD to Code and description of the primary diagnosis Standard Format and O Definition En	
c) Type of Hospital Indicate whether in network or non network Hospital Tick the right option d) Name of treating doctor Enter the name of the treating doctor Name of doctor in full e) Qualification Enter the qualifications of the treating doctor Abbreviations of educal Face to the qualifications of the treating doctor Abbreviations of educal Face to the qualifications of the treating doctor Abbreviations of educal Face to the qualifications of the treating doctor Abbreviations of educal Face to the qualifications of the treating doctor Abbreviations of educal Face to the qualifications of the treating doctor Abbreviations of educal Face to the qualification of the patient As allocated by the Med State code Indicate Code of the patient Include STD code with the SECTION B - DETAILS OF THE PATIENT a) Name of Patient Enter the name of hospital Name of hospital in full b) IP Registration Number Enter the name of hospital in full of the patient Tick Male or Female Indicate Gender of the patient Tick Male or Female Of Age Enter age of the patient Number of years and me Date of Admission Enter date of admission Use dd-mm-yy format Date of Discharge Enter date of admission Use hhmm format Time Enter time of admission Use hhmm format Time Enter time of admission Of Date of	
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f) If authorization by network	
g) 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	
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 auth	orities
If not reported to police, give reason Enter reason for not reporting to police Open Text	
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
[1] Block H. [2] [1] [1] [2] [2] [3] [4] [4] [4] [4] [4] [4] [4] [4] [4] [4	elephone number
b) Phone No. Enter the phone number of hospital Include STD code with t	oital
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	e Tax departmen
c) Registration No. Enter the registration number of patient As allocated by the Hos	e Tax departmen

SECTION F - DECLARATION BY THE INSURED
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.
SECTION G - DECLARATION BY THE HOSPITAL
Read declaration carefully and mention date (in dd:mm:vv format), place (open text) and sign and stamp

CHECK LIST OF ENCLOSURES FOR SUBMISSION OF CLAIM

Note:

- At the time of submission of original bills, receipts, prescriptions, reports and other documents to the other insurer or to the reimbursement provider, verified photocopies attested by such other organisation/provider have to be submitted.
- If original bills, receipts, prescriptions, reports and other documents are submitted to Us and Insured Person requires same for claiming from other organisation/provider, then on request from the Insured Person We will provide attested copies of the bills and other documents submitted by the Insured Person.

In-patient	t Treatment /Day Care Procedures
	Duly filled and signed Claim Form.
	Photocopy of ID card / Photocopy of current year policy.
	Original Detailed Discharge Summary with date of admission & discharge, clinical history, past history / procedure details/ Day care summary from the hospital.
	Original consolidated hospital bill with break up of each Item, duly signed by the insured.
	Original payment Receipt of the hospital bill.
	First Consultation letter and subsequent Prescriptions.
	Original bills, original payment receipts and Reports for investigation.
	Original medicine bills and receipts with corresponding Prescriptions.
	Original invoice/Sticker of implants/bills for Implants (viz. Stent /PHS Mesh/ IOL etc.) with original payment receipts.
D 1 T	W. A. Hard
Koad Ira	ffic Accident In addition to the In-patient Treatment documents:
	Copy of the First Information Report from Police Department / Copy of the Medico-Legal Certificate. In Non Medico legal cases
	Treating Doctor's Certificate giving details of injuries (How, when and where injury sustained) In Accidental Death cases
	Copy of Post Mortem Report & Death Certificate (If conducted)
For Death	n Cases
	In addition to the In-patient Treatment documents:
	Original Death Summary from the hospital.
	Copy of the Death certificate from treating doctor or the hospital authority.
	Copy of the Legal heir certificate, if the claim is for the death of the principle insured.
Pre and P	Post-hospitalisation expenses
	Duly filled and signed Claim Form.
	Photocopy of ID card / Photocopy of current year policy.
	Original Medicine bills, original payment receipt with prescriptions.
	Original Investigations bills, original payment receipt with prescriptions and report.
	Original Consultation bills, original payment receipt with prescription.
	Copy of the Discharge Summary of the main claim.
Organ Do	onation/Transplantation
	III addition to the documents of general hospitalization
	In addition to the documents of general hospitalization Organ Function test / blood test proving organ failure.
	Organ Function test / blood test proving organ failure. Treatment Certificate issued by the Transplant Surgeon of the hospital concerned.

Ambulance Benefit

ш	☐ Duly filled and signed Claim Form.					
	Photocopy of ID card / Photocopy of current year policy.					
	Original Bill with Original Payment Receipt.					
	☐ Treating Doctor's consultation prescription indicating Emergency Hospitalization.					
Customer Identification Procedure (as per KYC norms of IRDA)						
Please submit the following documents in case of claim amount exceeds Rs. 100,000						
Legal name and any other names used		Passport/ PAN Card/ Voter's Identity Card/ Driving License/				
(Any one of the mentioned documents)		Letter from a recognized public authority or public servant				
		verifying the identity and residence of the customer				
Proof of Residence		Telephone bill/ Bank account statement/ Letter from any				
(Any one	of the mentioned documents)	recognized public authority/ Electricity bill/ Ration card				