



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

TO BE FILLED IN BY THE INSURED

(To be filled in BLOCK LETTERS)

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

SECTION A - DETAILS OF PRIMARY INSURED

a) Type of claim
Hospitalization Pre Hospitalization Post Hospitalization Health check-up OPD
b) Pre authorization obtained Yes No
c) Policy type Individual Group
d) Group/Company name
e) Policy No f) Sl. No/Certificate No
g) Company/TPA ID No. h) Name
I) Address
City State Pincode
Phone No Email ID.
j) PAN No
k) Monthly Income: Up to ₹ 20,000 ₹ 20,001 to ₹ 50,000 ₹ 50,001 to ₹ 1,00,000 ₹ 1,00,001 and above

SECTION B - DETAILS OF INSURANCE HISTORY

a) Currently covered by any other Mediciam/Health Insurance Yes No
b) Date of commencement of first insurance without break
c) If yes, company name
Policy No Sum Insured ₹
d) Have you been hospitalized in the last four years since inception of the contact? Yes No
Date Diagnosis
e) Previously covered by any other Mediciam/Health Insurance Yes No
f) If yes Company Name

SECTION C - DETAILS OF INSURED PERSON HOSPITALIZED

a) Name
b) Gender Male Female c) Age - years Months d) Date of birth
e) Relationship to Primary insured: Self Spouse Child Father Mother Other - Please Specify
f) Occupation: Service Self Employed Homemaker Student Retired Other - Please Specify
g) Address (if different from above)
City State Pin Code
Phone No Email Id

An ISO 9001:2015 Certified Company

SECTION D - DETAILS OF HOSPITALIZATION

- a) Name of Hospital where admitted _____
- b) Room Category occupied Day care Single occupancy Twin sharing 3 or more beds per room
- c) Hospitalization due to Injury Illness Maternity
- d) Date of Injury/Date disease first detected /Date of delivery | d | d | m | m | y | y | y | y |
- e) Date of Admission | d | d | m | m | y | y | y | y | f) Time | H | H | M | M |
- g) Date of discharge | d | d | m | m | y | y | y | y | h) Time | H | H | M | M |
- i) If injury give cause: Self inflicted Road traffic accident Substance abuse /Alcohol consumption
- ii) If Medico legal Yes No ii) Reported to police Yes No
- iii) MLC report & Police FIR attached Yes No j) System of medicine _____

SECTION E - DETAILS OF CLAIM

- a) Details of treatment expenses claimed
- i. Pre hospitalization expenses ₹ _____ ii. hospitalization expenses ₹ _____
- iii. Post hospitalization expenses ₹ _____ iv. Health check up cost ₹ _____
- v. Ambulance charges ₹ _____ vi. Others(code) ₹ _____
- TOTAL ₹ _____
- vii. Pre hospitalization period _____ days viii. Post hospitalization period _____ days
- b) Claim for Domiciliary Hospitalization Yes No (if yes provide details in annexure)
- c) Details of Lump sum/cash benefit claimed i. Hospital Daily Cash ₹ _____/- ii Surgical cash ₹ _____/-
- iii Critical illness benefit- ₹ _____/ iv Convalescence ₹ _____/-
- v. Pre/Post hospitalization Lump sum benefit ₹ _____/- vi Others ₹ _____/-
- TOTAL ₹ _____/-

SECTION F - DETAILS OF BILLS ENCLOSED

S.No	Bill No	Date	Issued By	Towards	Amount ₹)
1		d d m m y y y y		Hospital main Bill	
2		d d m m y y y y		Pre hospitalization Bills _____Nos	
3		d d m m y y y y		Post hospitalization Bills _____Nos	
4		d d m m y y y y		Pharmacy Bills	
5		d d m m y y y y		Other expenses if any _____	
6		d d m m y y y y			
7		d d m m y y y y			
8		d d m m y y y y			
9		d d m m y y y y			
10		d d m m y y y y			

CLAIM DOCUMENTS SUBMITTED CHECK LIST

S.No	Documents	
1	<input type="checkbox"/> Claim form duly signed	7 <input type="checkbox"/> Pharmacy bill
2	<input type="checkbox"/> Copy of the claim intimation, if any	8 <input type="checkbox"/> Operation theatre notes
3	<input type="checkbox"/> Hospital main bill	9 <input type="checkbox"/> ECG
4	<input type="checkbox"/> Hospital break up bill	10 <input type="checkbox"/> Doctor's request for investigation
5	<input type="checkbox"/> Hospital bill payment receipt	11 <input type="checkbox"/> Investigation reports (including CT/MRI/USG/HPE)
6	<input type="checkbox"/> Hospital discharge summary	12 <input type="checkbox"/> Doctor's prescriptions
		13 <input type="checkbox"/> Others

As per policy terms & conditions, the Company reserves its right to have the Insured examined by a Doctor appointed by it for verification of diagnosis.

SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

1. Name of the Bank Account Holder Mr. Mrs. Ms. | F | I | R | S | T | | | | | M | I | D | D | L | E | | | | L | A | S | T |

2. Bank Account No.: | | | | | | | | | | | | | | | | | | | 3. Account: Saving Current Other

4. Name of the Bank | | | | | | | | | | | | | | | | | | | |

5. Branch | | | | | | | | | | | | | | | | | | | |

6. MICR Code (9 digit MICR code number of the bank and branch appearing on the cheque issued by the bank) | | | | | | | | |

7. IFSC Code (11 character code appearing on your cheque leaf) | | | | | | | | | | | |

I understand that any refund due on the premium payment / any payment / claims to be directly credited to my aforesaid Bank Account.*

*As per IRDAI, its mandatory that all payments made to the insured are only through electronic mode.

SECTION H - DECLARATION BY THE INSURED

I hereby declare that the information furnished in this claim form is true and correct to the best of my knowledge and belief. If I made any false or untrue statement, suppression or concealment of any material fact with respects to questions asked in relation to the claimed, 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 | d | d | | m | m | | y | y | y | y | | Place _____ Signature of the Insured _____