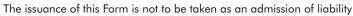
CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT - PART A TO BE FILLED IN BY THE INSURED

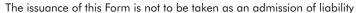




Toll Free No. 1800 266 3202

SECTION A - DETAILS	OF	PR	.lM/	٩RY	′ IN	1SC	IREI	D: (T	o be	e fil	led	in	blo	ck	let	ters)																
a) Policy No:															b) S	SI. No/	/ Ce	rtific	ate	No:	Г						П					
c) Company/ TPA ID No:																					_		•									
d) Name:																																
e) Address:																																
City:] {	State:																
Pin Code:											L	an	dlin	e (\	With	n STD	Cod	e):														
Mobile No:]																													
[PLEASE PROVIDE ACTIVE EM	AIL	ID (ONI	ΥA	S C	LAI <i>l</i>	AS C	ORRI	SPC	ND	ENC	CE	WILL	. BE	SEI	NT TO	THIS	EMA	AIL I	D.]												
Email ID:																																
Alternate Email ID:		L																									Ш	\Box	\Box			
		_	_																								_	_	_			_
SECTION B - DETAILS	S O	FΙ	NSI	UR/	AN	CE	HIS	STOR	Y:																							
a) Currently covered by any	oth	er /	Med	licla	im	/ H	ealth	n Insu	ranc	e:		Y	es		N	0		b)	If ye	es, P	olic	у Ту	pe:		In	div	idud	lc	L		Gro	υp
Company Name:																			Poli	cy N	lo.:											
c) Date of commencement of	of fi	rst Ir	nsur	ranc	e v	vitho	out k	reak										d)	Sun	n Ins	ure	d (R	s.):									
Have you been hospitalise	d ir	1 th	e lo	ıst f	our	ye	ars :	since	ince	eptio	on c	of t	the c	on	trac	:†?		Ye	S		N	0										
Diagnosis:																					T							П	П			\neg
f) Previously covered by any	oth	er /	Med	icla	im ,	/ He	ealth	Insu	anc	e:		\	Yes		N	0	•	•				•									•	_
g) If yes, Company Name:																												П	П			\neg
SECTION C - DETAIL:	s C)E I	NIS	ΙIR	FD	PF	PS/	JVI F	109	PIT	ΔΙΙ	SE	D.																			
a) Name:						. <u></u>							.D.						Ŧ		T	T	П					\equiv	\equiv		Ŧ	٩
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b) Gender:		, ,	ale	Sel			nale	use	c) A		rec nild	ars]	一	Fast] ther	Mon . □	ms Mot	M	M	_ `		te o r (Pl				רי ה	M	M	Y	Υ	Υ	<u> </u>
e) Relationship to Primary In		-	_	Sei	' [3pc	Juse	<u> </u>		IIIG	_	\Box	l di	T		70101	nei	누		T	T (F1	T	e si	Jeci	iy)	Н	=	一	T	T	닉
f) Address (if different from	n ak)OV	e): 					+	<u> </u>				1	<u>. </u>			+		$\frac{\perp}{1}$	<u> </u>	+	+	+	<u> </u>			Ш	\dashv	\dashv	<u> </u>	$\frac{1}{1}$	닉
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g) Occupation:		5e	rvic	e L		Self	Em	ploye	ed L	<u> </u>	Hon	ne	mak	er [Stude	nt L	^	(etir	ed [Off	ner	(Ple	ase T	spe	ecify	') —	=	_	_	닉
h) Name of Employer/ Firm's Name:																																
i) Address of the Employer/Firm:																																
SECTION D. DETAIL	s C	\F		CDI	TAI	LIC	\TI	211																								
SECTION D - DETAIL	3 C	ו דוע		SPI	IA	LIO	111	JIN:											_		_		_						_		_	
a) Name & Address of Hospital where Admitted:		Ĺ																														
City:																State:																
Pin Code:								Land	dma	rk:																						
b) Room Category occupied:		Do	ay c	are	:		ing	le oc	cupo	incy	/ [Twir	n sh	nari	ng [3	or r	nor	e be	ds	per	roo	m								
		0	ther	r (Pl	eas	se s	pec	ify)																								
c) Hospitalisation due to:		In	jury			llne	ss		Nate	erni	ty																					
d) Date of Injury / Date Di	isea	se '	first	de	tect	ed ,	/ Do	ate of	De	live	ry:		D	0 /	M	M Y	Υ	ΥY														
e) Date of Admission:	D	D	M	M	Υ	Υ	f)	Time	Н	Н	: 1	M	M	g)) Do	ate of	Disc	harg	je:	D	D	M N	ΛY	′ Y	ŀ	n) T	ime	: [1 1	:	M	M
i) In case of maternity,	I) [)ate	e of	De	live	ry:	D	DN	M	Υ	Υ		II) C	∂ra	vido	a Statu	ıs:								_		_					ヿ
j) If injury give cause:		,	elf-ir					Road	d Tro	ıffic	Aco	cid				Subst		e Ab	use	/ A	lcol	nol (Cor	sun	npti	on						
])		edic					Yes		N				ı poı	rtec	to po		_	Ye			No										
					_		olice	FIR	— notte	_	_		Yes			No			٠.,													
k) System of Medicine:	,								T				,	- L		· · •					Т	T	Т	Τ			П	\neg	\neg	\neg	Т	\neg

CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT - PART A TO BE FILLED IN BY THE INSURED





SECTION E - DETAILS OF CLAIM:

 a) Details of the other treatment exp 	senses claimed

S.N.	Cover Name	Amount (in Rs)	S.N.	Cover Name	Amount (in Rs)
	Pre Hospitalization Expenses			Green channel benefit claim against Health wearable device	
	Post Hospitalization Expenses			Compassionate Visit in case of Cl	
	Ambulance Cover			Vaccination for new born	
	Organ Donor Expenses			Out-patient Cover	
	Green channel benefit claim against Non payable expenses			Air Ambulance	
·	Worldwide emergency optional cover			Maternity benefit optional cover	

b)	Details	of	Lump	sum	/ cash	benefit	claime

S.N.	Cover Name	Claimed	S.N.	Cover Name	Claimed
	Hospital Cash	Yes No		Companion Benefit	Yes No
	Loss of income benefit	Yes No		Convalescence Benefit	Yes No
	Enhanced Daily cash benefit	Yes No		Benefit under Critical Illness optional Cover, if opted	Yes No
	Home treatment additional daily Cash benefit	Yes No		Benefit under Personal Accident optional Cover, if opted	Yes No
	Hospital cash optional cover	Yes No			
A a			Ala Dali		

Amount as per above covers, if claimed by you, will be paid as per the terms and conditions of the Policy plan.

Check List of Claim Documents to be submitted (In original)* - Please (\checkmark) tick relevant box

(101 1103pilat Casif belieff, photocopies of	cidini docomenis die dccepiablej						
Claim Form duly filled and signed	Copy of the Claim Intimation, if any	Hospital Bill Payment receipt					
Hospital Main Bill	Hospital Break-up Bill	Doctor's request for investigation					
Hospital Discharge Summary	Pharmacy Bill	Operation Theatre Notes					
Investigation Reports (Including CT /	MRI / USG / HPE / ECG)	Test report and prescription relating to first consultation for the Illness					
Doctor's prescription for medicines purinvestigation done outside hospital	Doctor's prescription for medicines purchased outside the hospital and investigation done outside hospital						
KYC document (Address proof, ID pro	oof only for claims exceeding ₹1 Lakh)	Original Death Summary (Wherever applicable)					
Cancelled cheque leaf of the bank as primary insured (Mandatory)	ccount held in the name of the	Any Other					

SECTION F - DETAILS OF BILLS ENCLOSED:

SI. No	Bill No	Date	Issued by	Towards	Amount (Rs)
1.				Hospital Main Bill	
2.				Pre-hospitalisation Bills: No	s
3.				Post-hospitalisation Bills: No	s
4.				Pharmacy Bills	
5.					
6.					
7.					
8.					
9.					
10.					

Note: If there are more bills, please attach additional sheets with this claim form giving the bill details in same format as below.

Hospital Main Bill Payment Receipts only

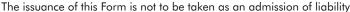
Receipt No.	Date	Amount (Rs)	Please (√) Tick R	Relevant Box
			Advance Receipt	Final Receipt
			Advance Receipt	Final Receipt
			Advance Receipt	Final Receipt
			Advance Receipt	Final Receipt

Note: Please attach separate sheet if necessary

[•] For new born baby cover, separate claim form to be filled & submitted. • For Fitness Reward points, please fill separate form "Fitness reward earning claim form" available on our website. • Benefits under Cumulative Bonus, Early joining Benefit, Restoration of Sum Insured will be provided automatically. You need not file a claim separately for these.

^{*}Please retain copy of complete set of claim documents for your records

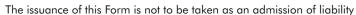
CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT - PART A TO BE FILLED IN BY THE INSURED





IF THE CLAIM IS FOR ACCIDENTAL INJURIES, PLEASE PROVIDE DETAILS OF DATE, TIME AND CIRCUMSTANCES OF ACCIDENT EVENT AND OTHER DETAILS AS RELEVANT: Time: Date: Circumstances of Accident event and other details: SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT: PLEASE PROVIDE YOUR BANK DETAILS: (PLEASE ATTACH CANCELLED CHEQUE LEAF OF BANK ACCOUNT IN THE NAME OF PRIMARY INSURED WITHOUT FAIL) a) PAN: b) Account Number: c) Bank Name and Branch d) IFSC Code: e) Cheque/ DD Payable Details: 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, suppressed or concealed any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent & authorise TPA / insurance company to seek necessary medical information / documents from any hospital / Medical Practitioner who has attended the person for 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 pre/post hospitalization claim and for additional covers, if any. Date: Place: Signature of the Insured: Please send this duly filled and signed claim form to our TPA at below address: Family Health Plan Insurance TPA Limited Srinilaya - cyber spazio suite, 101,102,Ground Floor, Road No. 2, Banjara Hills, Hyderabad, Telangana 500034 GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled in by the insured) DATA ELEMENT **DESCRIPTION FORMAT** SECTION A - DETAILS OF PRIMARY INSURED Enter the policy number a) Policy No. As allotted by the insurance company b) SI. No/ Certificate No. Enter the social insurance number or the certificate As allotted by the organisation number of social health insurance scheme 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 / Indicate whether currently covered by another Tick Yes or No Health Insurance? Mediclaim / Health Insurance Name of the organisation in full b) i. Company Name Enter the full name of the insurance company As allotted by the insurance company b) ii. Policy No. Enter the policy number c) Date of Commencement of first Insurance Enter the date of commencement of first Use dd-mm-yy format without break insurance d) Sum Insured Enter the total sum insured as per the policy In rupees Have you been Hospitalised in the last four years Indicate whether hospitalised in the last four years Tick Yes or No since inception of the contract? f) Date Enter the date of hospitalisation Use mm-yy format g) Diagnosis Enter the diagnosis details Open Text Indicate whether previously covered by another h) Previously Covered by any other Mediclaim/ Tick Yes or No Health Insurance? Mediclaim / Health Insurance i) Company Name Enter the full name of the insurance company Name of the organisation in full

CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT - PART A TO BE FILLED IN BY THE INSURED





GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled in by the insured)									
DATA ELEMENT	DESCRIPTION	FORMAT							
SECTI	ON C - DETAILS OF INSURED PERSON HOSPIT	ALIZED							
a) Name	Enter the full name of the patient	Surname, First name, Middle name							
b) Gender	Indicate gender of the patient	Tick Male or Female							
c) Age	Enter age of the patient	Number of years and months							
d) Date of Birth	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							
f) Address	Enter the full postal address	Include Street, City and Pin Code							
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							
g) Occupation	Indicate occupation of patient	Tick the right option. If others, please specify							
i) Address of the Employer	Complete address of the employer of the Insured	Include Street, City and Pin Code							
SECTION E	- DETAILS OF HOSPITALISATION FOR CLAIM I	BEING FILED							
a) Name of hospital where admitted	Enter the name of hospital	Name of hospital in full							
b) Room category occupied	Indicate the room category occupied	Tick the right option							
c) Hospitalisation due to	Indicate reason of hospitalisation	Tick the right option							
d) 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							
f) Time	Enter time of admission	Use hh:mm format							
g) Date of discharge	Enter date of discharge	Use dd-mm-yy format							
h) Time	Enter time of discharge	Use hh:mm format							
i) In case of maternity									
I. Date of delivery	Enter date of delivery	Use dd-mm-yy format							
ii. Gravida Status	Enter Gravida Status	Use standard format							
j) If Injury give cause	Indicate cause of injury	Tick the right option							
i. If Medico Legal	Indicate whether injury is Medico Legal	Tick Yes or No							
ii. Reported to Police	Indicate whether police report was filed	Tick Yes or No							
iii. MLC Report & Police FIR attached	Indicate whether MLC report and Police FIR attached	Tick Yes or No							
k) System of Medicine	Enter the system of medicine followed in treating the patient	Open Text							
	SECTION E - DETAILS OF CLAIM								
a) Details of Treatment Expenses	Enter the amount claimed as treatment expenses	In rupees (Do not enter paise values)							
b) Claim for Domiciliary Hospitalisation	Indicate whether claim is for domiciliary hospitalization	Tick Yes or No							
c) 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								
Indicate which bills are enclosed with the amounts	in rupees								
SECTION	n G - Details of Primary Insured's Bank A	CCOUNT							
a) PAN	Enter the permanent account number	As allotted by the Income Tax department							
b) Account Number	Enter the bank account number	As allotted by the bank							
c) Bank Name and Branch	Enter the bank name along with the branch	Name of the Bank in full							
d) IFSC Code	Enter the IFSC code of the bank branch	IFSC code of the bank branch in full							
	SECTION H - DECLARATION BY THE INSURED								
Road declaration carefully and mention date (in d									
Read declaration carefully and mention date (in d	u-mm-yy tormat), piace (open text) and sign.								



The issuance of this Form is not to be taken as an admission of liability Please include the original pre-authorisation request form in lieu of PART A

Toll Free No. 1800 266 3202

SEC	CTION A - DETAILS	OF F	HOSE	PITA	L (To	be	fille	d in	blo	ock	lette	ers))																			
a) N	lame of the hospital:																															
b) H	lospital ID:											c)	Тур	е	of H	losp	ital	: [Net	lwo	rk [No	n-l	Vetv	vor	k (Fo	or c	office	use	only)
d) N	lame of the treating c	doctor	:																													
e) G	Qualification:																															
f) Re	egistration No. with St	tate C	ode:																g) Ph	non	e No	0.:									
SE	CTION B - DETAILS	S OF	THE	PAT	IENT	ΓΑΙ	DMIT	TED)																							
a) N	lame of the Patient:		Т	П	Т	Т	П	T	Т	T						П										П				П	T	Т
b) IF	Registration Number	: 🗔		H	i	Ì		İ	Ì	i]	c)	Ge	end	er:				М	ale	_	П	Fe	mal	e	
d) A	ge:		Ye	ears			Мо	nths		-							1	e)	Do	ate (of b	irth	:	D	D	M	M	Υ	Υ	Υ	Υ	
f) Do	ate of Admission:	D [D M	M	ΥΥ	Y	Υ											g)	Tir	ne:				Н	Н	: N	۱ ۸	A				
h) D	ate of Discharge:	D	D M	M	ΥΥ	Y	Υ											i)	Tir	ne:				Н	Н	: N	\ \	Λ				
j) Ty	pe of Admission:		Emer	genc	у	T	Pla	nnec	1		Do	ау (Car	е			Mo	atei	rnit	У								_				
k) If	Maternity:	i. Do	ate of	Deli	very	. D	D	M M	Y	Υ	Υ	Υ]				,	ii.	Gr	avi	da :	Stati	us:									
I) Sto	atus at time of discha	rge:	Di	ischo	ırge	to h	ome	Ė	70	isch	arg	e to	o ar	not	her	hos	spito	lc			D	ecec	ase	d								
m) T	otal amount claimed	: 🔲						Ī																								
SE	CTION C - DETAIL	s of	AIL۸	ΛEN	T DI	AG	NOS	ED	(PR	IMA	\RY)																				
a)		ICD	10 C	odes	5		De	scrip	otio	n			а)							ICE) 10) P(CS (Со	des)es	cript	ion	
1	Primary Diagnosis:												1		Proc	cedu	re 1	:														
2	Additional Diagnosis:												2		Proc	cedu	re 2	:														
3	Co-morbidities:												3		Proc	cedu	re 3	:														
4	Co-morbidities:												4		Det	ails (of Pr	oce	edur	e:												
c) W	hether pre-authorisa	tion o	btain	ed:		Ye	s	No)	d) If `	Yes,	, pr	e-c	auth	oris	atic	n l	Vur	nbe	er:						_					
e) If	authorisation by netv	vork h	ospit	al no	ot ob	tain	ed, g	ive r	eas	son:																						
f) H	ospitalisation due to i	njury:		Yes	5		10 I	f Yes	, gi	ive c	aus	e:																				
		i.	Sel	f-infl	icted			Roac	d Tro	affic	Aco	cide	ent			Sub	star	ice	ab	use	/ 0	Ilcol	nol	cor	ารบ	mpt	ion	. [Oth	ner	
		ii. If I	Injury	due	to su	bstc	ince o	abuse	e / c	alcoh	nol d	ons	sum	pti	on,	test	con	duc	ted	to	estc	ıblisl	h th	is:		Ye	S		No)		
		(If Ye	es, att	tach	repo	rts)																										
		iii. If	Med	ico L	.egal	:	Yes			10		iv.	. Re	ро	rtec	d to	the	ро	lice	e: [Yes	6		N	0						
		v. FIF	R No.	.:								vi.	. If	no	t rep	port	ed t	o t	he	pol	ice,	give	e re	eas	on:							
																											—					
g) W	hen did the patient s							nt:	_			_	_		_												—	—				
			of fi					D	D	M	M)	Y)	Υ \	Y	Υ																	
	lease give previous m									16 113 4								_		_	_						—	—		—		
I) Is	the patient suffering f	from c	any o	t the	tollo	owin	ig dis	ease	s ¢	It "Ye	es" h	'lea	ise					luro	atio	n b	elo	W.					_		_	_		
_														Υ	es /	' No							[Dur	atio	n in	yec	ır &	mo	nths		
1	High or low blood pro disorder	essure,	, chest	t pair	n, or	any	other	cardi	ac																							
2	Tuberculosis, asthma, disorder	, bronc	chitis c	or any	y othe	er lu	ng / r	espir	ator	У																						
3	Ulcer (stomach / duo			or go	all blo	adde	er disc	rder	or																							
4	Kidney failure, stone i	in kidn	ey or					te																								
5	Stroke, epilepsy (fits), (brain, spinal cord, et	paraly	sis or					yster	n																							

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		Yes / No Duration in year & months
6	Diabetes, Impaired glucose tolerance (Pre-diabetes), Thyroid/Pituitary Disorder or any other endocrine disorder	
7	Tumor (swelling)-benign or malignant, any external ulcer / growth / cyst / mass anywhere in the body	
8	Arthritis, spondylosis or any other disorder of the muscle / bone / joint	
9	Diseases of the ear / nose / throat / teeth / eye (please mention dioptres in case of refractory error)	
10	HIV / AIDS or sexually transmitted diseases or any immune system disorder	
11	Anaemia, leukaemia, lymphoma or any other blood / lymphatic system disorder	
12	Psychiatric / mental illnesses or sleep disorder	
13	Uterine fibroid, fibroadenoma breast or any other gynaecological (female reproductive system) / breast disorder	
14	Any other illness or injury not mentioned above (other than common cold)	
If Yes h) His	the ailment a complication / sequel of a pre-existing disease o , please give details: story of alcoholism Yes No If yes: No of years: story of smoking / tobacco chewing: Yes No If Yes	Quantity consumed per day No of years: Units consumed per day
SEC	CTION D - CLAIM DOCUMENTS SUBMITTED - CHECK	LIST
	Claim Form duly signed	Investigation reports
Н	Original pre-authorisation request	CT/MR/USG/HPE investigation reports
$\frac{\square}{\square}$	Copy of the pre-authorisation approval letter	Doctor's reference slip for investigation
	Copy of photo ID card of patient verified by hospital	ECG
\vdash	Hospital discharge summary	Pharmacy bills
$\frac{\square}{\square}$	Operation theatre notes	MLC report & Police FIR
\blacksquare	Hospital main bill	Original death summary from hospital where applicable
Ш	Hospital break-up bill	Other, please specify
SEC	CTION E - ADDITIONAL DETAILS IN CASE OF NON-NET	WORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)
a) Ad	dress of the hospital:	
City:		State:
Pinco	de: b) Phone No:	
c) Reg	gistration No. with State Code:	d) Hospital PAN:
e) Nu	umber of Inpatient beds:	
	cilities available in the hospital: i. OT: Yes No ii. IC	U: Yes No iii. Round the clock Doctor / Nurses: Yes No
,	iv. Maintains daily record of po	
SEC	CTION F - DECLARATION BY THE HOSPITAL (PLEASE R	EAD VERY CAREFULLY)
		n is true & correct to the best of our knowledge and belief. If we have naterial fact, our right to claim under this claim shall be forfeited.
Date:		
Place		Signature and Seal of the Hospital Authority:
	ease send this duly filled and signed claim form to our TPA at be mily Health Plan Insurance TPA Limited	low address:

Srinilaya - cyber spazio suite, 101,102,Ground Floor, Road No. 2, Banjara Hills, Hyderabad, Telangana 500034

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Authorisation Letter (Mandatory)		Date: D D M M Y Y Y
From:		
To: The Manager / Medical Superintendent, Medical	al Records	
Dear Sir		
	Reg: Authorisation Letter.	
Name of the Patient:		
IP Number	(First admission) in	Hospit
IP Number	(Second admission) in	Hospit
IP Number	(Third admission) in	Hospit
hospital and share copies of indoor case sheets		ervice Providers to seek medical information from your meet / obtain statement from the Medical Practition to to
Thanking you,		
Yours sincerely,		
Signature of the Proposer		Signature of the Patient

DATA ELEMENT	DESCRIPTION	FORMAT
DATA ELEMENT		FORMAI
	SECTION A - DETAILS OF HOSPITAL	
a) Name of Hospital	Enter the name of hospital	Name of 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
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 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
	SECTION B - DETAILS OF THE PATIENT ADMITTE	ED
a) Name of Patient	Enter the name of hospital	Name of hospital 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 admission	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	Tick the right option	Tick the right option
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 amount claimed	Indicate the total amount claimed	In rupees (Do not enter paise values)

The issuance of this Form is not to be taken as an admission of liability Please include the original pre-authorisation request form in lieu of PART A



SECTION C - DETAILS OF AILMENT DIAGNOSED (PRIMARY) a) ICD 10 Code Primary Diagnosis Enter the ICD 10 Code and description of the primary diagnosis Additional Diagnosis Enter the ICD 10 Code and description of the combidities Enter the ICD 10 Code and description of the combidities Enter the ICD 10 PCS and description of the combidities Procedure 1 Enter the ICD 10 PCS and description of the first procedure Procedure 2 Enter the ICD 10 PCS and description of the second procedure Procedure 3 Enter the ICD 10 PCS and description of the second procedure Procedure 3 Enter the ICD 10 PCS and description of the second procedure Procedure 3 Enter the ICD 10 PCS and description of the second procedure Procedure 3 Enter the ICD 10 PCS and description of the second procedure Procedure 3 Enter the ICD 10 PCS and description of the second procedure Procedure 3 Enter the ICD 10 PCS and description of the second procedure Procedure 3 Enter the details of the procedure Open text Open text Indicate the there pre-outhorisation obtained Indicate whether pre-outhorisation obtained Indicate if hospitalisation is due to injury Indicate if hospitalisation is due to injury Indicate whether injury is Medico Legal Indicate whether relative police report was filed Indicate whether police report was filed Indicate whether procedure second procedure Open text Indicate whether police report was filed Indicate whether procedure second procedure Open text Indicate whether procedure second procedure Open text Indicate whether procedure second procedure Indicat	GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled in by the Insured)				
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morbidities Procedure 1 Procedure 2 Procedure 2 Enter the ICD 10 PCS and description of the first procedure Procedure 3 Procedure 3 Procedure 3 Procedure 3 Procedure 3 Procedure 4 Procedure 3 Procedure 5 Procedure 5 Procedure 6 Procedure 7 Procedure 8 Procedure 8 Procedure 9 Proced	Additional Diagnosis		Standard format and open text		
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e) Fre-authorisation Number e) If authorization by network hospital not obtained, give reason f) Hospitalization due to injury Cause Indicate if hospitalisation is due to injury Cause Indicate ause of injury Tick Yes or No Tick Yes or No Indicate substance abuse / alcohol consumption, test conducted to establish this Medica Legal Reported To police Indicate whether injury is Medica Legal Tick Yes or No Tick Yes or No Reported To police Indicate whether police report was filed Tick Yes or No Enter first information report number As issued by police authorities If not reported to the police, give reason Indicate whether best conducted 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 authorities If not reported to the police, give reason Indicate the date when the symptom / complaint Previous medical history To Specific diseases Tick Yes or No Indicate the date when the symptom / complaint Previous medical history To Specific diseases Tick Yes or No Indicate Whether present ailment is a complication of pre-existing diseases Indicate Whether present ailment is a complication of pre-existing diseases Indicate Whether present ailment is a complication that existed prior to policy inception Open text SECTION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST Indicate which supporting documents are submitted. SECTION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST Indicate which supporting documents are submitted. SECTION D - DECLAIM DOCUMENTS OF NON-NETWORK HOSPITAL As alloted by the Medical Council of India with the state code Present the registration number of the doctor along with the state code The registration number of inpatient beds Tick the right option. If others, please specify SECTION F - DECLARATION BY THE HOSPITAL Indicate Hospital Indicate the hospital Tick the right option. If others, please specify		·	Open text		
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obtained, give reason f) Hospitalization due to injury f) Hospital	d) Pre-authorisation Number	Enter pre-authorisation number	As allotted by TPA		
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If injury due to substance abuse / alcohol consumption, test conducted to establish this 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 authorities If not reported to the police, give reason Enter reason for not reporting to the police Open text Government of the police open text Indicate whether present ailment is a complication of pre-existing diseases Indicate whether present ailment is a complication of pre-existing diseases Indicate whether present ailment is a complication that existed prior to policy inception Indicate Yes or No. If 'yes' state quantity consumed 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 Enter the full postal address Enter the full postal address Enter the pone number of hospital Include STD code with telephone number As allocated by the Medical Council of India with the state code d) Hospital PAN Enter the Permanent Account Number As allotted by the Income Tax department Enter the number of inpatient beds Includes Tick Yes or No. If others, please specify SECTION F - DECLARATION BY THE HOSPITAL Tick Yes or No.	f) Hospitalization due to injury		Tick Yes or No		
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If not reported to the police, give reason Enter reason for not reporting to the police Open text Use dd-mm-yy format Open text	Reported To police	Indicate whether police report was filed	Tick Yes or No		
Indicate the date when the symptom / complaint Use dd-mm-yy format	FIR No.	Enter first information report number	As issued by police authorities		
Enter the medical history i) Specific diseases State Yes or No Duration should be in years and months Complication of pre-existing diseases Indicate whether present ailment is a complication that existed prior to policy inception Indicate Yes or No. If 'yes' state quantity consumed Open text Open text Open text Open text Open text 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 Diploma No. Enter the full postal address Include Street, City and Pin Code Enter the phone number of hospital Include STD code with telephone number Registration No. with State Code Enter the registration number of the doctor along with the state code (d) Hospital PAN Enter the Permanent Account Number As allocated by the Medical Council of India with the state code Enter the number of inpatient beds First the number of inpatient beds Enter the number of inpatient beds Enter the number of inpatient beds First the number of inpatie	If not reported to the police, give reason	Enter reason for not reporting to the police	Open text		
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complication that existed prior to policy inception k) Alcoholism Indicate Yes or No. If 'yes' state quantity consumed 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 Both Phone No. Enter the phone number of hospital C) Registration No. with State Code Both Hospital PAN Enter the Permanent Account Number Enter the number of Inpatient beds Enter the number of inpatient beds Enter the number of inpatient beds Facilities available at the hospital Indicate facilities available at the hospital Tick the right option. If others, please specify SECTION F - DECLARATION BY THE HOSPITAL	i) Specific diseases	State Yes or No	Duration should be in years and months		
Smoking of tobacco	j) Complication of pre-existing diseases		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 b) Phone No. Enter the phone number of hospital Include STD code with telephone number c) Registration No. with State Code Enter the registration number of the doctor along with the state code d) Hospital PAN Enter the Permanent Account Number As allotted by the Income Tax department e Number of Inpatient beds Enter the number of inpatient beds Digits Facilities available at the hospital Tick the right option. If others, please specify SECTION F - DECLARATION BY THE HOSPITAL	k) Alcoholism	Indicate Yes or No. If 'yes' state quantity consumed	Open text		
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Enter the number of inpatient beds Enter the number of inpatient beds Digits Indicate facilities available at the hospital SECTION F - DECLARATION BY THE HOSPITAL	c) Registration No. with State Code		As allocated by the Medical Council of India		
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SECTION F - DECLARATION BY THE HOSPITAL	e Number of Inpatient beds	Enter the number of inpatient beds	Digits		
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		SECTION F - DECLARATION BY THE HOSPITAL			
read the decidration carefully and mention date (in datinmtyy format), place (open text) and sign and stamp					
	Read the decidration carefully and mention adie (ii	r da.m.n.yy formarj, piace (open fext) and sign and si	ump		