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

TO BE FILLED BY THE INSURED
The issue of this Form is not to be taken as an admission of liablity

(To be Filled in block letters)

DETAILS OF PRIMARY INSURED:					
a) Policy No.:					
c) Company/ TPA ID No:					
d) Name: SURNAME FIRST NAME MIDDU	SECOND SECTION A				
e) Address:					
City: State: Sta					
Pin Code Phone No: Email ID:					
DETAILS OF INSURANCE HISTORY:					
a) Currently covered by any other Mediclaim / Health Insurance: Yes No b) Date of commencement of first Insurance without break: D D M M					
c) If yes, company name: Policy No. Policy No. Sum insured (Rs.) About the last four years since inception of the contract? Yes No	Date: M M Y Y				
Diagnosis: e) Previously covered by any other Mr f) If yes, company name:	edicialii / Healti insurance				
DETAILS OF INSURED PERSON HOSPITALIZED: :					
a) Name:	_				
e) Relationship to Primary insured: Self Spouse Child Father Mother Other (Please Specify)					
f) Occupation Service Self Employed Home Maker Student Retired Other (Please Specify)	SECTION SECTION				
g) Address (if diffrent from above) :					
City:					
Pin Code Phone No: Phone No:					
DETAILS OF HOSPITALIZATION:					
a) Name of Hospital where Admited:					
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:	M M Y Y Y Y				
e) Date of Admission: DDD MMM YY Y f) Time HHH MMH g) Date of Discharge: DD MMM Y	M M Y Y Y Y y h) Time: H H : M H				
b) If injury give cause: Self inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption Substance Abuse / Alcohol Consumption Version Vers					
I) If injury give cause: Self inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption I) If Medico legal	Yes No				
I) If injury give cause: Self inflicted	Yes No				
	Yes No				
ii) Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine: DETAILS OF CLAIM:	Yes No				
ii) Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine: DETAILS OF CLAIM:	Yes No No No No No No				
ii) Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine: DETAILS OF CLAIM: a) Details of the Treatment expenses claimed I. Pre -hospitalization expenses Rs.	laim Documents Submitted - Check List: Claim form duly signed Copy of the claim intimation, if any				
ii) Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine: DETAILS OF CLAIM: a) Details of the Treatment expenses claimed I. Pre -hospitalization expenses Rs.	laim Documents Submitted - Check List: Claim form duly signed Copy of the claim intimation, if any Hospital Main Bill				
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ii) Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine: DETAILS OF CLAIM: a) Details of the Treatment expenses claimed	Yes No				
ii) Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine:	Yes No				
ii) Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine:	Yes No No No No No No No N				
ii) Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine:	Yes No No No No No No No N				
iii. MLC Report & Police FIR attached Yes No j) System of Medicine: DETAILS OF CLAIM: a) Details of the Treatment expenses claimed I. Pre -hospitalization expenses Rs.	Yes No No				
ii) Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine:	Yes No No				
iii. MLC Report & Police FIR attached Yes No j) System of Medicine: DETAILS OF CLAIM: a) Details of the Treatment expenses claimed I. Pre -hospitalization expenses Rs.	Yes No No No No No No No N				
ii) Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine: DETAILS OF CLAIM: a) Details of the Treatment expenses claimed I. Pre -hospitalization expenses Rs. ii. Hospitalization expenses Rs. iv. Health-Check up cost: Rs. iv. Others (code): Rs. Total Rs. Rs. iii. Post -hospitalization period: days viii. Post -hospitalization period: days viiii. Post -hospitalization period: days viiii. Post -hospitalization period: days viiii. Po	Yes No No No No No No No N				
ii) Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine: DETAILS OF CLAIM: a) Details of the Treatment expenses claimed I. Pre -hospitalization expenses Rs. ii. Hospitalization expenses Rs. iii. Hospitalization expenses Rs. iv. Health-Check up cost: R	Yes No No No No No No No N				
ii) Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine: DETAILS OF CLAIM: a) Details of the Treatment expenses claimed Pre-hospitalization expenses Rs. ii. Hospitalization expenses Rs. iii. Hospitalization period: Rs. iii. Others (code): Rs. iii. Post-hospitalization period: days iii. Post-hospitalization period: days iii. Post-hospitalization period: days iii. Surgical Cash: Rs. iii. Surgical Cash: Iii. Surgical Cash: Iii. Surgical Cash:	Yes No No No No No No No N				
ii) Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine: DETAILS OF CLAIM: a) Details of the Treatment expenses claimed . Pre -hospitalization expenses Rs.	Yes No No No No No No No N				
In Reported to Police	Yes No No No No No No No N				
In Reported to Police	Yes No No No No No No No N				
iii. MLC Report & Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine: DETAILS OF CLAIM: a) Details of the Treatment expenses claimed I. Pre -hospitalization expenses Rs.	Yes No No No No No No No N				
III. MLC Report & Police III. MLC Report & Police FIR attached Yes No j) System of Medicine:	laim Documents Submitted - Check List: Claim form duly signed Copy of the claim intimation, if any Hospital Main Bill Hospital Break-up Bill Hospital Bill Payment Receipt Hospital Discharge Summary Pharmacy Bill Operation Theater Notes ECG Doctor's request for investigation Investigation Reports (Including CT / MRI / USG / HPE) Doctor's Prescriptions Others Amount (Rs)				
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III. MLC Report & Police III. MLC Report & Police FIR attached Yes No j) System of Medicine:	Yes No No				

SECTION H

I hereby declare that the information furnished in the claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealent of any material fact with respect to questions asked in relation to this claim, my right to claim reimbrusement shall be forfeited, I also consent & authorize TPA / Insurance Company, to seek necessary medical information / documents from any hospital / Medical Practitioner who has attended on the person against whom this claim is made. I hereby declare that I have included all the bills / receipts for the purpose of this claim & that I will not be making any supplementary claim except the pre/post-hospitalization claim, if any.

Date D D	M	YYYY	Place:		Signature of 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
))	SI. No/ Certificate No.	Enter the social Insurance number or the certificate number of social health insurance scheme	As allotted by the oraganization
:)	Company TPA ID No.	Enter the TPA ID No.	Licence number as allotted by IRDA and print in TPA documents.
i)	Name	Enter the full name of the policyholder	Surname, First name, Middle name
)	Address	Enter the full postal address	Include Street, City and Pin code
		SECTION B -DETAILS OF INSURANCE HISTORY	
)	Currently covered by any other Mediclaim / Health Insurance?	Indicate whether currently covered by another Mediclaim / Health Insurance	Tick Yes or No
)	Date of commencement of first Insurance without break	Enter the date of commencement of first Insurance	Use dd-mm-yy-forrmat
)	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
)	Have you been Hospitalized in the last four years since Inception of the contract?	Indicate whether hospitalized in the last four years	Tick Yes or No
	Date	Enter the date of Hospitalization	Use mm-yy format
_	Diagnosis	Enter the diagnosis details	Open Text
)	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
	SEC	TION C -DETAILS OF INSURED PERSON HOSPITALIZED	
)	Name	Enter the full name of the patient	Surname, First name, Middle name
<u>/</u>)	Gender	Indicate Gender of the patient	Tick Male or Female
<u>/</u>)	Age	Enter age of the patient	Number of years and months
)	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 specify
_	Occupation Occupation	indicate occupation of patient	Tick the right option. If others, please specify.
)	Address	Enter the full postal address	Include Street, City and Pin code
<u>,</u>)	Phone No	Enter the phone number of patient	Include STD code with telephone number
)			Complete e-mail address
)	E-mail ID	Enter e-mail address of patient SECTION D - DETAILS OF HOSPITALIZATION	Complete e-mail address
`	Name of Hospital where admited		Name of booking in full
1)	· · · · · · · · · · · · · · · · · · ·	Enter the name of hospital	Name of hospital in full Tick the right option
_	Room category occupied	indicate the room category occupied	Tick the right option
)	Hospitalization due to Date of injury/Date Disease first detected / Date of Delivery	indicate reason of hospitalization Enter the relevant date	Use dd-mm-yy format
:)	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
)	Time	Enter time of discharge	Use hh-mm- format
,	If injury give cause	indicate cause of injury	Tick the right option
	If Medico legal	indicate whether injury is medico legal	Tick Yes or No
	Reported to Police	indicate whether police report was filed	Tick Yes or No
	MLC Report & Police FIR attached	indicate whether MLC report and Police FIR attached	Tick Yes or No
,	System of Medicene	Enter the system of medicine followed in treating the patient	Open Text
		SECTION E - DETAILS OF CLAIM	
)	Details of Treatment Expences	Enter the amount claimed as treatment expences	In rupees (Do not enter paise values)
)	Claim for Domiciliary Hospitalization	indicate whether claim is for domiciliary hospitalization	Tick Yes or No
<i>)</i>)	Details of Lump sum/ Cash benifit claimed	Enter the amount claimed as lump sum / cash benefit	In rupees (Do not enter paise values)
)	Claim documents Submitted-Check List	indicate which supporting documents are submitted	Tick the right option
_		SECTION F - DETAILS OF BILLS ENCLOSED	
ıdi	cate which bills are enclosed with the amount in rupees	<u> </u>	
		ON G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT	
	PAN	Enter the permanent account number	As allotted by the Income Tax Department
_	Account Number	Enter the Bank account number	As allotted by the Bank
_		Enter the Bank name along with the branch	Name of the Bank in full
a) o)	Bank Name and Branch	5	
)		Enter the name of the beneficiary the cheque / DD should be made out to	Name of the individual / organization in full
)	Bank Name and Branch	Enter the name of the beneficiary the cheque / DD should be	Name of the individual / organization in full IFSC code of the Bank branch in full