GENERAL INSURANCE

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CLAIM FORM - PART B

(To be filled in BLOCK LETTERS)

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 preauthorization request form in lieu of PART A

SECTION A - DETAILS OF HOSPITAL

a) Name of the Hospital

b) Hospital ID

c) Type of Hospital ☐ Network ☐ Non Network (if non network fill section E)

d) Name of the treating doctor

e) Qualification

f) Registration No with state code g) Phone No

I) Email Id:

SECTION B - DETAILS OF PATIENT ADMITTED

a) Name of the patient

b) IP Registration Number

c) Gender ☐ Male ☐ Female c) Age - ___________ years __________Months d) Date of birth d d m m y y y y

e) Date of Admission d d m m y y y y g) Time H H M M

h) Date of Discharge d d m m y y y y i) Time H H M M

j) Type of admission ☐ Emergency ☐ Planned ☐ Day care ☐ Maternity

k) If Maternity: i) Date of Delivery d d m m y y y y ii) Gravida Status

l) Status at time of discharge ☐ Discharge to home ☐ Discharge to another hospital ☐ Deceased

m) Total claimed amount ₹ /-

SECTION C - DETAILS OF AILMENT DIAGNOSED (PRIMARY) - Part A

S.No	ICD 10 Codes	Description
1	Primary Diagnosis	
2	Additional Diagnosis	
3	Co-morbidities	
4	Co-morbidities	

SECTION C - DETAILS OF AILMENT DIAGNOSED (PRIMARY) - Part B

S.No	ICD 10 PCS	Description
1	Procedure 1	
2	Procedure 2	
3	Procedure 3	
4	Details of procedure	

c) Pre - authorization obtained ☐ Yes ☐ No

d) Pre - authorization number

e) If authorization by network hospital not obtained, give reason

f) Hospitalization due to injury ☐ Yes ☐ No

i. If Yes, give cause ☐ Self inflicted ☐ Road traffic accident ☐ Substance abuse/alcohol consumption

ii. If injury due to Substance abuse/alcohol consumption, Test conducted to establish this ☐ Yes ☐ No (If Yes, attach reports)

iii. If Medico Legal ☐ Yes ☐ No iv. Reported to police ☐ Yes ☐ No

v. FIR No vi. If not reported to police , give reason

SECTION D - CLAIM DOCUMENTS SUBMITTED - CHECK LIST

S.No	Documents	S.No	Documents
1	☐ Claim form duly signed	9	☐ Investigation reports
2	☐ Original pre authorization request	10	☐ CT/MRI/USG/HPE investigation reports
3	☐ Copy of pre - authorization approval letter	11	☐ Doctor's reference slip for investigation
4	☐ Copy of photo ID card of patient verified by hospital	12	☐ ECG
5	☐ Hospital discharge summary	13	☐ Pharmacy bills
6	☐ Operation theatre notes	14	☐ MLC report & police FIR
7	☐ Hospital main bill	15	☐ Original death summary from hospital where applicable
8	☐ Hospital break up bill	16	☐ Any other, please specify

SECTION E - DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON NETWORK HOSPITAL)

a) Address of the Hospital

City State Pin Code

b) Phone No c) Registration No with state code

d) Hospital PAN e) Number of Inpatients bed

f) Facilities available in the hospital i) OT ☐ Yes ☐ No ii) ICU ☐ Yes ☐ No iii) Others

SECTION F - DECLARATION BY THE HOSPITAL

We hereby declare that the information furnished in the claim form is true & correct to the best of my 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 d d m m y y y y Place ____________ Signature & Seal of Hospital Authority ____________