National Insurance Company Limited

Regd. Office 3, Middleton Street, Post Box 9229, Kolkata 700 071

National Mediclaim Policy

PLEASE FAX / SCAN PAGE 1 ONLY

REQUEST FOR CASHLESS HOSPITALISATION FOR MEDICLAIM INSURANCE POLICY

(To be filled in block letters)

DETAILS OF THE THIRD PARTY ADMINISTRATOR

a) Name of TPA / Insurance Company:
b) Toll free phone number:
c) Toll free Fax:

TO BE FILLED BY THE INSURED / PATIENT

a) Name of the patient:

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38

b) Gender : Male Female c) Age: years months d) Date of Birth:

e) Contact number: f) Insured card ID number:

g) Policy number / Name of corporate: h) Employee ID:

i) Currently do you have any other Mediclaim / Helath Insurance: Yes No Company Name:

Give details:

j) Do you have a family physician? Yes No k) Name of the family physician:

l) Contact number, if any: (PLEASE COMPLETE DECLARATION ON THE REVERSE SIDE OF THIS FORM)

TO BE FILLED BY THE TREATING DOCTOR / HOSPITAL

a) Name of the treating doctor: b) Contact number:

c) Nature of illness/ disease with presenting complaints d) Relevant clinical findins:

e) Duration of the present ailment: Days i. Date of first consultation: ii. Past history of present ailment, if any

f) Provisional diagnosis: i. ICD 10 Code

g) Proposed line of treatment: Medical Management Surgical Management Intensive Care Investigation Non allopathis Treatment

h) If investigation & / or Medical Management, provide details i. Route of drug administration:

i) If Surgical, name of surgery: i. ICD 10 PCS Code

j) If other treatments, provide details k) How did the injury occur?

l) In case of accident: i. Is it RTA? Yes No ii. Date of injury: iii. Reported to Police: Yes No iv. FIR No.:

v. Injury / Disease caused due to substance abuse / alcohol consumption: Yes No vi. Test conducted to extablish this? Yes No (If yes attach reports)

m) In case of maternity: G P L A Date of Delivery:

Details of the patient admitted

a) Date of admission: b) Time: :

c) Is this an emergency / a planned hospitalization event? Emergency Planned

d) Expected no. of days in hospital: Days e) Room Type:

f) Per Day Room Rent + Nursing & Service Charges + Patient's Diet: ₹

g) Expected cost of investigation + diagnostics: ₹

h) ICU Charges: ₹

i) OT Charges: ₹

j) Professional fees Surgeon + Anesthetist Fees + consultation charges: ₹

k) Medicines + Consumables + Cost of implants (if applicable, please specify), other hospital expenses, if any: ₹

l) All inclusive package charges, if any applicable: ₹

m) Sum Total, expected cost of hospitalization: ₹

Mandatory : Past history of any chronic illness — **If Yes, since (month / year)**

Diabetes
Heart Disease
Hypertension
Hyperlipidemia
Osteoarthritis
Asthma / COPD / Bronchitis
Cancer
Alcohol or drug abuse
Any HIV or STD / Related ailments

Any other Ailment, give details:

(PLEASE READ VERY CAREFULLY)

DECLARATION

We confirm having read, understood and agreed to the Declaration on the reverse of this form

a) Name of the treating doctor:

b) Qualification: c) Registration No. with state code:

Hospital Seal (must contain hospital ID) Patient / Insured Name & Signature

(IMPORTANT: PLEASE TURN OVER)

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DECLARATION BY THE PATIENT / REPRESENTATIVE

1. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Insurer/T.P.A after the discharge. I agree to sign on the Final Bill & the Discharge Summary, before my discharge.

2. Payment to hospital is governed by the terms and conditions of the policy. In case the Insurer / TPA is not liable to settle the hospital bill, I undertake to settle the bill as per the terms and conditions of the policy.

3. All non-medical expenses and expenses not relevant to current hospitalization and the amounts over & above the limit authorized by the Insurer/T.P.A not governed by the terms and conditions of the policy will be paid by me. In case any clarification is needed on admissibility of a particular item I shall contact T.P.A at the Toll Free Number on the reverse of this form.

4. I hereby declare to abide by the terms and conditions of the policy and if at any time the facts disclosed by me are found to be false or incorrect I forfeit my claim and agree to indemnify the Insurer / T.P.A

5. I agree and understand that T.P.A is in no way warranting the service of the hospital & that the Insurer / TPA is in no way guaranteeing that the services provided by the hospital will be of a particular quality or standard.

6. I hereby warrant the truth of the forgoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppression or concealment, my right to claim reimbursement of the said expenses shall be absolutely forfeited. I further declare that, in respect of the above treatment, no benefits are admissible under any other Medical Scheme or Insurance

7. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer / TPA.

a) Patient's / Insured's Name: ______________________________

b) Contact number: ______________________ **d) Patient's / Insured's Signature:** ______________________

HOSPITAL DECLARATION

1. We have no objection to any authorized TPA / Insurance Company official verifying documents pertaining to hospitalization.

2. All valid original documents duly countersigned by the insured / patient as per the checklist below will be sent to TPA / Insurance Company within 7 days of the patient's discharge.

3. All non medical expenses , OR expenses not relevant to hospitalization or illness, OR expenses disallowed in the Authorization Letter of the TPA / Insurance Co, OR arising out of incorrect information in the pre-authorisation form will be collected from the patient.

4. WE AGREE THAT TPA / INSURANCE COMPANY WILL NOT BE LIABLE TO MAKE THE PAYMENT IN THE EVENT OF ANY DISCREPANCY BETWEEN THE FACTS IN THIS FORM AND DISCHARGE SUMMARY or other documents.

5. The patient declaration has been signed by the patient or by his representative in our presence.

6. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications.

7. We will abide by the terms and conditions agreed in the MOU.

Hospital Seal **Doctor's Signature**

DOCUMENTS TO BE PROVIDED BY THE HOSPITAL IN SUPPORT OF THE CLAIM

1. Detailed Discharge Summary and all Bills from the hospital

2. Cash Memos from the Hospitals / Chemists supported by proper prescription.

3. Receipts and Pathological Test Reports from Pathologists, supported by note from the attending Medical Practitioner / Surgeon recommending such pathological Tests.

4. Surgeon's Certificate stating nature of operation performed and Surgeon's Bill and Receipt.

5. Certificates from attending Medical Practitioner / Surgeon that the patient is fully cured.

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National Mediclaim Policy

CLAIM FORM - PART A

TO BE FILLED IN BY THE INSURED

The issue of theis form is not to be taken as admission of liability

(To be filled in block letters)

DETAILS OF PRIMARY INSURED

a) Policy no: b) Sl. No/ Certificate No:

c) Company/ TPA ID No:

d) Name:

e) Address:

City: State:

Pin Code: Phone No: Email ID:

SECTION A

DETAILS OF INSURANCE HISTORY

a) Currently covered by any other Mediclaim/ 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 contract? Yes No Date:

Diagnosis: e) Previously covered by any other Mediclaim/ Health Insurance : Yes No

f) If yes, Company Name :

SECTION B

DETAILS OF INSURED PERSON HOSPITALIZED

a) Name :

b) Gender : Male Female d) Date of Birth: e) Sum insured: ₹ i) CB (if any)

f) Relatuionship to Primary Insured: Self Spouse Child Father Mother Other (Please specify)

g) Occupation: Service Self Employed Homemaker Student Retired Other (Please specify)

h) Address (if different from above):

City: State:

Pin Code: Phone No: Email ID:

SECTION C

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:

e) Date of Admission: f) Time: : g) Date of Discharge: h) Time: :

i) If injury, give cause: Self inflicted Road Traffic Accident Substance abuse / Alcohol Consumption i. If Medico Legal: Yes No

ii. Reported to police: Yes No iii. MLC Report & Police FIR attached: Yes No j) System of medicine:

SECTION D

DETAILS OF CLAIM

a) Details of treatment expenses claimed

i. Pre Hospitalization Expenses ₹ ii. Pre hospitalization period: days

i.Room, boarding, nursing expenses days @ ₹ per day [Limit of 1% of SI per day, max ₹5,000]

ii. ICU, boarding, nursing expenses days @ ₹ per day [Limit of 2% of SI per day, max ₹10,000]

Maximum limit of 25% of SI for any one illness

i. Medical practitioner's fees ₹ Maximum limit of 25% of SI for any one illness

i. Anaesthesia, blood, oxygen, OT ₹

ii. Surgical appliances ₹

iii. Medicines, drugs ₹

iv. Diagnostic test ₹

v. Pacemaker, artificial limbs, stent and imp ₹

vi. Dialysis ₹

vii. Chemotherapy ₹

viii. Radiotherapy ₹

ix. Expense for organ donor's treatment ₹

Maximum limit of 50% of SI for any one illness

x. Ambulance Charges ₹ [Limit of 1% of SI per day, max ₹2,000]

i. Ayurveda and Homeopathy ₹ Maximum limit of 20% of SI for any one illness

i. Post Hospitalization Expenses ₹ ii. Post hospitalization period: days

i. Health Check up Cost ₹

Total claimed amount ₹

Claim Documents Submitted- Check List:

- Claim FormDuly signed
- Copy of the claim intimation, if any
- Hospital Main bill
- Hospital Break-up bill
- Hospital Discharge Summary
- Pharmacy Bill
- Operation Theatre Notes
- ECG
- Doctor's request for investigation
- Investigation Reports (including CT /
- Doctor's Prescription
- Others

SECTION E

DETAILS OF BILLS ENCLOSED

Sl. No.	Bill No.	Date	Issued By	Towards	Amount (₹)
1				Hospital Main Bill	
2				Pre hospitalisation Bills: ___ Nos	
3				Post hospitalisation Bills: ___ Nos	
4				Pharmacy Bills:	
5					
6					
7					
8					
9					
10					

SECTION F

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

a) PAN: b) Account Number:

c) Bank Name and Branch

d) Cheque/ DD Payable details: e) IFSC Code:

SECTION G

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 the insured:

SECTION H

National Insurance Company Limited

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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 social health insurance scheme	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 break	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 since inception of the contract?	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
e) Previously Covered by any other Mediclaim/ Health Insurance?	Indicate whether previously covered by another Mediclaim / Health Insurance	Tick Yes or No
f) Company Name	Enter the full name of the insurance company	Name of the organization in full
SECTION C - DETAILS OF INSURED PERSON HOSPITALIZED		
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) Occupation	Indicate occupation of patient	Tick the right option. If others, please specify.
g) Address	Enter the full postal address	Include Street, City and Pin Code
h) Phone No	Enter the phone number of patient	Include STD code with telephone number
i) E-mail ID	Enter e-mail address of patient	Complete e-mail address
SECTION D - DETAILS OF HOSPITALIZATION		
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) Hospitalization due to	Indicate reason of hospitalization	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) 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
j) 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 Hospitalization	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 G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT		
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) Cheque/ DD payable details	Enter the name of the beneficiary the cheque/ DD should be made out to	Name of the individual/ organization in full
e) IFSC Code	Enter the IFSC code of the bank branch	IFSC code of the bank branch in full
SECTION H - DECLARATION BY THE INSURED		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.		

नेशनल इन्श्योरेन्स
National Insurance

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National Mediclaim Policy

CLAIM FORM - PART B

TO BE FILLED IN BY THE HOSPITAL

The issue of theis form is not to be taken as admission of liability

Please include the original preauthorization request form in lieu of PART A

(To be filled in block letters)

DETAILS OF HOSPITAL

SECTION A

a) Name of the Hospital:

c) 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.

DETAILS OF PATIENT ADMITTED

SECTION B

a) Name of Patient:

b) IP Registration No.: c) Gender : Male ☐ Female ☐ d) Age: years months e) Date of Birth:

f) Date of Admission: g) Time: : h) Date of Discharge: i) Time: :

j) Type of Admission: Emergency ☐ Planned ☐ Day Care ☐ Maternity ☐ k) If Maternity: i. Date of Delivery: ii. Gravida Status:

l) Status at time of discharge: Discharged to home ☐ Discharged to another hospital ☐ Deceased ☐ m) Total claimed amount

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

SECTION C

a) ICD 10 Codes / Description

i. Primary Diagnosis :

ii. Additional Diagnosis :

iii. Co-morbidities :

iv. Co-morbidities :

b) ICD 10 PCS / Description

i. Procedure 1 :

ii. Procedure 2 :

iii. Procedure 3 :

iv. 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 injurydue 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:

CLAIM DOCUMENTS SUBMITTED - CHECKLIST

SECTION D

- ☐ Claim Form duly signed
- ☐ Original Pre-authorization request
- ☐ Copy of the Pre-authorization approval letter
- ☐ Copy of photo ID card of patient verified by hospital
- ☐ Hospital discharge summary
- ☐ Oparation Theatre Notes
- ☐ Hospital main bill
- ☐ Hospital break-up bill
- ☐ Investigation reports
- ☐ CT/ MRI/ USG/ HPE/ Investigation reports
- ☐ Doctor's referance slip
- ☐ ECG
- ☐ Pharmacy bills
- ☐ MLC report & Police FIR
- ☐ Original death summary from hospital, where applicable
- ☐ Any other, please specify

DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON NETWORK HOSPITAL)

SECTION E

a) Address of the hospital:

City: State:

Pin Code: b) Phone No: c) Registration No. with State Code:

d) Hospital PAN e) Number of inpatient beds f) Facilities available in the hospital: i. OT: ☐ Yes ☐ No ii. ICU: ☐ Yes ☐ No

iii. Others:

DECLARATION BY THE HOSPITAL

(Please read very carefully)

SECTION F

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, suppress or concealment of anu material fact, our right to claim under this claim shall be forfeited.

Date:

Place: Signature of the hospital:

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GUIDANCE FOR FILLING CLAIM FORM – PART B (To be filled in by the hospital)		
DATA ELEMENT	**DESCRIPTION**	**FORMAT**
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 nospital	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 ADMITTED		
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 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) Type of Admission	Indicate type of admission of patient	Tick the right option
j) If Maternity		
Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format
Gravida Status	Enter Gravida status if maternity	Use standard format
k) Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
SECTION C – DETAILS OF AILMENT DIAGNOSED (PRIMARY)		
a) ICD 10 Code		
Primary Diagnosis	Enter the ICD 10 Code and description of the primary diagnosis	Standard Format and Open text
Additional Diagnosis	Enter the ICD 10 Code and description of the additional diagnosis	Standard Format and Open text
Co-morbidities	Enter the ICD 10 Code and description of the co-morbidities	Standard Format and Open text
b) ICD 10 PCS		
Procedure 1	Enter the ICD 10 PCS and description of the first procedure	Standard Format and Open text
Procedure 2	Enter the ICD 10 PCS and description of the second procedure	Standard Format and Open text
Procedure 3	Enter the ICD 10 PCS and description of the third procedure	Standard Format and Open text
Details of Procedure	Enter the details of the procedure	Open text
c) Pre-authorization obtained	Indicate whether pre-authorization obtained	Tick Yes or No
d) Pre-authorization Number	Enter pre-authorization number	As allotted by TPA
e) If authorization by network hospital not obtained, give reason	Enter reason for not obtaining pre-authorization number	Open text
f) 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 conducted to establish this	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 authorities
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
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	As allocated by the Medical Council of India
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
f) Facilities available in the hospital	Indicate facilities available in the hospital	Tick the right option. If others, please specify
SECTION F - DECLARATION BY THE INSURED		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.		