



REIMBURSEMENT CLAIM FORM

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

(To be Filled in block letters)

DETAILS OF PRIMARY INSURED:

Form fields for primary insured details including Policy No., Company / TPA ID (MA ID)No., Name, Address, City, State, Pin Code, Phone No., Email ID.

DETAILS OF INSURANCE HISTORY:

Form fields for insurance history including Currently covered by any other Medclaim / Health Insurance, Date of commencement of first Insurance, Previously covered by any other Medclaim / Health insurance.

DETAILS OF INSURED PERSON HOSPITALIZED:

Form fields for insured person hospitalized including Name, Gender, Age years, Date of Birth, Relationship to Primary insured, Occupation, Address, City, State, Pin Code, Phone No., Email ID.

DETAILS OF HOSPITALIZATION:

Form fields for hospitalization including Name of Hospital where Admitted, Room Category, Hospitalization due to, Date of Admission, Date of Discharge, Time of admission and discharge.

DETAILS OF CLAIM:

Form fields for claim details including Treatment expenses (Pre, Post, Ambulance, Surgical, Convalescence, etc.), Claim Documents Submitted - Check List, and Hospitalization/Post-hospitalization periods.

DETAILS OF BILLS ENCLOSED:

Table with columns: Sl. No., Bill No., Date, Issued by, Towards, Amount (Rs). Rows 1-10 for bill details.

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT:

Form fields for primary insured's bank account including PAN, Account Number, Bank Name and Branch, IFSC Code.

DECLARATION BY THE INSURED:

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 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.

Date DD MM YYYY Place: Signature of the Insured

SECTION A SECTION B SECTION C SECTION D SECTION E SECTION F SECTION G SECTION H

| 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) Sl. 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. | Licence 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 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 |
| 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 |
| 1) 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 |
| l) 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 Medicene | Enter the system of medicine followed in treating the patient | Open Text |
| SECTION E - DETAILS OF CLAIM | | |
| a) Details of Treatment Expences | Enter the amount claimed as treatment expences | 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 amount 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 |
| c) 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 |
| c) 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. | | |