

CLAIM FORM

(The issue of this Form is not to be taken as an admission of liability)

PART ATO BE FILLED IN BY THE INSURED

ECTIO	N A - DETAILS OF PRIMARY INSURED	
a)	Policy No.: b) SI. No/ Certificate No.:	
c)	Company/ TPA ID No :	
d)	Name:	
e)	Address:	Ī
	Phone No.: Email ID:	Ī
ECTIO	N B - DETAILS OF INSURANCE HISTORY	_
a)	Currently covered by any other mediclaim health insurance Yes \Box / No \Box	
b)	Date of commencement of first Insurance for the person (without break) : (DD/MM/YYYY) : D D M M Y Y Y Y	
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 □ (DD/MM/YYYY): □ □ □ M M Y Y Y Y	
e)	Previously covered by any other Mediclaim/Health insurance Yes $\ \square$ / No $\ \square$	
f)	If Yes, Company Name :	
SECTIO	N C - Details of the Insured Person Hospitalised :	
	a)Name :	
b)	Relationship: Self	
d)	Age (YY/MM):	
f)	Address:	
	(If different than above)	
g)	Occupation : Service $\ \square$ / Self employed $\ \square$ / Homemaker $\ \square$ / Student $\ \square$ / Retired $\ \square$ / Others	
h)	Telephone No : Mobile No :	
i)	E-mail ID, if any :	
ECTIO	N D - DETAILS OF HOSPITALISATION :	
a)	Name of the Hospital where admitted :	
b)	Room Category occupied: Day care	
c)	Hospitallisation due to Illness □/ Injury □/ Maternity □ : Details :	
d)	Date of Injury/ Date of disease first detected/ Date of delivery: (DD/MM/YYYY):	
e)	Date of admission: (DD/MM/YYYY): D D M M Y Y Y Y F) Time: (HH/MM): H H M M	
g)	Date of discharge: (DD/MM/YYYY): DD MM MYYYYY h) Time: (HH/MM): H H M M	
i)	If injury, give cause : Self Inflicted	
i)	If Medico legal Yes □ / No □ ii) Reported to police? Yes □ / No □ iii) MLC Report, & Police FIR attached? Yes □ / No □	
j)	System of medicine: Allopathic / Other systems of medicine	
ECTIO	N E - DETAILS OF CLAIM :	
a)	Details of the treatment expenses claimed:	
i)	Pre-hospitalisation Expenses Rs. ii) Hospitalisation Expenses Rs.	
iii)	Post-hospitalisation Expenses Rs. iv) Health-Check up Cost Rs.	
v)	Ambulance Charges Rs. Vi) Others (code) Rs.	



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DATA ELEMENT	DESCRIPTION	TORWAI
SECTION A - DETAILS OF PRIMARY	Y 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 INSURAL		
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	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 Medi claim/ 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 INSURE	D PERSON HOSPITALIZED	
a) Name	Enter the full name of the patient	Surname, First name, Middle name
b) Relationship to primary Insured	Indicate relationship of patient with policyholder	Tick the right option. If others, please specify
c) Date of Birth	Enter Date of Birth of patient	Use dd-mm-yy format
d) Age	Enter age of the patient	Number of years and months
e) Address	Enter the full postal address	Include Street, City and Pin Code
f) Gender	Indicate Gender of the patient	Tick Male or Female
g) Occupation	Indicate occupation of patient	Tick the right option. If others, please specify
h) Phone No	Enter the phone number of patient	Include STD code with telephone
i) E-mail ID	Enter e-mail address of patient	Complete e-mail address
SECTION D - DETAILS OF HOSPITA	ALIZATION	
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 CLIAM		
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 EI		
Indicate which bills are enclosed with the amo		
SECTION G - DETAILS OF PRIMAR		
a) PAN	Enter the permanent account number	As allotted by the Income Tax
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 TH		
	(in dd:mm:yy format), place (open text) and sign.	
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PART B

(TO BE FILLED IN BY THE HOSPITAL IN CASE OF CASHLESS CLAIMS)

The issue of this Form is not to be taken as an admission of liability. Please include the original preauthorisation request form in lieu of PART A

SEC	TION A - DETAILS OF HOSPITAL
a)	Name of the Hospital where treated :
b)	Hospital ID : c) Type of Hospital : Network □ / Non-Network □
	(If non network fill form section E).
d)	Name of the treating Doctor :
e)	Qualification:
f)	Registration No with state code : g) Phone No :
SEC	TION B - DETAILS OF PATIENT ADMITTED
a)	Name of the patient :
b)	IP Registration Number : c) Gender: Male
d)	Age (YY/MM): Y Y M M Date of Birth (DD/MM/YYYY): H H M M
e)	Date of Admission (DD/MM/YYYY): D D M M Y Y Y Y Y f)
g)	Date of Discharge (DD/MM/YYYY): D D M M Y Y Y Y H
i)	Type of Admission : Emergency $\ \Box$ / Planned $\ \Box$ / Day-care $\ \Box$ / Maternity $\ \Box$
j)	If Maternity
	i) Date of delivery (DD/MM/YYYY): D D M M Y Y Y Y III) Gravida Status:
k)	Status at time of discharge : Discharged to Home
	Total Claimed Amount Rs.
SEC	TION C - DETAILS OF AILMENTS DIAGNOSED (PRIMARY)
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 No. :
e)	If authorization by network hospital not obtained, give reason :
f)	Hospitalisation due to Injury? Yes 🗆 / No 🗆
	i) If Yes, give cause
	Self inflicted? Yes 🗆 / No 🗆 Road Traffic Accident Yes 🗆 / No 🗆 Substance Abuse /Alcohol Consumption Yes 🗀 / No 🗆
	ii) Ilf Injury due to Substance abuse / alcohol consumption, Test Conducted to establish this: Yes 🖂 / No 🖂 (If yes, attach reports)
	iii) Medico Legal Yes 🗆 / No 🗆 iv) Reported to Policy Yes 🗆 / No 🗆 v) FIR No :
	vi) If not reported to Policy give reasons

Date of Delivery

Gravida Status

k) Status at time of discharge

☐ Claim form duly filled and signed



SECTION D - CLAIM DOCUMENTS SUBMITTED - CHECKLIST

		Original Pre authorization Request			CT	/MRI	I/USG/	/HPE inv	estigation	n Repo	rt													
		Copy of Pre-authorization approval	Letter		Do	ctor's	s refer	ence slip	o for Inve	stigatio	n													
		Copy of photo ID card of patient ver	rified by Hospital		EC	CG																		
		Hospital Discharge Summary			Pha	arma	acy Bill	ls																
		Operation Theatre Notes			ML	_C Re	eport 8	& Police	FIR															
		Hospital Main Bill			Ori	iginal	I death	n summa	ry from h	ospital	wher	e apr	olicat	ole										
		Hospital break up Bill				•		specify	•	,														
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		E - ADITIONAL DETAILS IN	CASE OF NON NI	ETWO	RK I	HOS	SPITA	AL .				1					_		_	_	_	-		
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b)	Phon	e No. :					c)	Registra	tion no w	ith Stat	e Co	de :												
d)	Hosp	ital PAN :					e)	No of In-	patient B	eds :														
f)	Facili	ties available in Hospital :															_							
	i) (OT: Yes □ / No □ ii) IC	CU: Yes □ / No □	iii)	Othe	ers :																		
		declare that the information furnished nent of any material fact, our right to					ne bes	st of our i	knowieag	je and t	Jellel.	II WE	enav	e mad	ле а	ny iai	ise (or uni	rue	Sla	teme	ent, s	supp	ession
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Investigation reports

Use dd-mm-yy format

Use standard format

Tick the right option

Enter Date of Delivery if maternity

Enter Gravida status if maternity

Indicate status of patient at time of discharge



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		Standard Format and Open text
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	
Details of Procedure	Enter the details of the procedure	Open text
c) Present Ailment is a Complication of PED	Indicate whether present ailment is a complication of some pre- existing disease	Tick Yes or No
d) Pre-authorization obtained	Indicate whether pre-authorization obtained	Tick Yes or No
e) Pre-authorization Number	Enter pre-authorization number	As allotted by TPA
f) If authorization by network hospital not obtained, give reason	Enter reason for not obtaining pre-authorization number	Open text
g) 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 O	F 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.	Enter the registration number of patient	As allocated by the Hospital
d) 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

SECTION F - DECLARATION BY THE INSURED

Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.

SECTION G - DECLARATION BY THE HOSPITAL

Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign and stamp



CUSTOMER IDENTIFICATION PROCEDURE (AS PER KYC NORMS OF IRDA)

Please submit clear and legible copy of one document (valid and effective as on date of claim submission) each from Part A and Part B and your recent passport size photograph (not more than 6 months old) incase claim amount exceeds Rs 100,000.

Photograph

Part A Proof of legal name and any other names used	 i. Pan Card ii. If Pan Card is not available please submit any of the documents mentioned below stating reason for not having Pan Card. a) Passport b) Voter's Identity Card c) Driving License d) Personal Identification and Certification of the employees for your identity. e) Letter issued by Unique identification Authority of India containing details of name address and Aadhar Number f) Job Card issued by NREGA duly signed by an officer of the State Government
Part B Proof of Residence	 i. Electricity Bill not older than 6 months from the date of Insurance Contract ii. Telephone Bill pertaining to any kind of telephone connection like mobile, landline, wireless etc. Provided it is not older than 6 months from the date of claim submission iii. Ration Card iv. Valid lease agreement along with rent receipts which is not more than 3 months old as a residence proof v. Saving Bank Passbook with details of permanent/ present residence address (updated upto 1 month prior to claim submission document) vi. Statement of saving bank account with details of present/ present address (updated upto 1 month prior to claim submission document)

I hereby declare that I have submitted above mentioned documents and recent photograph (not more than 6 months old) for the purpose of claim and the said documents are valid and effective.

Date: D D M M Y Y Y Y	Signature of Policyholder :	V



CHECK LIST OF ENCLOSURES FOR SUBMISSION OF CLAIM

 In-patient Treatment /Day Care Procedures □ Duly filled and signed Claim Form. □ Photocopy of ID card / Photocopy of current year policy. 	Daily Cash Benefit □ Duly filled and signed Claim Form. □ Photocopy of ID card / Photocopy of current year policy.
Original Detailed Discharge Summary / Day care summary from the hospital.	
Original consolidated hospital bill with break up of each Item, duly signed by the insured.	Organ Donation/Transplantation
Original payment Receipt of the hospital bill.	In addition to the documents of general hospitalization
☐ First Consultation letter and subsequent Prescriptions.	☐ Organ Function test / blood test proving organ failure.
Original bills, original payment receipts and Reports for investigation.	☐ Treatment Certificate issued by the Transplant Surgeon of the hospital
Original medicine bills and receipts with corresponding Prescriptions.	concerned.
 Original invoice/bills for Implants (viz. Stent /PHS Mesh / IOL etc.) with original payment receipts. 	
рауптепт гесетріз.	Ambulance Benefit
	Duly filled and signed Claim Form.
Road Traffic Accident	□ Photocopy of ID card / Photocopy of current year policy.
In addition to the In-patient Treatment documents:	☐ Original Bill with Original Payment Receipt.
□ Copy of the First Information Report from Police Department / Copy of the	
Medico-Legal Certificate.	☐ Treating Doctor's consultation prescription indicating Emergency Hospitalization.
In Non Medico legal cases	
 Treating Doctor's Certificate giving details of injuries (How, when and where injury sustained) 	
In Accidental Death cases	Maternity Expenses
☐ Copy of Post Mortem Report & Death Certificate	In addition to the In-patient Treatment documents:
	☐ Obstetric history (Gravida, Para, Living children, Abortions) from treating doctor.
For Death Cases	
In addition to the In-patient Treatment documents:	Critical Illness Benefit
Original Death Summary from the hospital.	☐ Duly filled and signed Claim Form.
Copy of the Death certificate from treating doctor or the hospital authority.	☐ Photocopy of ID card / Photocopy of current year policy.
Copy of the Legal heir certificate, if the claim is for the death of the principle insured.	☐ A medical certificate confirming the diagnosis of critical illness from a doctor not less qualified than MD/MS.
	☐ Investigation reports/ other related documents reflecting the critical illness
Dre and Deat hasnitalization synances	diagnosis.
Pre and Post-hospitalisation expenses	
 Duly filled and signed Claim Form. Photocopy of ID card / Photocopy of current year policy. 	
	Health Check up
☐ Original Medicine bills, original payment receipt with prescriptions.	□ Duly filled and signed Claim Form.
 Original Investigations bills, original payment receipt with prescriptions and report. 	☐ Photocopy of ID card / Photocopy of current year policy.
☐ Original Consultation bills, original payment receipt with prescription.	
☐ Copy of the Discharge Summary of the main claim.	☐ Original Investigation bills, original payment receipts with Reports.
Copy of the discharge Summary of the main dains.	Original Consultation bills and original payment receipts with prescription.
Outpatient Benefit/Dental	
□ Duly filled and signed Claim Form.	Expenses for spectacles/contact lenses, hearing aids
Photocopy of ID card / Photocopy of current year policy.	□ Duly filled and signed Claim Form.
☐ Original Medicine bills, original payment receipt.	□ Photocopy of ID card / Photocopy of current year policy.
☐ Original Investigations bills, original payment receipt with report.	Prescription of the Treating Doctor.
Original Consultation bills, original payment receipt with prescription.	☐ Original Invoice/bills, original payment receipt of the device, appliances, lens
 Details of any Outpatient Procedures, If any 	etc.
☐ Dental X-ray film	