Claim Form

Toll Free Number **1800-209-5846 (1800-209-LTIN)** | Website **www.ltinsurance.com** | SMS **'LTI' to 5607058 (56070LT)**

GUIDELINES TO FILL THE FORM

1. Please fill the form in BLOCK LETTERS. Please answer all questions fully and correctly. All details with * are mandatory.
2. Please leave one box blank between two words while writing the ADDRESS.
3. Kindly contact the Company's Office or TPA for any doubts or clarifications on the claim form.

PLEASE USE ONLY ORIGINAL CLAIM FORM. PHOTO COPIES WILL NOT BE ACCEPTED BY THE COMPANY.

PART A

TO BE FILLED IN BY THE INSURED / INSURED PERSON

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

Policy No : Claim No.:

Group / Company Name:

Period of Insurance: D D M M Y Y Y Y To D D M M Y Y Y Y

INSURED PERSON'S INFORMATION (Please enter details of the Insured Person - Employee / Member)

Title* (Pls. Tick): ☐ Mr. ☐ Ms. ☐ Mrs.

Name*: F I R S T M I D D L E L A S T

Employee / Membership ID: Certificate No.:

Correspondence Address

Block/Flat No.*: Floor No.: Building Name*:

Street Name*: Locality:

Landmark*:

City/Village*: Pincode*:

Post Office: Fax No.:

Mobile No.: Landline*: S T D

Email ID 1:

Email ID 2:

DETAILS OF INSURANCE HISTORY

a. Currently covered by any other Mediclaim / Health insurance: ☐ Yes ☐ No

b. If Yes, Date of commencement of first Insurance without break: D D M M Y Y Y Y (Copies of Policies to be attached)

c. Company name: .....

Policy No.

Sum Insured ₹

d. Have you been hospitalized in the last 4 years? ☐ Yes ☐ No

If Yes, Date: D D M M Y Y Y Y

Diagnosis: .....

e. Previously covered by any other Mediclaim / Health insurance: ☐ Yes ☐ No

f. If Yes, Company Name: .....

DETAILS OF INSURED PERSON HOSPITALIZED

a. Name: FIRST MIDDLE LAST

b. Gender: ☐ Male ☐ Female c. Date of Birth: D D M M Y Y Y Y

d. Company / TPA ID No.: d. Age: Y Y M M

e. Occupation: ☐ Service ☐ Self Employed ☐ Homemaker ☐ Student ☐ Retired ☐ Other (Please Specify) .....

f. Relationship to Insured Person (Employee / Member) : ☐ Self ☐ Spouse ☐ Child ☐ Father ☐ Mother ☐ Other (Please Specify) .....

g. Address: ☐ Same as above

Block/Flat No.*: Floor No.: Building Name*:

Street Name*: Locality:

Landmark*:

City/Village*: Pincode*:

Post Office: Fax No.:

Mobile No.: Landline*: STD

Email ID 1:

Email ID 2:

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: D D M M Y Y Y Y

e. Date of Admission: D D M M Y Y Y Y f. Time: H H : M M

g. Date of Discharge: D D M M Y Y Y Y h. Time: H H : M M

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:

DETAILS OF CLAIM:

a. Details of the treatment expenses claimed

i. Pre-hospitalization Expenses: ₹

ii. Hospitalization Expenses: ₹

iii. Post-hospitalization Expenses: ₹

b. Add on Covers: - (Attach separate sheet indicating the covers and amount) ₹

c. Details of lump sum / cash benefit claimed ₹

Total ₹

Claim Documents Submitted - Check List:

- ☐ Claim Form Duly signed
- ☐ Copy of the claim intimation
- ☐ Hospital Main Bill
- ☐ Hospital Break - up Bill
- ☐ Hospital Bill Payment Receipt
- ☐ Hospital Discharge Summary
- ☐ Pharmacy Bill
- ☐ Operation Theatre Notes
- ☐ ECG/X-Ray/USG/CT/MRI etc.
- ☐ Doctor's request for investigation
- ☐ Pathology Reports
- ☐ Doctor's Prescriptions
- ☐ Others

PART B

TO BE FILLED IN BY THE HOSPITAL

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

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:

B. DETAILS OF THE PATIENT ADMITTED

a. Name of the Patient: FIRST MIDDLE LAST

b. IP Registration Number: c. Gender: ☐ Male ☐ Female d. Age: Y Y M M

e. Date of birth: D D M M Y Y Y Y f. 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

k. Status at time of discharge: ☐ Discharge to home ☐ Discharge to another Hospital ☐ Deceased

C. DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a. ICD 10 Codes Description

i. Primary Diagnosis: .....

ii. Additional Diagnosis: .....

iii. Co-morbidities: .....

iv. Co-morbidities: .....

b. ICD 10 Codes Description

i. Procedure 1: .....

ii. Procedure 2: .....

iii. Procedure 3: .....

iv. Details of Procedure: .....

c. Present ailment is a complication of PED? ☐ Yes ☐ No (If Yes, specify details) .....

d. Pre-authorization obtained: ☐ Yes ☐ No e. Pre-authorization Number:

f. If authorization by network hospital not obtained, give reason:.....

g. 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: .....

D. CLAIM DOCUMENTS SUBMITTED - CHECK LIST

☐ Claim Form Duly signed ☐ Investigation reports ☐ Hospital Discharge Summary

☐ CT / MR / USG / HPE investigation reports ☐ ECG ☐ Pharmacy Bills

☐ Docotor's reference slip for investigation ☐ Operation Theater Notes ☐ Hospital break-up bill

DETAILS OF BILLS ENCLOSED

Sr. No.	Bill No.	Date	Issued by	Towards	Amount (₹)
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

DETAILS OF PAYEE'S (INSURED / INSURED PERSON) BANK ACCOUNT

a. PAN No.:

b. Account Number:

c. Bank Name and Branch:

d. Cheque / DD Payable details:

e. IFSC Code:

REASON FOR DELAY / NO INTIMATION

If claim is not intimated or intimated beyond stipulated time given in the Policy, provide reasons for the same: .....

.....

If the claim is submitted beyond stipulated time period given in the Policy, provide reasons for the same: .....

.....

DECLARATION

I hereby agree, affirm and declare that:

a. The statements / information given / stated by me in this claim form is true, correct and complete.

b. No material information which is relevant to the processing of the claim or which in any manner has a bearing on the claim has been withheld or not disclosed.

c. If I have given / made any false or fraudulent statement / information, or suppressed or concealed or in any manner failed to disclose material information, the policy shall be void & that I shall not be entitled to all / any rights to recover thereunder in respect of any claims, past, present or future.

d. The receipt of this claim form / other supporting / related documents does not constitute or be deemed to constitute an agreement by the Company of the claim and the Company reserves the right to process or reject or require further / additional information in respect of the claim.

e. I hereby provide my consent and authorize L&T Genenral Insurance Company Limited / TPA to seek any medical information from any hospital / Medical Practioner who has at any time attended on the insured person.

f. I hereby declare that I have included all the bills / receipts for the purpose of this claim and that I will not be making any supplementary claim except the pre / post hospitalisation, if any.

g. ☐ I / We authorize Company to use and disclose any personal information collected or available with the company (whether contained in this application or otherwise obtained) to claims investigation companies / agencies and Insurance / Reinsurance companies for the purpose of this claim and providing subsequent services.

Signature of Insured

Signature of Insured Person

☐ Original death summary from hospital (where applicable) ☐ MLC report & Police FIR (where applicable) ☐ Hospital main bill

☐ Any other, please specify: .....

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

Address:

Block/Flat No.*: Floor No.: Building Name*:

Street Name*: Locality:

Landmark*:

City/Village*: Pincode*:

Post Office: PAN No:

Landline*: S T D Registration No:

Facilities available in the hospital: i. OT: ☐ Yes ☐ No ii. ICU: ☐ Yes ☐ No

iii. Others: .....

Number of Inpatient beds:

DECLARATION BY THE HOSPITAL

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 of concealment of any material fact, our right to reimbursement under this claim shall be forfeited.

Place: .....

Date: .....

Signature and seal of the Hospital Authority

This page has been left blank intentionally