CLAIM FORM - PART B TO BE FILLED IN BY THE HOSPITAL

The issuance of this Form is not to be taken as an admission of liability
Please include the original pre-authorisation request form in lieu of PART A

MAGMA HDI
General Insurance Company Ltd.

Toll Free No. 1800 266 3202

SECTION A - DETAILS OF HOSPITAL (To be filled in block letters)

a) Name of the hospital:

b) Hospital ID: c) Type of Hospital: ☐ Network ☐ Non-Network (For office use only)

d) Name of the treating doctor:

e) Qualification:

f) Registration No. with State Code: g) Phone No.:

SECTION B - DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient:

b) IP Registration Number: c) Gender: ☐ Male ☐ Female

d) Age: ☐☐ Years ☐☐ Months 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:

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

m) Total amount claimed:

SECTION C - DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a)		ICD 10 Codes	Description	a)		ICD 10 PCS Codes	Description
1	Primary Diagnosis:			1	Procedure 1:		
2	Additional Diagnosis:			2	Procedure 2:		
3	Co-morbidities:			3	Procedure 3:		
4	Co-morbidities:			4	Details of Procedure:		

c) Whether pre-authorisation obtained: ☐ Yes ☐ No d) If Yes, pre-authorisation Number:

e) If authorisation by network hospital not obtained, give reason: _____

_____

f) Hospitalisation due to injury: ☐ Yes ☐ No If Yes, give cause:

i. ☐ Self-inflicted ☐ Road Traffic Accident ☐ Substance abuse / alcohol consumption ☐ Other

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 the police: ☐ Yes ☐ No

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

_____

g) When did the patient start suffering of the complaint: _____

Date of first consultation: D D M M Y Y Y Y

h) Please give previous medical history of the patient: _____

I) Is the patient suffering from any of the following diseases? If "Yes" Please mention the duration below.

		Yes / No	Duration in year & months
1	High or low blood pressure, chest pain, or any other cardiac disorder		
2	Tuberculosis, asthma, bronchitis or any other lung / respiratory disorder		
3	Ulcer (stomach / duodenal), liver or gall bladder disorder or any other digestive tract disorder		
4	Kidney failure, stone in kidney or urinary tract, prostate disorder or any other kidney / urinary tract disorder		
5	Stroke, epilepsy (fits), paralysis or any other nervous system (brain, spinal cord, etc) disorder		

		Yes / No	Duration in year & months
6	Diabetes, Impaired glucose tolerance (Pre-diabetes), Thyroid/Pituitary Disorder or any other endocrine disorder		
7	Tumor (swelling)-benign or malignant, any external ulcer / growth / cyst / mass anywhere in the body		
8	Arthritis, spondylosis or any other disorder of the muscle / bone / joint		
9	Diseases of the ear / nose / throat / teeth / eye (please mention dioptres in case of refractory error)		
10	HIV / AIDS or sexually transmitted diseases or any immune system disorder		
11	Anaemia, leukaemia, lymphoma or any other blood / lymphatic system disorder		
12	Psychiatric / mental illnesses or sleep disorder		
13	Uterine fibroid, fibroadenoma breast or any other gynaecological (female reproductive system) / breast disorder		
14	Any other illness or injury not mentioned above (other than common cold)		

g) Is the ailment a complication / sequel of a pre-existing disease or condition? ☐ Yes ☐ No

If Yes, please give details: _____

h) History of alcoholism ☐ Yes ☐ No If yes: No of years: ☐☐ Quantity consumed per day ☐☐☐

I) History of smoking / tobacco chewing: ☐ Yes ☐ No If Yes: No of years: ☐☐ Units consumed per day ☐☐☐

SECTION D - CLAIM DOCUMENTS SUBMITTED - CHECK LIST

☐ Claim Form duly signed	☐ Investigation reports
☐ Original pre-authorisation request	☐ CT/MR/USG/HPE investigation reports
☐ Copy of the pre-authorisation approval letter	☐ Doctor's reference slip for investigation
☐ Copy of photo ID card of patient verified by hospital	☐ ECG
☐ Hospital discharge summary	☐ Pharmacy bills
☐ Operation theatre notes	☐ MLC report & Police FIR
☐ Hospital main bill	☐ Original death summary from hospital where applicable
☐ Hospital break-up bill	☐ Other, please specify

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

a) Address of the hospital:

City: State:

Pincode: 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. Round the clock Doctor / Nurses: ☐ Yes ☐ No

iv. Maintains daily record of patients: ☐ Yes ☐ No v. Others:

SECTION F - DECLARATION BY THE HOSPITAL (PLEASE READ VERY CAREFULLY)

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, suppressed or concealed any material fact, our right to claim under this claim shall be forfeited.

Date: D D M M Y Y Y Y

Place:

Signature and Seal of the Hospital Authority:

Please send this duly filled and signed claim form to our TPA at below address:
Family Health Plan Insurance TPA Limited
Srinilaya - cyber spazio suite, 101,102,Ground Floor, Road No. 2, Banjara Hills, Hyderabad, Telangana 500034

CLAIM FORM - PART B TO BE FILLED IN BY THE HOSPITAL

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MAGMA HDI
General Insurance Company Ltd.

Authorisation Letter (Mandatory)

Date: D D M M Y Y Y Y

From:

To:
The Manager / Medical Superintendent, Medical Records

Dear Sir

Reg: Authorisation Letter.

Name of the Patient: _____

IP Number_____ (First admission) in _____Hospital

IP Number_____ (Second admission) in _____Hospital

IP Number_____ (Third admission) in _____Hospital

I consent and authorise M/s Magma HDI General Insurance Co. Limited and their Authorised Service Providers to seek medical information from your hospital and share copies of indoor case sheets and such other relevant medical records and / or meet / obtain statement from the Medical Practitioner who has at any time attended on the patient for the hospitalisation dated ..... to .....

Thanking you,

Yours sincerely,

Signature of the Proposer

Signature of the Patient

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 hospital	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 Birth	Enter date of admission	Use dd-mm-yy format
f) Date of Admission	Enter date of admission	Use dd-mm-yy format
g) Time	Enter time of admission	Use hh:mm format
h) Date of Discharge	Enter date of discharge	Use dd-mm-yy format
I) Time	Enter time of discharge	Use hh:mm format
j) Type of Admission	Indicate type of admission of patient	Tick the right option
k) If Maternity	Tick the right option	Tick the right option
Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format
Gravida Status	Enter Gravida Status if maternity	Use standard format
l) Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
m) Total amount claimed	Indicate the total amount claimed	In rupees (Do not enter paise values)

GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled in by the Insured)

DATA ELEMENT	DESCRIPTION	FORMAT
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) Whether pre-authorisation obtained	Indicate whether pre-authorisation obtained	Tick Yes or No
d) Pre-authorisation Number	Enter pre-authorisation number	As allotted by TPA
e) If authorization by network hospital not obtained, give reason	Enter reason for not obtainingpre-authorisation number	Open text
f) Hospitalization due to injury	Indicate if hospitalisation 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 the police, give reason	Enter reason for not reporting to the police	Open text
g) Complaints / Symptoms	Indicate the date when the symptom / complaint	Use dd-mm-yy format
h) Previous medical history	Enter the medical history	Open text
i) Specific diseases	State Yes or No	Duration should be in years and months
j) Complication of pre-existing diseases	Indicate whether present ailment is a complication that existed prior to policy inception	Open text
k) Alcoholism	Indicate Yes or No. If 'yes' state quantity consumed	Open text
l) Smoking of tobacco	Indicate Yes or No. If 'yes' state units consumed	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 at the hospital	Indicate facilities available at the hospital	Tick the right option. If others, please specify
SECTION F - DECLARATION BY THE HOSPITAL		
Read the declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign and stamp		