RELIANCE GENERAL INSURANCE

reliancegeneral.co.in
022 4890 3009 (Paid)
74004 22200

CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT - PART A

(To be filled in BLOCK LETTERS)

TO BE FILLED IN BY THE INSURED

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

SECTION A - DETAILS OF PRIMARY INSURED

a) Type of claim

☐ Hospitalization ☐ Pre Hospitalization ☐ Post Hospitalization ☐ Health check-up ☐ OPD

b) Pre authorization obtained ☐ Yes ☐ No

c) Policy type ☐ Individual ☐ Group

d) Group/Company name

e) Policy No f) Sl. No/Certificate No

g) Company/TPA ID No. h) Name

I) Address

City State Pincode

Phone No Email ID.

j) PAN No

k) Monthly Income: ☐ Up to ₹ 20,000 ☐ ₹ 20,001 to ₹ 50,000 ☐ ₹ 50,001 to ₹ 1,00,000 ☐ ₹ 1,00,001 and above

SECTION B - DETAILS OF INSURANCE HISTORY

a) Currently covered by any other Mediclaim/Health Insurance ☐ Yes ☐ No

b) Date of commencement of first insurance without break 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 contact? ☐ Yes ☐ No

Date d d m m Diagnosis

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

f) If yes Company Name

SECTION C - DETAILS OF INSURED PERSON HOSPITALIZED

a) Name

b) Gender ☐ Male ☐ Female c) Age - _____ years _____Months d) Date of birth d d m m y y y y

e) Relationship to Primary insured: ☐ Self ☐ Spouse ☐ Child ☐ Father ☐ Mother Other - Please Specify

f) Occupation: ☐ Service ☐ Self Employed ☐ Homemaker ☐ Student ☐ Retired Other - Please Specify

g) Address (if different from above)

City State Pin Code

Phone No Email Id

SECTION D - 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 _____

SECTION E - DETAILS OF CLAIM

a) Details of treatment expenses claimed

i. Pre hospitalization expenses ₹ _____ ii. hospitalization expenses ₹ _____

iii. Post hospitalization expenses ₹ _____ iv. Health check up cost ₹ _____

v. Ambulance charges ₹ _____ vi. Others(code) ₹ _____

TOTAL ₹ _____

vii. Pre hospitalization period _____ days viii. Post hospitalization period _____ days

b) Claim for Domiciliary Hospitalization ☐ Yes ☐ No (if yes provide details in annexure)

c) Details of Lump sum/cash benefit claimed i. Hospital Daily Cash ₹ _____/- ii Surgical cash ₹ _____/-

iii Critical illness benefit- ₹ _____/ iv Convalescence ₹ _____/-

v. Pre/Post hospitalization Lump sum benefit ₹ _____/- vi Others ₹ _____/-

TOTAL ₹ _____/-

SECTION F - DETAILS OF BILLS ENCLOSED

S.No	Bill No	Date	Issued By	Towards	Amount ₹)
1		d d m m y y y y		Hospital main Bill	
2		d d m m y y y y		Pre hospitalization Bills _____Nos	
3		d d m m y y y y		Post hospitalization Bills _____Nos	
4		d d m m y y y y		Pharmacy Bills	
5		d d m m y y y y		Other expenses if any _____	
6		d d m m y y y y			
7		d d m m y y y y			
8		d d m m y y y y			
9		d d m m y y y y			
10		d d m m y y y y			

CLAIM DOCUMENTS SUBMITTED CHECK LIST

S.No	Documents
1	☐ Claim form duly signed
2	☐ Copy of the claim intimation, if any
3	☐ Hospital main bill
4	☐ Hospital break up bill
5	☐ Hospital bill payment receipt
6	☐ Hospital discharge summary
7	☐ Pharmacy bill
8	☐ Operation theatre notes
9	☐ ECG
10	☐ Doctor's request for investigation
11	☐ Investigation reports (including CT/MRI/USG/HPE)
12	☐ Doctor's prescriptions
13	☐ Others

As per policy terms & conditions, the Company reserves its right to have the Insured examined by a Doctor appointed by it for verification of diagnosis.

SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

1. Name of the Bank Account Holder ☐ Mr. ☐ Mrs. ☐ Ms. F I R S T M I D D L E L A S T
2. Bank Account No.: 3. Account: ☐ Saving ☐ Current ☐ Other
4. Name of the Bank
5. Branch
6. MICR Code (9 digit MICR code number of the bank and branch appearing on the cheque issued by the bank)
7. IFSC Code (11 character code appearing on your cheque leaf)

☐ I understand that any refund due on the premium payment / any payment / claims to be directly credited to my aforesaid Bank Account.*

*As per IRDAI, its mandatory that all payments made to the insured are only through electronic mode.

SECTION H - DECLARATION BY THE INSURED

I hereby declare that the information furnished in this claim form is true and correct to the best of my knowledge and belief. If I made any false or untrue statement, suppression or concealment of any material fact with respects to questions asked in relation to the claimed, 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 d d m m y y y y Place ______________ Signature of the Insured ______________

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CLAIM FORM - PART B

(To be filled in BLOCK LETTERS)

TO BE FILLED IN BY THE HOSPITAL

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

SECTION 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

I) Email Id:

SECTION B - DETAILS OF PATIENT ADMITTED

a) Name of the patient

b) IP Registration Number

c) Gender ☐ Male ☐ Female c) Age - _____ years _____Months d) Date of birth d d m m y y y y

e) 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 claimed amount ₹ /-

SECTION C - DETAILS OF AILMENT DIAGNOSED (PRIMARY) - Part A

S.No	ICD 10 Codes	Description
1	Primary Diagnosis	
2	Additional Diagnosis	
3	Co-morbidities	
4	Co-morbidities	

SECTION C - DETAILS OF AILMENT DIAGNOSED (PRIMARY) - Part B

S.No	ICD 10 PCS	Description
1	Procedure 1	
2	Procedure 2	
3	Procedure 3	
4	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 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 _____

SECTION D - CLAIM DOCUMENTS SUBMITTED - CHECK LIST

S.No	Documents	S.No	Documents
1	☐ Claim form duly signed	9	☐ Investigation reports
2	☐ Original pre authorization request	10	☐ CT/MRI/USG/HPE investigation reports
3	☐ Copy of pre - authorization approval letter	11	☐ Doctor's reference slip for investigation
4	☐ Copy of photo ID card of patient verified by hospital	12	☐ ECG
5	☐ Hospital discharge summary	13	☐ Pharmacy bills
6	☐ Operation theatre notes	14	☐ MLC report & police FIR
7	☐ Hospital main bill	15	☐ Original death summary from hospital where applicable
8	☐ Hospital break up bill	16	☐ Any other, please specify

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

a) Address of the Hospital _____

City _____ State _____ Pin Code _____

b) Phone No _____ c) Registration No with state code _____

d) Hospital PAN _____ e) Number of Inpatients bed _____

f) Facilities available in the hospital i) OT ☐ Yes ☐ No ii) ICU ☐ Yes ☐ No iii) Others _____

SECTION F - DECLARATION BY THE HOSPITAL

We hereby declare that the information furnished in the claim form is true & correct to the best of my knowledge and belief. If we have made any false or untrue statement, suppression or concealment of any material fact our right to claim under this claim shall be forfeited.

Date d d m m y y y y Place _____ Signature & Seal of Hospital Authority _____