

## MediPrime

## **PART A**

	e issue of this Form is not to be tak	CII u		aaii	113310	) I I O I	IIIai	אווונץ	/																					
o	licy No.															SI	. <b>N</b>	lo.	. /C	erti	ifica	ate	No	ο.						
Va	me of the TPA:																													
ns	ured / Claimant Details (In block I	ettei	rs)																											
I.	Name & Address of the Policyhol	der																												
	Name																		L											
	Address																													
		City	/													Sta	ate	)												
			Cod	de																										
	Contact Information	Мо	bile				$\overline{}$				T					Ph	nor	ne				T								
		Em									$\overline{}$									T	$\perp$									
2.	Details of the Hospitalised Person																													
	Name												T				T		T			T								
	Relationship										$\overline{}$	$\overline{}$				D:	ato	of	f Bir	th			D	D	M	M	Y	Y	Υ	Υ
	Address										+					D.	alc	Ü		uı		L	U		IVI	IVI	T	T	T	T
	Addiess						<u> </u>				_		_		_					+	+	+								_
		City					_						_			Sta	ate	)	L			_								
		Pin	Cod	de																										
		Ger	nder			Mal	le			Fen	ale			0	ccupa	ation	ı													
	Contact Information	Мо	bile													Ph	or	ne												
		Em	ail																											
			1								2.1																			
3.			IIIn	ess			ınju	Hospitalisation due to Illness Injury Others																						
	etails																													
	Details																													
													Die	2022	e fire	t de	ter	rte	d /											_
	Date of Injury sustained	D	D	M	M	Υ	Υ	Y	Y						e firs								) )	D	M	M	Υ	Υ	Υ	Y
		D	D	M	M	Υ	Υ	Υ	Υ														)	D	M	M	Υ	Υ	Υ	Y
	Date of Injury sustained	D	D	M	M	Υ	Υ	Υ	Υ														) )	D	M	M	Υ	Υ	Υ	Y
	Date of Injury sustained					Υ	Υ	Y	Y													[		D	M	M	Y		Y	Y
	Date of Injury sustained  If injury, how did it occur?	gal (				Y	Υ	Y	Y														D	D	М	M		S	Y	
	Date of Injury sustained  If injury, how did it occur?  If injury, whether is it a Medico Le	gal (	Case		C)	Y				stem	s of	· med	Las	st M								]	D	D	М	M	YE	S	Y	NO
1.	Date of Injury sustained  If injury, how did it occur?  If injury, whether is it a Medico Le  If MLC, whether reported to police  System of medicine:	gal (	Case	(ML	C)	Y				etem	s of	med	Las	st M								]	D	D	M	M	YE	S	Y	NO
1.	Date of Injury sustained  If injury, how did it occur?  If injury, whether is it a Medico Le  If MLC, whether reported to police	gal (	Case	(ML	C)	Y				etem	s of	· med	Las	st M								]		D	M	M	YE	S	Y	NO
1.	Date of Injury sustained  If injury, how did it occur?  If injury, whether is it a Medico Le  If MLC, whether reported to police  System of medicine:  Insurance History	gal (e?	Case All	(ML	C)		0	the	r sys			· med	Las	st M									D	D	M	M	YE	S	Y	NO
1.	Date of Injury sustained  If injury, how did it occur?  If injury, whether is it a Medico Le  If MLC, whether reported to police  System of medicine:  Insurance History  Name of the Company & Policy No.	gal (e?	Case All	(ML) lopat	C) thic	ersoi	O n (w	othe	r sys	oreak	:)		Las	st M													YE	SS SS	Y	NO
1.	Date of Injury sustained  If injury, how did it occur?  If injury, whether is it a Medico Le  If MLC, whether reported to police  System of medicine:  Insurance History  Name of the Company & Policy N.  Date of commencement of first In	gal (	Case All .:	(ML) opat	C) thic	ersoi m / F	O n (w	vithe vithc	r sys	oreal ance	) Po	licy?	Las	ne	lenst	rual											YE	SS SS	Y	NO NO
1.	Date of Injury sustained  If injury, how did it occur?  If injury, whether is it a Medico Le  If MLC, whether reported to police  System of medicine:  Insurance History  Name of the Company & Policy No  Date of commencement of first In  Are you presently covered with an	gal (	Case All .:	(ML lopat	C) thic	ersoi m / F	O n (w	vithe vithc	r sys	oreal ance	) Po	licy?	Las	ne	lenst	rual											YE	SS SS	Y	NO NO
1.	Date of Injury sustained  If injury, how did it occur?  If injury, whether is it a Medico Le  If MLC, whether reported to police  System of medicine:  Insurance History  Name of the Company & Policy No  Date of commencement of first In  Are you presently covered with an	gal (	Case All nce ther	(ML lopat	C) thic	ersoi m / F	O n (w	vithe vithc	r sys	oreal ance	) Po	licy?	Las	ne	lenst	rual											YE	SS SS	Y	NO NO
1. 5.	Date of Injury sustained  If injury, how did it occur?  If injury, whether is it a Medico Le  If MLC, whether reported to police  System of medicine:  Insurance History  Name of the Company & Policy N.  Date of commencement of first In  Are you presently covered with at  If Yes, give details - Company / P.	gal (	Case All nce ther	(ML lopat	C)  thic  ne pe iclair  m In	ersoi m / F	O n (w Heal	vithe vith li	out k	oreal ance	Po	licy?	Las	ne	lenst	)	Pe	erio	od	3	3 or		D				YE	SS SS	Y	NO NO
<b>1</b> .	Date of Injury sustained  If injury, how did it occur?  If injury, whether is it a Medico Le  If MLC, whether reported to police  System of medicine:  Insurance History  Name of the Company & Policy N.  Date of commencement of first In  Are you presently covered with a  If Yes, give details - Company / P  Name of the Hospital where adm	gal (	Case All nce ther	(ML lopat	C)  thic  ne pe iclair  m In	erson m / F	O n (w Heal	vithe vith li	out k	oreal ance	Po	licy?	Las	ne	ched	)	Pe	erio	od	3	3 or		D				YE	SS SS	Y	NO NO
<b>1</b> .	Date of Injury sustained  If injury, how did it occur?  If injury, whether is it a Medico Le  If MLC, whether reported to police  System of medicine:  Insurance History  Name of the Company & Policy No  Date of commencement of first In  Are you presently covered with an  If Yes, give details - Company / Policy No  Name of the Hospital where adm  Room Category occupied	gal (e?	Case All : nce t ther / No.	(ML lopat	C) thic ne pe iiclair m In	erson m / F	O n (w Heal	vithe vith li	out k	oreal ance	Po	licy?	Las	ne	ched	)	Pe	erio	od	3	3 or		D				YE	Y	Y	NO NO
i. 5.	Date of Injury sustained  If injury, how did it occur?  If injury, whether is it a Medico Le  If MLC, whether reported to police  System of medicine:  Insurance History  Name of the Company & Policy N.  Date of commencement of first In  Are you presently covered with a  If Yes, give details - Company / P  Name of the Hospital where adm  Room Category occupied  Past Hospitalisation History	gal (e?	Case All : nce t ther / No.	(ML lopat	C) thic ne pe iiclair m In	erson m / F	O n (w Heal	vithe vith li	out k	oreal ance	Po	licy?	Las	ne	ched	)	Pe	erio	od	3	3 or		D				YE	Y	Y	NO NO
1.	Date of Injury sustained  If injury, how did it occur?  If injury, whether is it a Medico Le  If MLC, whether reported to police  System of medicine:  Insurance History  Name of the Company & Policy No  Date of commencement of first In  Are you presently covered with an  If Yes, give details - Company / P  Name of the Hospital where adm  Room Category occupied  Past Hospitalisation History  a) Have you been hospitalised in	gal (e)?  ame sura ny of olicy  nitted	Case All : nce t ther / No.	(ML lopat	C) thic ne pe iiclair m In	erson m / h esure	O n (w Heal	vithe vith li	out k	oreal ance	Po	licy?	Las	ne	ched	)	Pe	erio	od	3	3 or		D				YE	Y	Y	NO NO
j.	Date of Injury sustained  If injury, how did it occur?  If injury, whether is it a Medico Lee  If MLC, whether reported to police System of medicine:  Insurance History  Name of the Company & Policy No Date of commencement of first In Are you presently covered with a  If Yes, give details - Company / P  Name of the Hospital where adm  Room Category occupied  Past Hospitalisation History  a) Have you been hospitalised in  b) If Yes, Diagnosis	gal (e?)	Case All :nnce f ther / No. d	(ML (ML dopated)) (Med / Su 4 year)	C) thic ne pe iiclair m In	erson m / h esure	O (was the control of	vithe vith li	out k	oreal ance	Po	licy?	Las	ne	ched	)	Pe	erio	od	3	3 or		D				YE	Y SS	Y	NO NO

8.	Poli	cyholder's Bank Account	t nart	iculars																					
		Policyholders PAN No.									e)	ı	FSC (	Code											
	b)	Account No.									f)	N	MICR	No.									Ì		
						1					,														
	c)	Payable details:	С	heque		DD	Ш	NEFT	(* P	lease a	ittach a	Ca	ancel	led ch	eque	per	tain	ing t	o the	e sar	me)				
	. ,	Bank Name / Branch*																							
		is agreed that the Policyho				intimat	te in v	vriting	to TA	ATA AIC	Gener Gener	ral	Insur	ance C	o. Lt	d. ab	out	any	chan	ge ir	n bank	acco	ount	details	j.
		ails of the treatment exp Pre-hospitalisation Expe			ned S					b)	Hoon	ito	liootic	n Evr	ono	00		Do.							
		Post-hospitalisation Expe									Hosp Healt					25									
		Ambulance Charges									Organ			•											
	g)	Domiciliary hospitalisation	on	Rs	s					. h)	Other	rs						Rs							
10.	Det	ails of bills enclosed																							
SI.	No	Bill No		Dat	е		lss	sued b	У					Towar	ds						Amo	unt (l	Rs.)		
																			4						
																			4						
																			+						
																			$\dashv$						
																			+						_
																			+						-
			<u> </u>																						-
		details of Claim Docume	ents 1	to be su	ubmit	ted to 1	the TI	PA, ple	ease	refer to	the C	HE	ECK L	.IST											
		ion by the Insured declare that the information	on furi	nished i	n this (	Claim F	orm is	s true a	nd co	orrect to	o the be	est	of my	/ know	leda	e and	l be	lief. l	f I ha	ve m	nade a	nv fal	lse o	r untrı	16
state	eméi	nt or suppressed or concea forfeited.																							
I als	о со	nsent and authorize TPA /							y me	dical in	formati	on	/ doc	ument	s fro	m an	y h	ospit	al / N	/ledic	cal Pra	ctitio	ner /	Insur	eı
		attended on the person a declare that I have included							this (	claim/H	osnitaliz	zati	ion / e	vent a	nd th	at Iw	ill n	ot he	mak	ing a	any fur	ther	clain	ns und	ΑI
this	inpa	tient hospitalization for the	illnes	s / injur	y exce	pt the F	re / P	ost - ho	ospita	alization	claim,	if a	any.							_	•				
		also agree that in the event e) or the legal heir in case							Insur	ed Pers	son, the	e c	laim <sub>l</sub>	oayme	nt w	ill be	ma	de to	the the	Non	ninee	(as n	ame	d in th	16
		-, <del>g-</del>																							
Plac	e:_			_										- Si	anat	uro	of th	o In	CUro	4 / D	Poliovk	oldo	r / C	laima	ni
Date	Э	D D M M Y Y Y	′ Y											01	griat	uic c	) [[	10 111	Suice	u / I	Olicyi	ioiac	.1 / C	iaiiiiai	
Co	mm	nunication details of TPA	(kind	Ny eubi	mit the	a dully	filled	& cian	ad c	laim fo	rm alou	na	with	origin	al de	ocum	ont	c at	follo	wing	n addı	.occ/			
Fa	mily	Health Plan (TPA) Ltd -	Clair	ns Dep	artmei	nt <b>Tata</b>	AIG	Gener	al Ins	surance	e Comp	pa	ny (T	AGIC)							g addi	C33)			
Gr	oun	d Floor, Srinilaya – Cybe	r Spa	zio, Ro	ad No	: 2, Bar	njara l	Hills, F	lyde	rabad 5	500 034	1 •	FHPI	_ Toll	Free	No:	180	0 42	5 40	90					
			(	CHECK	( LIS	T OF I	ENCI	LOSU	IRES	FOR	SUBI	MI	ISSI	о ис	F C	LAII	VI								Ī
In-pa	atier	nt Treatment / Day Care F	roceo	dures							Original	m	edicir	ne bills	. nav	men	t red	ceint	with	pres	scripti	ons.			
	-	filled and signed Claim Fo									Original	in	vestig	ations									ons a	ınd	
		tocopy of ID card / Photoc			•			o boon	ital		nvestiga				c										
	_	inal detailed discharge sum inal consolidated hospital		-		-			ııldı.		Original <b>n Dona</b>						mer	it red	eipt.						
	sign	ed by the insured.			·		,	,		_	dition to						eral	hos	pitali	zatio	n:				
	_	inal payment receipt of the									Organ fu					-									
		consultation letter and su inal bills, payment receipts									reatme oncern			icate is	ssued	d by	the	trans	plant	t sur	geon	of the	e hos	pital	
	_	inal medicine bills and rec				_		iptions	<b>.</b>	-	oncern ulance														
	_	inal invoice / bills for Impla inal payment receipts.	ants (	viz. Ster	nt / PH	S Mesh	/ IOL	etc.) v	vith		Original			paym	ent r	eceip	ot.								
	_	affic Accident									reating			s cons	ultat	ion p	reso	cripti	on in	ndica	iting e	merg	ency	′	
In ac	dditio	on to the In-patient Treatm									iospitali I <b>al Heal</b>			k un											
		y of the first information re Medico Legal Certificate.	eport	from po	olice de	epartme	ent / C	copy of	f		Ouly fille				Clain	n For	m.								
		Medico Legal Cases:									hotoco				-:11- (				!4		داد : داد	4	.a.:		
		ting Doctor's certificate giver injury sustained).	ving d	letails o	f injuri	es (Hov	v, whe	en and			Original Original		_									_			
		ental Death cases:								Daily	Cash E	Bei	nefit				•							-	
		y of post mortem report (i	f cond	ducted).							Ouly fille				Clain	n For	m.								
		y of Death Certificate. th Cases									hotoco <b>atient l</b>				lenta	I & D	net	Rite	Vac	rinat	tion				
In ac	dditio	on to the In-Patient Treatm			nts:						Ouly fille							שונפ	v au	unal					
	_	inal Death summary from			ooto-	or the b	neni+al	autho	rit.	P	hotoco	ру	of ID	card.											
	-	y of the Death Certificate from y of the Legal Heir Certificate.		_					iity.		Original Original					•				1 10/14	th inve	etico	ation	ranari	
		ciple insured.									Original Original		_			-	-					_		report	
		Post-hospitalisation expe									Details o	of a	any o	utpatie											
		r filled and signed Claim Fo tocopy of ID card.	orm.								Dental X	<-ra	ay filn	٦.											
		coopy or in card.																							

## **PART B**

For Office Use Only (Refer IRDA / TAC Master for codes wherever applicable) TPA Code 1) Insurer Code 3) **Product Code** Policy Number 4) 5) Policy Start Date 6) Policy End Date M Υ Υ Υ Υ M Υ Υ Υ 7) Sum Insured Bonus Sum Insured 9) Master Claim ID Accrued, if any Diagnosis Code Primary Diagnosis Additional Diagnosis Co-morbidities Procedure Code Procedure 1 11) Procedure 2 Procedure 3 **Details of Claim Paid Indemnity Benefit** Room & **ICU Charges Nursing Charges OT Charges** Medicine & Consummable d. c. Charges e. Professional Investigation Charges Fees' Charges Ambulance Miscellaneous Charges Charges 13) **Total Claim Paid** 14) Total Rejected Amount Reason for Rejection Reason for Reduction 15) 16) of Claim of Claim 18) If Yes, PED Code 17) Whether claim paid was for PED Whether claim paid under alternate medicine 19) Yes No Amount of co-payment / deductible applicable 20) 21) Corporate Buffer Utilized, if any M M 22) Date of Payment 23) Payment Reference Number Date of Claim 24) 25) Date of receipt of complete D D M M Y D D M M Y Y Y Intimation claim documents PART C (TO BE FILLED IN BY THE HOSPITAL) The insurance 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 Name of the Hospital where treated Hospital ID: 3. Type of Hospital: Network Non Network In case of Non Network, please provide below details Address of the Hospital City Pin Code State Telephone No. (with STD) Registration No. No.of Inpatient beds Hospital PAN No. Other facilities available in the hospital: i) OT YES NO ii) ICU YES NO iii) Others: Details of the patient admitted Name of the patient IP Registration No. Gender: Male Female D D M Υ Date of Birth M Υ Υ Date of Admission D M M Time AM / PM M Υ Time AM / PM D D Υ Υ Date of Discharge

6.	Ailment Diagnosed (Primary)						
	ICD 10 Code		Primary Diagnosis				
	Additional Diagnosis		Co-morbidities				
	Details of Procedure/s done :						
	ICD 10 PCS : Prod	cedure 1 :	Procedure 2 :	Procedure 3	:		
7.	Type of Admission						
	Emergency	ned Day-care	Others :				
	Date of delivery, if maternity D D N	M M Y Y Y	Gravida Status :				
8.	Is the treatment for an injury? If, yes, g	jive details					
	a) Was it self inflicted?				Y	ES	NC
	b) Whether Road Traffic Accident				YF	ES	NC
	c) If Medico Legal Certificate (MLC), w	hether notified to police -			YE	ES	NC
	d) MLC / FIR No.:						
	e) If MLC not notified, give reasons:						
9.	Was the Injury/ disease caused due to	Substance abuse / Alcohol o	onsumption		Y	ES	NC
	If Yes whether any test was conducted				YI	ES	NC
10	Whether the present ailment is a comp	olication of any illness suffers	d in the nact		V	ES	NC
10.	If Yes, specify details	modifier of any filliess suffere	— Hast				
11	Whether Pre-authorisation obtained				YE	s [	NC
• • •	a) If Yes, Pre Auth No.:					.5	140
	b) If authorisation by network hospital	not obtained, give reason :					
40		, 5					
12.	Details of the Treating Doctor  a) Name of the Treating Doctor						
	b) Registration No. with state code						
	c) Mobile No.						
	d) Qualification :						
	u) Qualification .						
13.	For details of Claim Documents to be s	submitted to the TPA, please	refer to the Capital				
	claration by the hospital  hereby declare that the information furnis	hed in this Claim Form is true a	and correct to the best of our knowl	ledge and belief. If	we have m	nade ar	nv fals
	untrue statement, suppressed or concealed				vvo navo n	iaao ai	iy idio
Se	al & Signature Of The Hospital Authority						
Dat							
Da	te DDMMYYYYY						
С	ustomer Identification Procedure (as per K	YC norms of IRDA)					
-	ease submit the following documents in ca						
	egal name and any other names used (Any tentioned documents) identity and residenc		ort/ PAN Card/ Voter's Identity Card/ from a recognized public authority of		erifying the		

Insurance is the subject matter of the solicitation. For more details on risk factors, terms and conditions, please read sales brochure carefully, before concluding a sale.

Proof of Residence

(Any one of the mentioned documents)

Telephone bill/ Bank account statement/ Letter from any recognized public authority/ Electricity bill/ Ration card