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

TO BE FILLED BY THE INSURED
The issue of this Form is not to be taken as an admission of liablity

(To be Filled in block letters)

DETAILS OF PRIMARY INSURED:		— r
a) Policy No.: b) SI. No/ Certificate no.		
c) Company/ TPA ID No:		
d) Name: SURNAME FIRST NAME MIDDLE N	AME	<u> </u>
e) Address:		ةِ الله
City: State: State:		┚□▮
Pin Code		
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	YY	
c) If yes, company name:		i c
Sum insured (Rs.)	M Y Y	5
Diagnosis:  e) Previously covered by any other Mediclaim /Health i	nsurance : Yes	□ No
f) If yes, company name:		
DETAILS OF INSURED PERSON HOSPITALIZED: :		
a) Name: SURNAMEN FIRST NAMEN MIDDLEN	AME	
b) Gender Male Female c) Age years Y Y Months M M d) Date of Birth D D M M Y Y Y Y		
f) Occupation Service Self Employed Home Maker Student Other (Please Specify)		}
g) Address (if diffrent from above):		
City: State: State:		
Pin Code Phone No: Phone No: Email ID:		
DETAILS OF HOSPITALIZATION: :		
a) Name of Hospital where Admited:		
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	YYYY	S C
		_ =
e) Date of Admission: D D M M Y Y f) Time H H M H g) Date of Discharge: D D M M Y Y h) Tim	ie: H H : M H	H 9
e) Date of Admission: D D M M Y Y 1) Time H H M H g) Date of Discharge: D D M M Y Y N 1) Time H H S Discharge: D D M M Y Y N 1 Ime H H M H G) Date of Discharge: D D M M Y Y Y N) Time H H M H G) Date of Discharge: D D M M M Y Y Y N) Time H H M H G) Date of Discharge: D D M M M Y Y Y N) Time H H M H G) Date of Discharge: D D M M M Y Y Y N) Time H H M H G) Date of Discharge: D D M M M Y Y Y N) Time H H M H G) Date of Discharge: D D M M M Y Y Y N) Time H H M H G) Date of Discharge: D D M M M Y Y Y N) Time H H M H G) Date of Discharge: D D M M M Y Y Y N) Time H H M H G) Date of Discharge: D D M M M Y Y Y N) Time H H M H G) Date of Discharge: D D M M M Y Y Y N) Time H M H G) Date of Discharge: D D M M M Y Y Y N) Time H M H G) Date of Discharge: D D M M M Y Y Y N) Time H M M H G) Date of Discharge: D D M M M Y Y Y N) Time H M M H G) Date of Discharge: D D M M M Y Y Y N) Time H M M M M M M M M M M M M M M M M M M		H
I) If injury give cause: Self inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption I) If Medico legal Yes N		
I) If injury give cause: Self inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption I) If Medico legal Yes N ii) Reported to Police III. MLC Report & Police FIR attached Yes No j) System of Medicine:  DETAILS OF CLAIM:	0	
I) If injury give cause: Self inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption I) If Medico legal Yes N ii) Reported to Police III. MLC Report & Police FIR attached Yes No j) System of Medicine:  DETAILS OF CLAIM:  a) Details of the Treatment expenses claimed  Claim Documents	o Submitted - Check List:	
I) If injury give cause: Self inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption I) If Medico legal Yes N ii) Reported to Police 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 Rs. Claim Documents  Claim form	o Submitted - Check List:	
I) If injury give cause: Self inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption I) If Medico legal Yes N ii) Reported to Police 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 Rs. Claim Documents iii. Hospitalization expenses Rs. Claim form iv. Health-Check up cost: Rs. Copy of the	o  Submitted - Check List: duly signed claim intimation, if any	
I) If injury give cause: Self inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption I) If Medico legal Yes N  ii) Reported to Police 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 Rs. Claim Documents  iii. Hospitalization expenses Rs. Claim form iv. Health-Check up cost: Rs. Copy of the Hospital Mark v. Ambulance Charges: Rs. No Chers (code): Rs. Hospital Mark vi. Others (code): Rs. Hospital Bre	o  Submitted - Check List: duly signed claim intimation, if any in Bill	
I) If injury give cause: Self inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption I) If Medico legal Yes N ii) Reported to Police 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 Rs. Claim Documents iii. Hospitalization expenses Rs. Claim formula iii. Hospitalization expenses Rs. Claim formula iii. Hospitalization expenses Rs. Copy of the V. Ambulance Charges: Rs. Vi. Others (code): Rs. Hospital Bra. Hospital Bra. Hospital Bill	o  Submitted - Check List: duly signed claim intimation, if any in Bill	
I) If injury give cause: Self inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption I) If Medico legal Yes N ii) Reported to Police 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 Rs. Claim Documents iii. Hospitalization expenses Rs. Claim form of the iii. Hospitalization expenses Rs. Claim form of the iii. Post-hospitalization expenses Rs. Rs. Rs. Rs. Rs. Rs. Rs. Rs. Rs. Rs	o Submitted - Check List: duly signed claim intimation, if any in Bill bak-up Bill Payment Receipt charge Summary	
I) If injury give cause: Self inflicted  Road Traffic Accident  Substance Abuse / Alcohol Consumption  I) If Medico legal  Yes  Neighbor New Notation  New Notation  Substance Abuse / Alcohol Consumption  I) If Medico legal  Yes  Notation New Notation  Ne	o Submitted - Check List: duly signed claim intimation, if any in Bill eak-up Bill Payment Receipt charge Summary	
I) If injury give cause: Self inflicted  Road Traffic Accident  Substance Abuse / Alcohol Consumption  I) If Medico legal  Yes  Neighbor Network  Noi  iii. MLC Report & Police FIR attached  Yes  Noi  i) System of Medicine:    DETAILS OF CLAIM:	o Submitted - Check List: duly signed claim intimation, if any in Bill bak-up Bill Payment Receipt charge Summary	
I) If injury give cause: Self inflicted  Road Traffic Accident  Substance Abuse / Alcohol Consumption  I) If Medico legal  Yes  Neighbor Network  Noi  iii. MLC Report & Police FIR attached  Yes  Noi  i) System of Medicine:    DETAILS OF CLAIM:	o Submitted - Check List: duly signed claim intimation, if any in Bill eak-up Bill Payment Receipt ccharge Summary Sill heater Notes	
I) If injury give cause: Self inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption I) If Medico legal Yes Noing Reported to Police III. MLC Report & Police FIR attached Yes Noing System of Medicine:    DETAILS OF CLAIM:	o Submitted - Check List: duly signed claim intimation, if any in Bill Payment Receipt scharge Summary Sill heater Notes guest for investigation n Reports (Including CT	
It injury give cause: Self inflicted   Road Traffic Accident   Substance Abuse / Alcohol Consumption   I) If Medico legal   Yes   No   No   No   No   No   No   No   N	o Submitted - Check List: duly signed claim intimation, if any in Bill bak-up Bill Payment Receipt charge Summary still heater Notes quest for investigation in Reports (including CT if HPE)	
It injury give cause: Self inflicted   Road Traffic Accident   Substance Abuse / Alcohol Consumption   I) If Medico legal   Yes   No   No   No   No   No   No   No   N	o Submitted - Check List: duly signed claim intimation, if any in Bill bak-up Bill Payment Receipt charge Summary still heater Notes quest for investigation in Reports (including CT if HPE)	
Diffiniting give cause: Self inflicted   Road Traffic Accident   Substance Abuse / Alcohol Consumption   1) If Medico legal   Yes   No   No   No   No   No   No   No   N	Submitted - Check List: duly signed claim intimation, if any in Bill Payment Receipt scharge Summary Sill heater Notes juest for investigation n Reports (Including CT is / HPE) sscriptions	
I) If injury give cause: Self inflicted  Road Traffic Accident  Substance Abuse / Alcohol Consumption  I) If Medico legal  Yes  No  ii) Reported to Police  Iii. MLC Report & Police FIR attached  Yes  No  i) System of Medicine:    DETAILS OF CLAIM:	o Submitted - Check List: duly signed claim intimation, if any in Bill bak-up Bill Payment Receipt charge Summary still heater Notes quest for investigation in Reports (including CT if HPE)	
Diffinjury give cause: Self inflicted   Road Traffic Accident   Substance Abuse / Alcohol Consumption   I) If Medico legal   Yes   N	Submitted - Check List: duly signed claim intimation, if any in Bill Payment Receipt scharge Summary Sill heater Notes juest for investigation n Reports (Including CT is / HPE) sscriptions	SECTIONE
Diffiniting give cause: Self inflicted	Submitted - Check List: duly signed claim intimation, if any in Bill Payment Receipt scharge Summary Sill heater Notes juest for investigation n Reports (Including CT is / HPE) sscriptions	SECTIONE
Diffinjury give cause: Self inflicted   Road Traffic Accident   Substance Abuse / Alcohol Consumption   I) If Medico legal   Yes   N	Submitted - Check List: duly signed claim intimation, if any in Bill Payment Receipt scharge Summary Sill heater Notes juest for investigation n Reports (Including CT is / HPE) sscriptions	
1)	Submitted - Check List: duly signed claim intimation, if any in Bill Payment Receipt scharge Summary Sill heater Notes juest for investigation n Reports (Including CT is / HPE) sscriptions	
	Submitted - Check List: duly signed claim intimation, if any in Bill Payment Receipt scharge Summary Sill heater Notes juest for investigation n Reports (Including CT is / HPE) sscriptions	
Injury give cause: Self inflicted   Road Traffic Accident   Substance Abuse / Alcohol Consumption   Injury give cause: Self inflicted   Road Traffic Accident   Substance Abuse / Alcohol Consumption   Injury give cause: Self inflicted   Road Traffic Accident   Substance Abuse / Alcohol Consumption   Injury give cause: Self inflicted   Road Traffic Accident   Substance Abuse / Alcohol Consumption   Injury give cause: Self inflicted   Road Traffic Accident   Substance Abuse / Alcohol Consumption   Injury give cause: Self inflicted   Road Traffic Accident   Road Traffic Acciden	Submitted - Check List: duly signed claim intimation, if any in Bill Payment Receipt scharge Summary Sill heater Notes juest for investigation n Reports (Including CT is / HPE) sscriptions	
If injury give cause:	Submitted - Check List: duly signed claim intimation, if any in Bill Payment Receipt scharge Summary Sill heater Notes juest for investigation n Reports (Including CT is / HPE) sscriptions	
If injury give cause:	Submitted - Check List: duly signed claim intimation, if any in Bill Payment Receipt scharge Summary Sill heater Notes juest for investigation n Reports (Including CT is / HPE) sscriptions	SECTIONE
If injury give cause:	Submitted - Check List: duly signed claim intimation, if any in Bill Payment Receipt scharge Summary Sill heater Notes juest for investigation n Reports (Including CT is / HPE) sscriptions	SECTION E
If injury give cause:	Submitted - Check List: duly signed claim intimation, if any in Bill Payment Receipt scharge Summary Sill heater Notes juest for investigation n Reports (Including CT is / HPE) sscriptions	SECTION E

## DECLARATION BY THE INSURED:

I hereby declare that the information furnished in the claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealent of any material fact with respect to questions asked in relation to this claim, my right to claim reimbrusement 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	YYYY	Place:		Signature of the Insured	

SECTION H

	DATA ELEMENT	FOR FILLING CLAIM FORM - PART A (To be filled in by the insured  DESCRIPTION	FORMAT
	DATA ELEMENT	SECTION A - DETAILS OF PRIMARY INSURED	FORMAI
,	D.E. N		
a)	Policy No.	Enter the policy number  Enter the social Insurance number or the certificate number of	As allotted by the Insurance Company
b)	SI. No/ Certificate No.	social health insurance scheme	As allotted by the oraganization  Licence number as allotted by IRDA and printed
c)	Company TPA ID No.	Enter the TPA ID No.	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
- 1	Commonths account his any other Mediclains / Health	SECTION B -DETAILS OF INSURANCE HISTORY	I
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-forrmat
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
i)	Have you been Hospitalized in the last four years since Inception of the contract?	Indicate whether hospitalized in the last four years	Tick Yes or No
	Date	Enter the date of Hospitalization	Use mm-yy format
	Diagnosis	Enter the diagnosis details	Open Text
)	Previously covered by any other Mediclaim / Health Insurance?	Indicate whether previously covered by another mediclaim / Health Insurance	Tick Yes or No
)	Company Name	Enter the full name of the Insurance Company	Name of the organization in full
	SEC	TION C -DETAILS OF INSURED PERSON HOSPITALIZED	-
)	Name	Enter the full name of the patient	Surname, First name, Middle name
)	Gender	Indicate Gender of the patient	Tick Male or Female
<u>′</u>	Age	Enter age of the patient	Number of years and months
')  )	Date of Birth	Enter Date of Birth of patient	Use dd-mm-yy format
<u>′</u>	Relationship to primary Insured	Indicate relationship of patient with policyholder	Tick the right option, if others, please specify
)	Occupation	indicate occupation of patient	Tick the right option. If others, please specify.
) ()	Address	Enter the full postal address	Include Street, City and Pin code
1)	Phone No	Enter the phone number of patient	Include STD code with telephone number
1)	E-mail ID	Enter the prove number of patient  Enter e-mail address of patient	Complete e-mail address
,	L-IIIaii ID	SECTION D - DETAILS OF HOSPITALIZATION	Tompiete e-mail address
1)	Name of Hospital where admited	Enter the name of hospital	Name of hospital in full
) )	Room category occupied	indicate the room category occupied	Tick the right option
<u></u>	Hospitalization due to	indicate the room category occupied	Tick the right option
;) I)	Date of injury/Date Disease first detected / Date of	Enter the relevant date	Use dd-mm-yy format
	Delivery		
;)	Date of admission	Enter date of admission  Enter time of admission	Use dd-mm-yy format
)	Time		Use hh-mm- format
)	Date of discharge	Enter date of discharge	Use dd-mm-yy format Use hh-mm- format
)	Time	Enter time of discharge	
)	If injury give cause	indicate cause of injury	Tick the right option
	If Medico legal	indicate whether injury is medico legal indicate whether police report was filed	Tick Yes or No
	Reported to Police		Tick Yes or No
	MLC Report & Police FIR attached	indicate whether MLC report and Police FIR attached	Tick Yes or No
		Enter the system of medicine followed in treating the patient	Open Text
1	System of Medicene	SECTION E - DETAILS OF CLAIM	
		SECTION E - DETAILS OF CLAIM	In runees (Do not enter paice values)
a)	Details of Treatment Expences	Enter the amount claimed as treatment expences	In rupees (Do not enter paise values)
a) D)	Details of Treatment Expences  Claim for Domiciliary Hospitalization	Enter the amount claimed as treatment expences indicate whether claim is for domiciliary hospitalization	Tick Yes or No
a) o)	Details of Treatment Expences  Claim for Domiciliary Hospitalization  Details of Lump sum/ Cash benifit claimed	Enter the amount claimed as treatment expences indicate whether claim is for domiciliary hospitalization  Enter the amount claimed as lump sum / cash benefit	Tick Yes or No In rupees (Do not enter paise values)
a) o) o)	Details of Treatment Expences  Claim for Domiciliary Hospitalization	Enter the amount claimed as treatment expences indicate whether claim is for domiciliary hospitalization Enter the amount claimed as lump sum / cash benefit indicate which supporting documents are submitted	Tick Yes or No
a) o) c)	Details of Treatment Expences Claim for Domiciliary Hospitalization Details of Lump sum/ Cash benifit claimed Claim documents Submitted-Check List	Enter the amount claimed as treatment expences indicate whether claim is for domiciliary hospitalization  Enter the amount claimed as lump sum / cash benefit	Tick Yes or No In rupees (Do not enter paise values)
n) n) :)	Details of Treatment Expences Claim for Domiciliary Hospitalization Details of Lump sum/ Cash benifit claimed Claim documents Submitted-Check List iicate which bills are enclosed with the amount in rupees	Enter the amount claimed as treatment expences indicate whether claim is for domiciliary hospitalization Enter the amount claimed as lump sum / cash benefit indicate which supporting documents are submitted SECTION F - DETAILS OF BILLS ENCLOSED	Tick Yes or No In rupees (Do not enter paise values)
a) () () () ()	Details of Treatment Expences Claim for Domiciliary Hospitalization Details of Lump sum/ Cash benifit claimed Claim documents Submitted-Check List icate which bills are enclosed with the amount in rupees	Enter the amount claimed as treatment expences indicate whether claim is for domiciliary hospitalization Enter the amount claimed as lump sum / cash benefit indicate which supporting documents are submitted SECTION F - DETAILS OF BILLS ENCLOSED  ON G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT	Tick Yes or No In rupees (Do not enter paise values) Tick the right option
i) i) i) l)	Details of Treatment Expences Claim for Domiciliary Hospitalization Details of Lump sum/ Cash benifit claimed Claim documents Submitted-Check List licate which bills are enclosed with the amount in rupees SECTION	Enter the amount claimed as treatment expences indicate whether claim is for domiciliary hospitalization Enter the amount claimed as lump sum / cash benefit indicate which supporting documents are submitted SECTION F - DETAILS OF BILLS ENCLOSED  ON G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT Enter the permanent account number	Tick Yes or No In rupees (Do not enter paise values) Tick the right option  As allotted by the Income Tax Department
a) b) c) d)	Details of Treatment Expences Claim for Domiciliary Hospitalization Details of Lump sum/ Cash benifit claimed Claim documents Submitted-Check List licate which bills are enclosed with the amount in rupees SECTION PAN Account Number	Enter the amount claimed as treatment expences indicate whether claim is for domiciliary hospitalization Enter the amount claimed as lump sum / cash benefit indicate which supporting documents are submitted SECTION F - DETAILS OF BILLS ENCLOSED  ON G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT Enter the permanent account number Enter the Bank account number	Tick Yes or No In rupees (Do not enter paise values) Tick the right option  As allotted by the Income Tax Department As allotted by the Bank
a) c) d) nd a)	Details of Treatment Expences Claim for Domiciliary Hospitalization Details of Lump sum/ Cash benifit claimed Claim documents Submitted-Check List licate which bills are enclosed with the amount in rupees SECTION	Enter the amount claimed as treatment expences indicate whether claim is for domiciliary hospitalization Enter the amount claimed as lump sum / cash benefit indicate which supporting documents are submitted SECTION F - DETAILS OF BILLS ENCLOSED  ON G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT Enter the permanent account number Enter the Bank account number Enter the Bank name along with the branch	Tick Yes or No In rupees (Do not enter paise values) Tick the right option  As allotted by the Income Tax Department
(a) (b) (d) (d) (d) (d) (e)	Details of Treatment Expences Claim for Domiciliary Hospitalization Details of Lump sum/ Cash benifit claimed Claim documents Submitted-Check List licate which bills are enclosed with the amount in rupees SECTION PAN Account Number	Enter the amount claimed as treatment expences indicate whether claim is for domiciliary hospitalization Enter the amount claimed as lump sum / cash benefit indicate which supporting documents are submitted  SECTION F - DETAILS OF BILLS ENCLOSED  ON G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT Enter the permanent account number Enter the Bank account number Enter the Bank name along with the branch Enter the name of the beneficiary the cheque / DD should be made out to	Tick Yes or No In rupees (Do not enter paise values) Tick the right option  As allotted by the Income Tax Department As allotted by the Bank Name of the Bank in full Name of the individual / organization in full
a)  b)  c)  d)	Details of Treatment Expences Claim for Domiciliary Hospitalization Details of Lump sum/ Cash benifit claimed Claim documents Submitted-Check List  licate which bills are enclosed with the amount in rupees  SECTION PAN Account Number Bank Name and Branch	Enter the amount claimed as treatment expences indicate whether claim is for domiciliary hospitalization Enter the amount claimed as lump sum / cash benefit indicate which supporting documents are submitted  SECTION F - DETAILS OF BILLS ENCLOSED  ON G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT Enter the permanent account number Enter the Bank account number Enter the Bank name along with the branch Enter the name of the beneficiary the cheque / DD should be	Tick Yes or No In rupees (Do not enter paise values) Tick the right option  As allotted by the Income Tax Department As allotted by the Bank Name of the Bank in full