CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT – PART A
TO BE FILLED IN BY THE INSURED
The issue of this Form is not to be taken as an admission of liability

(To be filled in block letters)

SECTION A

DETAILS OF PRIMARY INSURED:

a) Policy No: ☐ b) Sl. No/ Certificate No: ☐

c) Company/ TPA ID No: ☐

d) Name: SURNAME FIRST NAME MIDDLE NAME

e) Address: ☐

City: ☐ State: ☐

Pin Code: ☐ Phone No: ☐ Email ID: ☐

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: DD MM YY

c) If yes, company name: ☐ Policy No. ☐

Sum Insured (Rs.) ☐ d) Have you been hospitalized in the last four years since inception of the contract? ☐ Yes ☐ No Date: MM YY

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: SURNAME FIRST NAME MIDDLE NAME

b) Gender: Male ☐ Female ☐ c) Age: years YY months MM d) Date of Birth: DD MM YY

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: ☐ E-mail 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: DD MM YY

e) Date of Admission: DD MM YY f) Time: HH : MM g) Date of Discharge: DD MM YY h) Time: HH : MM

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 the treatment expenses claimed

i. Pre-hospitalization Expenses: Rs. ☐ ii. Hospitalization Expenses: Rs. ☐

iii. Post-hospitalization Expenses: Rs. ☐ iv. Health-Check up Cost: Rs. ☐

v. Ambulance Charges: Rs. ☐ vi. Others (code): ☐ Rs. ☐

Total Rs. ☐

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: Rs. ☐ ii. Surgical Cash: Rs. ☐

iii. Critical Illness Benefit: Rs. ☐ iv. Convalescence: Rs. ☐

v. Pre/Post hospitalization Lump sum benefit: Rs. ☐ vi. Others: ☐ Rs. ☐

Total Rs. ☐

Claim Documents Submitted- Check List:

- ☐ Claim Form Duly signed
- ☐ Copy of the claim intimation, if any
- ☐ Hospital Main Bill
- ☐ Hospital Break-up Bill
- ☐ Hospital Bill Payment Receipt
- ☐ Hospital Discharge Summary
- ☐ Pharmacy Bill
- ☐ Operation Theatre Notes
- ☐ ECG
- ☐ Doctor's request for investigation
- ☐ Investigation Reports (Including CT / MRI / USG / HPE)
- ☐ Doctor's Prescriptions
- ☐ Others

SECTION F

DETAILS OF BILLS ENCLOSED:

Sl. No	Bill No	Date	Issued by	Towards	Amount (Rs)
1.		DD MM YY		Hospital Main Bill	
2.		DD MM YY		Pre-hospitalization Bills: ___ Nos	
3.		DD MM YY		Post-hospitalization Bills: ___ Nos	
4.		DD MM YY		Pharmacy Bills	
5.		DD MM YY			
6.		DD MM YY			
7.					
8.		DD MM YY			
9.		DD MM YY			
10		DD MM YY			

SECTION G

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT:

☐ ☐

c) Bank Name and Branch: ☐

d) Cheque/ DD Payable details: ☐ e) IFSC Code: ☐

(IMPORTANT: PLEASE TURN OVER)