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

| a) Policy No.: | | VIA. | XI B | NSL | JKE | U. | | | | | | | 1 | 11.3 | | | | | | | | - | - | | O III I | DIOCK | lette |
|--|---|----------|--|---|---|--|--------------------|-------------|-----------|--------|----------|-------|------------|-------|------|-------|-------|---------------------|------|----------|------|------|------|--------|---------|-------|-------|
| | | 20 | | | | | | | | | | | | | | | | | | | | | | | | | |
|) SI. No/ Cer | tificat | e no |). | , | Y i | | | | | | | | | 1 | 500 | | | | | | 1 | 1 | | | 6.0 | | |
| c) Company/ | TPA II | D N | o: | | | | | | | IA I | | | | | | | | 7 | | | | | | | | | |
| d) Name: | | | | i i | S | U | R | N | A | M | E | 1 | | 13 | Ì | 100 | | | T Ya | | | | | | | | 92 |
| FI | R | S | T | 4, | N | A | M | E | | | | | | 174.8 | 17.5 | EU/O | | 188 | | | | | | | | Ţ, | |
| M | D | D | L | E | VA. | N | A | M | E | M | | | | | | A | 10,13 | | | | | | | | | 1.7 | 84 |
| e) Address: | | T | T | 10 | T | | | | T | T | 1 | | | 1 | | 7. | - | | - | | | | T | | | | |
| | | Ť | 7 | Ť | T | 1 | | | 1 | | | | | | | Ť | | 770 | | | | 7.1 | T | | T | | |
| | | | | | | T | | | | | | | | | T | 1 | | | - | | | | t | | v. 1 | | |
| City: | | 1 | | | | | | T | | | | T | T | | | | 1 | | | 64 | THI | | 1 | | 1 | 23/2 | |
| State: | | | | 1 | | + | + | 1 | | 1 | 1 | 1 | | | | H | 1 | 1 | | Pin Co | del | | TE | | | 1 | 1 |
| Phone No: | | | + | - | + | + | 1 | + | 1 | 1 | + | 1 | l_ Emai | IDI | | - | | | ' | 11100 | | 1 | 17 | | - | | 1 |
| DETAILS OF | INSI | IRA | NCF | HIS | STO | RY: | | | 3 | | 10 | OI. | Liliai | 10. | | | | PU. | | y v | 1 | 87. | Ay | TR. | 31 | 1 | T I |
| a) Currently of | | 153 | | | JUL | | clair | n / H | ealth | n Ins | uran | ce: | | Yes | | 7 N | 0 | N. B. | 711. | i. | SIN, | | | 101 | | | |
| o) Date of co | | | | | | | | | | | 1 | D | D | M | M | | Y | Y | Y | Y | | *** | | | | | |
| c) If yes, com | - 5 | | - | | | | | 1 | | T | T | | | | | JL | | | 7 | v | | | | | | | |
| The state of the s | Party | Tall | T | T | 1 | 1 | 1 | 1 | T | 1 | I | 1 | 1 | 1 | | 1 | L | 1 | | | | 2/1 | 345 | | | 1 | 15 |
| Policy No. | (5) | | | 480 | - | 1 | 1 | | + | | 1 | | | | k | 1 | 1 | | | | | | | | | | |
| Sum insured d) Have you b | | 200 | litali- | 704 | in th | o lo | et for | IT 1/2 | arc | cinco | ina | ontic | n of | the - | onte | 2010 | | 1 | | | | 04. | | | 4 | ×/ [| N |
| | been I | iosp | ntaliz | .eu | m tu | e id | ot 10 | ur ye | वाड ३ | SITICE | HIC | epuc | m Ol | me (| ontr | act? | | Ye | S | No | ט נ | ate: | 1 13 | II I F | VI | Y | Υ |
| Diagnosis: | | | 40 | | 30 | AA | | 12/ | 10 | Já. | 5 | | 12 | | | | 5 N F | | | - | 20 1 | Q C | | | | 610 | 0 |
| e) Previously | | | - | 1y o | ther | Med | dicla | im /H | ealt | h ins | uran | ice : | | Yes | | | 0 | | | | | 1000 | 18 | | | | |
|) If yes, comp | 721 | | | 200 | | 100 | | | | | | | | | | | | | | | | | | | | | |
| | | | | KSC | JNF | 1OS | PHA | LIZE | :U: | 150 | 1 | | | N. L. | 300 | - | | | | | | | | | | | |
| ETAILS OF | INSU | KEL | PE | | | | 1 | | 200 | 10 | | | | | 1 | | 117 | Г | 1 | - | _ | 1 | T | 1 | | | |
| DETAILS OF | | | 1 | | S | U | R | N | A | M | E | | | | | | | | | 10 | I | I | 7 | / | | | |
| ETAILS OF | R | S | T | 8" | S | U | M | E | 4 | IV: | E | | | | | | | | | c | | | n | | | | |
| DETAILS OF Name: M I | R D | | 1 | E | N | UAAN | M | E | A | IV: | E | | | | | | | | | c | | | 2 | | | | |
| DETAILS OF I) Name: III III III III III III III III III I | R D | s D | 1 | E | N | UAAN | M | E | 4 | | E Mon | ths | M | M | d) D | ate o | of Bi | rth[| 0 | 0 | M | I | | Y | Y | Y | |
| DETAILS OF a) Name: M I O O O O O O O O O O O O O O O O O | R D | S D | T L | E | N | A N O) Ag | M A je ye | E | E | | Mon | | M Child | | | ate o | | rth[| 0 | 0 | M | I | 4 | Y | Υ | Y | |
| DETAILS OF a) Name: F | R D D D D D D D D D D D D D D D D D D D | S D F | T L | E le | N | A N O) Ag | A A Self | M ars | E Y Sp | Y | Mon | | 1 | | | | | rth[| | 0 | M | N | 7 | Y | Y | Y | 1 |
| DETAILS OF a) Name: F | R D D D D D D D D D D D D D D D D D D D | S D F | emal | E le r | N or construction of the same | A N A od: S | A A Self | M ars [| Y Sp | Y | Mon |] | Child | | Fa | ithe | | rtth[| D | 0 | I WI | N N | 4 [| Y | Y | Y | |
| PETAILS OF Name: M Gender Ma Relationsh Occupation | R D D D D D D D D D D D D D D D D D D D | S D F | emal | E le representation E representation E | sure Plea | N N N N N S N S S S S S S S S S S S S S | M A ge ye self spe | ears [cify) | Y Sp | Y | Mon |] | Child | | | ithe | | rth[| 0 | 0 | M | N | A][| Y | Υ | У | 1 |
| PETAILS OF Name: Name: | R D D D D D D D D D D D D D D D D D D D | S D F | emal | E le representation E representation E | N or construction of the same | N N N N N S N S S S S S S S S S S S S S | M A ge ye self spe | ears [cify) | Y Sp | Y | Mon |] | Child | | Fa | ithe | | rth | 0 C | 0 | W | N N | 4][| Y | Υ | У | |
| DETAILS OF I) Name: IM I I) Gender Ma I) Relationsh Mother Occupation Retired (| R D D D D D D D D D D D D D D D D D D D | S D Fris | t la | E E F E F E E F E E | N Consumer | N N N N N S N S S S S S S S S S S S S S | M A ge ye self spe | ears [cify) | Y Sp | Y | Mon |] | Child | | Fa | ithe | | rtth[| 0 | D | M | I N | | Y | Y | Y | |
| DETAILS OF a) Name: M 1 Occupation Occupation Retired Occupation | R D D D D D D D D D D D D D D D D D D D | S D Fris | t la | E E F E F E E F E E | N Consumer | N N N N N S N S S S S S S S S S S S S S | M A ge ye self spe | ears [cify) | Y Sp | Y | Mon |] | Child | | Fa | ithe | | rtth[| D | 0 | M | N N | 4 | Y | Y | Y | |
| DETAILS OF a) Name: M 1 Occupation Occupation Retired Occupation | R D D D D D D D D D D D D D D D D D D D | S D Fris | t la | E E F E F E E F E E | N Consumer | N N N N N S N S S S S S S S S S S S S S | M A ge ye self spe | ears [cify) | Y Sp | Y | Mon |] | Child | | Fa | ithe | | rtth | 0 | D | M | I N | 1 1 | Y | Y | Y | |
| DETAILS OF a) Name: M 1 Occupation Occupation | R D D D D D D D D D D D D D D D D D D D | S D Fris | t la | E E F E F E E F E E | N Consumer | N N N N N S N S S S S S S S S S S S S S | M A ge ye self spe | ears [cify) | Y Sp | Y | Mon |] | Child | | Fa | ithe | | rtth[| D | D) | M | N | 4 [| Y | Y | Y | |
| DETAILS OF a) Name: b) Name: c) Gender Max d) Relationsh Mother c) Occupation | R D D D D D D D D D D D D D D D D D D D | S D Fris | t la | E E F E F E E F E E | N Consumer | N N N N N S N S S S S S S S S S S S S S | M A ge ye self spe | ears [cify) | Y Sp | Y | Mon |] | Child | | Fa | ithe | | rth | | D in Coo | | N N | | Y | Y | Y | |

| a) Name of Hosp | | | 1000 | | - | | | | | + | | | | | 111 | | | | + | | 1 | | DU. | | - | |
|---|---|--|--|---|---------------------------------------|---------|--------------------------------|-----------------------|-------|-------------|--|--|---------------------------------|---------------------------|---------|----------|-------|--------|--------------------|------------------------|-------------------------------|------------|----------------------|-------------|------|------|
| | | -6 | | L. | | | | | | | 1 | | | | - 1 | | | | | | | | 143 | | | |
|) Room Catego | гу осси | piec | l: | D | ay c | are | 50 | Sing | gle d | occup | pancy | | Tw | in sh | arin | g | | 3 01 | r mo | re be | eds | per | roc | om [| . 1 | |
|) Hospitalization of | lue to:In | jury | YEL | IIIn | ess | | Mate | rnity | Can. | d) Da | ate of in | jury / D | ate Dis | sease fi | rst del | tected | /Dat | e of E |)eliver | y: D | D | M | M | Y | Y | Y |
| e) Date of Admission: | D D | M | vi T | Y | YY | Υ | f) Tim | еН | Н | M | M g) l | Date o | Disch | arge: | D | | VI N | | YY | Υ | Υ | f) Ti | me | Н | 1 | M I |
|) If injury give caus | e: Selfi | nflict | ed | 1 | Road | i Trafi | ic Acc | cident | t | Subs | stance | Abus | e / Al | cohol | Con | sum | ption | | 1) [| Med | ico | lega | al Y | 'es | 1 | 10 |
| ii) Reported to P | olice | T |] | . M | LC I | Repo | rt & I | Polic | e FI | R att | ache | d | Yes | | No | | | | | | | | | - | _ | - |
| j) System of Med | dicine: | - | _ | | | - | - | | | | | - | 1000 | | 100 | | | | | | - | 11.5 | 7 | 1, | | |
| DETAILS OF CL | | | | | - 18 | To. | 194 | 75 | | | | 7.4 | | 1/8 | 77- | 01 | | 13 | 1.0 | , | | | | | | |
| a) Details of the | Treatm | ent | ехре | ens | es c | laime | ed | | Te. | | | | | | | | * | 17.7 | | | | | | X | | |
| I. Pre -hospitaliza | tion exp | erise | es F | Rs. | | | 2 24 | | 1 | | | ii. Ho | spita | lizatio | on e | xpe | nses | Rs | | | T | T | | | | Τ |
| iii. Post-hospitaliza | ation ex | ens | es F | Rs. | | | | | | | | | | -Che | | | | | = | H | + | + | | , 10 , X | | T |
| v. Ambulance C | | | | Rs. | | | | | | - | = | | | (cod | 0.1 | | 1 | Rs | - | | | + | | - | | - |
| | | | 3 | ۱۵.۲ | | | | | 1.0 | | | | 1010 | (000 | - | | | | - | - | + | + | | PLI | | H |
| vii Pre hoonital | izotion | no=i | od. | do | | | | | 7 | | | 4.1 | | . 12 | | otal | | Rs | _ | - | - | | | - | | |
| /ii. Pre -hospital | | | | - 3 | _ | | | | | | i. Po | 50 | | | | | i y | | - | | 1 | 1 | | | 1 12 | |
| o) Claim for Dom | | | | | | | Yes | | No | | (If ye | es, pi | ovid | e det | ails | in a | nne | kure |) | | | | | | 1 | |
| c) Details of Lum | ip sum | / ca | | - 1 | tit c | laime | ed: | | - | | ii | i. Su | gica | l Cas | h: | | | Rs | | | | | | 3 4 | 4 | |
| Hospital Daily cash: | W. F. | | R | F | 1 | | | | | | i | v. Co | nvale | escer | nce: | | | Rs. | | | | | 4 | | 8 | |
| i. Critical Illness benefit | | | R | S. | | 0 -51 | 1214 | 1276 | 1 | 1 | 41 | | - XI | | | | | | | - | - | | - | | | Î |
| | 12 | | | - | - | - | | 1 | | | _ \ | /i. Ot | hers: | , sur | | 4 | | Rs. | | | | | | N K | | |
| | | | | | | | | | | | \ | /i. Ot | hers: | | To | otal | | Rs. | | | | | | | | |
| Claim Documen | ts Sub | mitt | ed - | | eck | | | | | | | | | | To | otal | | Rs. | | | | | | | | |
| | ts Sub | mitt | ed - | | eck | | | of the | cla | im in | timati | | | | To | otal | | Rs. | | pital | | in B | ill | | | |
| Claim Documen | ts Sub | mitt sigi | ed - ned | | eck | C | ору с | | | | | on, if | | | To | otal | | Rs. | Hos | pital tor's | | | | ns | | |
| Claim Documen Claim fo | ts Sub rm duly Break- | mitt sigi | ed - ned | | eck | C | ору с | | | ymer | timati | on, if | any | | i | | | Rs. | Hos | or's | | | | ns , | | |
| Claim Documen Claim fo Hospital | ts Sub rm duly Break- cy Bill | mitt sigi up E | ed - ned Bill | Ch | eck | C H | opy o ospita | al Bil | l Pa | ymer Hos | timati | on, if ceipt Disch | any | | i | | | Rs. | Hos Doc Othe | or's er's stigat | Pre | scri | ptio | s | | |
| Claim Documen Claim fo Hospital Pharmac Operatio | ts Sub rm duly Break- cy Bill on Thea | sigi up E ter N | ed - ned sill Note: | Ch | eck | C H | opy o ospita CG octor | al Bil ['s red | l Pa | ymer Hos | timati nt Rec spital inves | on, if ceipt Disch | any narge | | i | | | Rs. | Hos Doc Othe | tor's ers | Pre | scri | ptio | s | G/I | -IPI |
| Claim Documen Claim fo Hospital Pharmac Operatio DETAILS OF BILLS SI. No. Bill No. | ts Sub rm duly Break- cy Bill on Thea | mitter N | ed - ned sill Note: D: | Ch | | C H | opy o ospita CG octor | al Bil | l Pa | ymer Hos | timati nt Rec spital inves | on, if ceipt Discl tigati | any narge on | e Sum | i | | | Rs. | Hos Doc Othe | or's er's stigat | Pre | scri Re | ptio | ts US | | -IPI |
| Claim Documen Claim fo Hospital Pharmac Operatio | Break- cy Bill on Thea | mitter N | ed - ned sill Note: D: | Ch | eck | C H | opy o ospita CG octor | al Bil ['s red | l Pa | ymer Hos | timation Receipted | on, if ceipt Disch tigati | any narge on s | e Sum | nmai | | | Rs. | Hos Doc Othe | or's er's stigat | Pre | scri Re | ptio port RI / | ts US | | HPI |
| Claim Documen Claim fo Hospital Pharmac Operatio SI. No. Bill No. 1. | Break- cy Bill on Thea S ENCL | r sign | ed - ned sill Note: D: | Ch | | C H | opy o ospita CG octor | al Bil ['s red | l Pa | ymer Hos | timation Reconspital inves | on, if ceipt Discharge tigation Toward Hospita | any narge on s I main | e Sum | nma | ry | | Rs. | Hos Doc Othe | or's er's stigat | Pre | scri Re | ptio port RI / | ts US | | HPI |
| Claim Documen Claim fo Hospital Pharmac Operatio DETAILS OF BILL: SI. No. Bill No. 1. 2. 3. 4. | Break- cy Bill on Thea S ENCL | mittor significant | ed - ned iiii Note: late M M | Cho Y Y Y | Y Y Y | C H | opy o ospita CG octor | al Bil ['s red | l Pa | ymer Hos | timation Reconstruction Reconstructi | on, if ceipt Discharge tigation Toward Hospita | any narge on is I main pitaliza | e Sum Bill ation Bi | nma | ry No | | Rs. | Hos Doc Othe | or's er's stigat | Pre | scri Re | ptio port RI / | ts US | | -IPI |
| Hospital Pharmac Operatic SI. No. Bill No. 1. 2. 3. 4. 5. | Break- cy Bill on Thea BENCL | mitter N OSE CO ON | ed - ned iiii Notes ate | Cho Y Y Y Y Y | Y Y Y Y Y | C H | opy o ospita CG octor | al Bil ['s red | l Pa | ymer Hos | timation Reconstruction Reconstructi | on, if ceipt Disclusive Disclusive Toward Hospital Pre-hospital Pre-ho | any narge on is I main pitaliza | e Sum Bill ation Bi | nma | ry No | | Rs. | Hos Doc Othe | or's er's stigat | Pre | scri Re | ptio port RI / | ts US | | HPE |
| Claim Documen Claim fo Hospital Pharmac Operatio DETAILS OF BILL: SI. No. Bill No. 1. 2. 3. 4. | Break- cy Bill on Thea B ENCL | mitter is significant of the sig | ed - ned iiii | Cho Y Y Y | Y Y Y | C H | opy o ospita CG octor | al Bil ['s red | l Pa | ymer Hos | timation Reconstruction Reconstructi | on, if ceipt Disclusive Disclusive Toward Hospital Pre-hospital Pre-ho | any narge on is I main pitaliza | e Sum Bill ation Bi | nma | ry No | | Rs. | Hos Doc Othe | or's er's stigat | Pre | scri Re | ptio port RI / | ts US | | HPI |
| Claim Documen Claim fo Hospital Pharmac Operatic SI. No. Bill No. 1. 2. 3. 4. 5. 6. | Break- cy Bill on Thea BENCL | mitter N CC OSE CC N N M M | ed - ned iiii Notes ate | Chi Y Y Y Y Y Y | Y Y Y Y Y | C H | opy o ospita CG octor | al Bil ['s red | l Pa | ymer Hos | timation Reconstruction Reconstructi | on, if ceipt Disclusive Disclusive Toward Hospital Pre-hospital Pre-ho | any narge on is I main pitaliza | e Sum Bill ation Bi | nma | ry No | | Rs. | Hos Doc Othe | or's er's stigat | Pre | scri Re | ptio port RI / | ts US | | -IPE |
| Claim Documen Claim for Hospital Pharmac Operation St. No. Bill No. 1. 2. 3. 4. 5. 6. 7. 8. 9. | Break- cy Bill on Thea S ENCL D I D I D I D I D I | mitter N OSE C ON N ON N ON M ON M ON M ON M ON M | ed - ned iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii | Cho Y Y Y Y Y Y Y Y | Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y | C H | opy o ospita CG octor | al Bil ['s red | l Pa | ymer Hos | timation Reconstruction Reconstructi | on, if ceipt Disclusive Disclusive Toward Hospital Pre-hospital Pre-ho | any narge on is I main pitaliza | e Sum Bill ation Bi | nma | ry No | | Rs. | Hos Doc Othe | or's er's stigat | Pre | scri Re | ptio port RI / | ts US | | - PE |
| Claim Documen Claim fo Hospital Pharmac Operation SI. No. Bill No. 1. 2. 3. 4. 5. 6. 7. 8. 9. 10. | Break- cy Bill on Thea B ENCL D I D I D I D I D I D I D I D I D I D | mitter NOSE | ed - ned Silk Note: D: late M M M M M M M | Che Y Y Y Y Y Y Y Y Y Y Y Y | Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y | Co Ho | opy cospita | al Bil | l Pa | ymer Hos | timation Reconstruction Reconstructi | on, if ceipt Disclusive Disclusive Toward Hospital Pre-hospital Pre-ho | any narge on is I main pitaliza | e Sum Bill ation Bi | nma | ry No | | Rs. | Hos Doc Othe | or's er's stigat | Pre | scri Re | ptio port RI / | ts US | | -Pe |
| Claim Documen Claim fo Hospital Pharmac Operatic DETAILS OF BILLS SI. No. Bill No. 1. 2. 3. 4. 5. 6. 7. 8. 9. 10. DETAILS OF PRIM | Break- cy Bill on Thea B ENCL D I D I D I D I D I D I D I D I D I D | mitter NOSE | ed - ned Silk Note: D: late M M M M M M M | Che Y Y Y Y Y Y Y Y Y Y Y Y | Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y | Co Ho | opy cospita | al Bil | l Pa | ymer Hos | timation Reconstruction Reconstructi | on, if ceipt Disclusive Disclusive Toward Hospital Pre-hospital Pre-ho | any narge on is I main pitaliza | e Sum Bill ation Bi | nma | ry No | | Rs. | Hos Doc Othe | or's er's stigat | Pre | scri Re | ptio port RI / | ts US | | -Pi |
| Claim Documen Claim for Hospital Pharmac Operation DETAILS OF BILLS SI. No. Bill No. 1. 2. 3. 4. 5. 6. 7. 8. 9. 10. DETAILS OF PRIM PAN: | Break- cy Bill on Thea SENCL D D D D D D D D D D D D D D D D D D | mitter NOSE | ed - ned Silk Note: D: late M M M M M M M | Che Y Y Y Y Y Y Y Y Y Y Y Y | Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y | Co Ho | opy cospita | al Bil | l Pa | ymer Hos | timation Reconstruction Reconstructi | on, if ceipt Disclusive Disclusive Toward Hospital Pre-hospital Pre-ho | any narge on is I main pitaliza | e Sum Bill ation Bi | nma | ry No | | Rs. | Hos Doc Othe | or's er's stigat | Pre | scri Re | ptio port RI / | ts US | | -IPI |
| Claim Documen Claim for Hospital Pharmac Operation St. No. Bill No. 1. 2. 3. 4. 5. 6. 7. 8. 9. | Break- cy Bill on Thea SENCL D D D D D D D D D D D D D D D D D D | mitter NOSE | ed - ned Silk Note: D: late M M M M M M M | Che Y Y Y Y Y Y Y Y Y Y Y Y | Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y | Co Ho | opy cospita | al Bil | l Pa | ymer Hos | timation Reconstruction Reconstructi | on, if ceipt Disclusive Disclusive Toward Hospital Pre-hospital Pre-ho | any narge on is I main pitaliza | e Sum Bill ation Bi | nma | ry No | | Rs. | Hos Doc Othe | or's er's stigat | Pre | scri Re | ptio port RI / | ts US | | -Pi |
| Claim Documen Claim for Hospital Hospital Pharmac Operation DETAILS OF BILLS SI. No. Bill No. 1. 2. 3. 4. 5. 6. 7. 8. 9. 10. DETAILS OF PRIM | Break- cy Bill on Thea SENCL D D D D D D D D D D D D D D D D D D | mitter NOSE | ed - ned Silk Note: D: late M M M M M M M | Che Y Y Y Y Y Y Y Y Y Y Y Y | Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y | Co Ho | opy cospita | al Bil | l Pa | ymer Hos | timation Reconstruction Reconstructi | on, if ceipt Disclusive Disclusive Toward Hospital Pre-hospital Pre-ho | any narge on is I main pitaliza | e Sum Bill ation Bi | nma | ry No | | Rs. | Hos Doc Othe | or's er's stigat | Pre | scri Re | ptio port RI / | ts US | | -Pi |
| Claim Documen Claim for Hospital Pharmac Operation DETAILS OF BILLS SI. No. Bill No. 1. 2. 3. 4. 5. 6. 7. 8. 9. 10. DETAILS OF PRIM PAN: Account Number: | Break- cy Bill on Thea SENCL D D D D D D D D D D D D D D D D D D | mitter NOSE | ed - ned Silk Note: D: late M M M M M M M | Che Y Y Y Y Y Y Y Y Y Y Y Y | Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y | Co Ho | opy cospita | al Bil | l Pa | ymer Hos | timation Reconstruction Reconstructi | on, if ceipt Disclusive Disclusive Toward Hospital Pre-hospital Pre-ho | any narge on is I main pitaliza | e Sum Bill ation Bi | nma | ry No | | Rs. | Hos Doc Othe | or's er's stigat | Pre | scri Re | ptio port RI / | ts US | | -Pi |
| Claim Documen Claim for Hospital Pharmac Operation DETAILS OF BILLS SI. No. Bill No. 1. 2. 3. 4. 5. 6. 7. 8. 9. 10. DETAILS OF PRIM PAN: Account Number: | Break- cy Bill on Thea S ENCL D D D D D D D MARY II | mitter significant | ed - ned Silk Note: D: late M M M M M M M | Che Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y | Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y | Co Ho | opy cospita | al Bil | l Pa | ymer Hos | timation Reconstruction Reconstructi | on, if ceipt Disclusive Disclusive Toward Hospital Pre-hospital Pre-ho | any narge on is I main pitaliza | e Sum Bill ation Bi | nma | ry No | | Rs. | Hos Doc Othe | or's er's stigat | Pre | scri Re | ptio port RI / | ts US | | †P |

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 bellef. 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

SECTION

| claim, if any. | | any supported y claim except the pre-post-hospitalization |
|----------------------|--------|---|
| Date D D M M Y Y Y Y | Place: | |

Signature of the Insured GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled in by the insured) DATA ELEMENT DESCRIPTION **FORMAT** SECTION A - DETAILS OF PRIMARY INSURED a) Policy No. Enter the policy number As allotted by the Insurance Company Enter the social insurance number or the certificate number of social health insurance scheme SI, No/ Certificate No. b) As allotted by the oraganization Licence number as allotted by IRDA and printed 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 Pln code SECTION B - DETAILS OF INSURANCE HISTORY a) Currently covered by any other Mediclaim / Health Indicate whether currently covered by another Mediclaim / Insurance? Tick Yes or No. Health Insurance b) Date of commencement of first Insurance without break Enter the date of commencement of first Insurance Use dd-mm-yy-forrmat 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 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-vv format Diagnosis Enter the diagnosis details Open Text e) Previously covered by any other Mediclaim / Health Insurance? Indicate whether previously covered by another mediclaim / Tick Yes or No Health Insurance n Company Name Enter the full name of the Insurance Company Name of the organization in full SECTION C - DETAILS OF INSURED PERSON HOSPITALIZED a) Name Enter the full name of the patient Surname, First name, Middle name Gender Indicate Gender of the patient b) Tick Male or Female c) 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 e) Relationship to primary Insured Indicate relationship of patient with policyholder Tick the right option, if others, please specify f) Occupation indicate occupation of patient Tick the right option. If others, please specify g) Address Enter the full postal address Include Street, City and Pirr code h) Phone No Enter the phone number of patient Include STD code with telephone number E-mail ID Enter e-mail address of patient Complete e-mail address SECTION D - DETAILS OF HOSPITALIZATION 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 Hospitalization due to indicate reason of hospitalization Tick the right option Date of injury/Date Disease first detected / Date of Enter the relevant date Delivery Use dd-mm-yy format e) Date of admission Enter date of admission Use dd-mm-yy format Time Enter time of admission Use hh-mm-format Date of discharge Enter date of discharge Use dd-mm-yy formal h) Enter time of discharge Use hh-mm- formal If injury give cause indicate cause of injury Tick the right option If 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 MLC Report & Police FIR attached indicate whether MLC report and Police FIR attached Tick Yes or No System of Medicene Enter the system of medicine followed in treating the patient Open Text SECTION E - DETAILS OF CLAIM **Details of Treatment Expences** Enter the amount claimed as treatment expences In rupees (Do not enter paise values) Claim for Domiciliary Hospitalization indicate whether claim is for domiciliary hospitalization c) Details of Lump sum/ Cash benifit claimed Enter the amount claimed as lump sum / cash benefit In rupees (Do not enter paise values) Claim documents Submitted-Check List indicate which supporting documents are submitted Tick the right option SECTION F - DETAILS OF BILLS ENCLOSED Indicate which bills are enclosed with the amount in rupees SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT a) Enter the permanent account number As allotted by the Income Tax Department b) Account Number Enter the Bank account number As allotted by the Bank Bank Name and Branch Enter the Bank name along with the branch Name of the Bank in full Enter the name of the beneficiary the cheque / DD should be Cheque/ DD payable details Name of the individual / organization in full IFSC Code c) Enter the IFSC code of the Bank branch IFSC code of the Bank branch in full

SECTION H - DECLARATION BY THE INSURED

Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign

CLAIM FORM - PART B

(To be Filled in block letters)

TO BE FILLED 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 **DETAILS OF HOSPITAL** a) Name of the hospital: c) Type of Hospital: Network: Non Network: (if non network fill section E) a) Hospital ID: c) Name of the treating doctor: N A S U R E R S E N A M E E M D D N M A g) Phone No. e) Qualification: f) Registration No. with State Code: **DETAILS OF THE PATIENT ADMITTED** a) Name of the Patient: A M E S U R N F S T A E R N M E D D N M E A d) Age: Years Y Months b) IP Registration Number: c) Gender: Male M M Female e) Date of birth: D D Y Y f) Date of Admission: D D M YY g) Time: Н H M M M M j) Type of Admission: Emergency **Planned** h) Date of Discharge: D i) Time: H D M M Y M M Day Care Maternity k) If Maternity i) Date of Delivery: D D Y ii) Gravida Status: Discharge to another hospital m) Total claimed amount 1) Status at time of discharge: Discharge to home Deceased **DETAILS OF AILMENT DIAGNOSED (PRIMARY)** Description ICD 10 Codes a) I. Primary Diagnosis ii. Additional Diagnosis: iii. Co-morbidities: iv. Co-morbidities: SECTION ICD 10 PCS Description b) i. Procedure: 1 ii. Procedure: 2 iii. Procedure 3: iv. Details of Procedure: c) Pre-authorization obtained: d) Pre-authorization Number: No

| e) If authorization by network hospital not obtained, give reason: | |
|---|----------|
| P) Hospitalization due to injury: Yes No I. If Yes, give cause Self-inflicted Road Traffic Accider | ıt [|
| Substance abuse / alcohol consumption ii) If injury due to substance abuse / alcohol consumption, Test conducted to estable | ish t |
| Yes No (If Yes, attach reports) iii. If Medico legal: Yes No iv. Reported to Police Yes | |
| : FIR No. | |
| ri. If not reported to police give reason: | |
| CLAIM DOCUMENTS SUBMITTED - CHECK LIST | |
| Claim Form duly signed Investigation reports | |
| Original Pre-authorization request CT/MR/USG/HPE investigation reports | |
| Copy of the Pre-authorization approval letter Doctor's reference slip for investigation | |
| Copy of Photo ID Card of patient Verified by hospital ECG | 3 |
| Hospital Discharge summary Pharmacy bills | |
| Operation Theatre Notes MLC reports & Police FIR | |
| | |
| Hospital main bill Original death summary from hospital where applica | ble |
| Hospital break-up bill Any other, please specify | |
| ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL) | |
| a) Address of the Hospital | |
| | 1 |
| | |
| | 1 |
| | AV |
| City: | 314 |
| State: | |
| Pin Code Phone No: | 11 |
| c) Registration No. with State Code: | |
| d) Hospital PAN: | <u> </u> |
| e) Number of inpatient beds | |
| Systemicor of impatient beds | P(v) |
| f) Facilities available in the hospital i. OT Yes No ii. ICU Yes No | |
| ii. Others: | |
| FOLARATION DV TUE HOODITAL | |
| ECLARATION BY THE HOSPITAL (PLEASE READ VERY CAREF | JLL |
| le 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 less or untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited. | |
| | N |
| ate: DDMMMYYYYY | |
| | 3.13 |
| ace: Signature and Seal of the Hospital Authority | |

| | DATA ELEMENT | DESCRIPTION | FORMAT |
|---------|--|--|--|
| N. | A SHOULD BE SHOULD BE SHOULD BE | SECTION A - DETAILS OF HOSPITAL | |
| 1) | Name of the hospital: | Enter the name of hospital | Name of the hospital in full |
|) | Hospital ID | Enter ID number of hospital | As allocated by the TPA |
| · :) | Type of Hospital | Indicate whether in network or non network hospital | Tick the right option |
| ;) | Name of treating doctor | Enler the name of the treating doctor | Name of doctor in full |
|) | Qualification | Enter the qualification of the treating doctor | Abbreviations of educational qualifications |
|) | 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 |
|) | Phone No. | Enter the phone number of doctor | Include STD code with telephone number |
| 9: | SEC | CTION B - DETAILS OF THE PATIENT ADMITTED | Service of the American |
| 1) | Name of Patient | Enter the name of patient | Name of patient in full |
|) | IP registration Number | Enter insurance provider registration number | As allotted by the insurance provider |
|) | Gender | Indicate Gender of the patient | Tick Male or Female |
|) | | Enter age of the patient | Number of years and months |
|) | Age Date of Birth | Enter date of birth | Use dd-mm-yy format |
|) | Date of Admission | Enter date of admission | Use dd-mm-yy format |
| | Time | Enter Time of admission | Use hh:mm format |
| 1) | Date of Discharge | Enter date of Discharge | Use dd-mm-yy formal |
| | | Enter time of Discharge | Use hh:mm format |
|) | Time Type of Admission | Indicate type of admission of patient | Tick the right option |
|) | | Indicate type of admission of particular type of admission of the particular type | |
| () | If Maternity | Enter Date of Delivery if maternity | Use dd-mm-yy format |
| | Date of Delivery Gravida Status | Enter Gravida status if maternily | Use standard format |
| | | Indicate status of patient at time of discharge | Tick the right option |
| , | Status at time of discharge | Indicate the total claimed amount | In rupees (Do not enter paise values) |
| VI) | Total claimed amount | N C - DETAILS OF AILMENT DIAGNOSED (PRIMARY) | intubees (Do not enter paise values) |
| - | | C - DETAILS OF ALMENT BIAGNOSED (FRIMARY) | |
| 1) | ICD 10 Code | | Steedard Format and Open tout |
| | Primary Diagnosis | Enter the ICD 10 Code and description of the primary diagnosis | Standard Format and Open text |
| 3 | Additional Diagnosis | Enter the ICD 10 Code and description of the additional diagnosis | Standard Format and Open text |
| ı | Co-morbidities | Enter the ICD 10 Code and description of the Co-morbidities | Standard Format and Open text |
| 0) | ICD 10 PCS | | Transfer and the |
| T. | Procedure 1 | Enter the ICD 10 Code and description of the first procedure | Standard Format and Open text |
| | Procedure 2 | Enter the ICD 10.Code and description of the second procedure | Standard Format and Open text |
| 13 | Procedure 3 | Enter the ICD 10 Code and description of the third procedure | Standard Format and Open text |
| 1 | Details of Procedure | Enter the details of the procedure | Open text |
| c) | Pre-authorization obtained | Indicate whether pre-authorization obtained | Tick Yes or No |
| d) | Pre-authorization Number | Enter pre-authorization number | As allotted by TPA |
| e) | If authorization by network hospital not obtained, give reason | Enter reason for not obtaining pre-authorization number | Open text |
| f) | Hospitalization due to injury | Indicate if hospitalization is due to injury | Tick Yes or No |
| | Cause | Indicate cause of injury | Tick the right option |
| i i | If injury due to substance abuse/alcohol consumption test | Indicate whether test conducted | Tick Yes or No |
| ii. | conducted to establish this | Indicate whether injury is medico legal | Tick Yes or No |
| | Medico Legal | Indicate whether police report was filed | Tick Yes or No |
| | Reported to Police FIR No. | Enter first information report number | As issued by police authrities |
| 1 | | | Open lext |
| 1.5 | If not reported to police, give reason | Enter reason for not reporting to police | - Sport town |
| | SECTIO | DN D - CLAIM DOCUMENTS SUBMITTED - CHECK LIST | |
| ndi | cate which supporting documents are submitted | | |
| | SEC | TION 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 Hospital obtained from local body | As allocated by the City Corporation / Municip |
| ú | | like City Corporation / Municipality Enter the permanent account number | As allocated by the Income Tax Department |
| d) | Hospital PAN | Enter the number of inpatient beds | Digits |
| e) n | Number of Inpatient beds Facilities available in the hospital | Indicate facilities available in the hospital | Tick the right option. If others, please specify |
| 1) | i adiitioo avaiiamo iii alo iloopital | SECTION F - DECLARATION BY THE HOSPITAL | |
| _ | ad da alarakkan aras ilih gada masikan data (t. dalaman sarah sa | | |
| Ke | ad declaration carefully and mention date (in dd:mm:yy format), pl | add toball toxil and sign, and stamp | |