CLAIM FORM - PART B

TO BE FILLED IN BY THE HOSPITAL

The issue of this Form is not to be taken as an admission of liability
(To be filled in block letters)

Please include the original preauthorization request form in lieu of PART 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) Ph No.			

DETAILS OF THE PATIENT ADMITTED											
a)	Name of the Patient										
b)	IP Registration Number		c) Gender	Male		Female		d) Age	Years		Months
e)	Date of birth	DD / MM / YYYY	f) Date of Admission	DD / MM / YYYY		g) Time	HH	MM			
h)	Date of Discharge	DD / MM / YYYY	i) Time	HH	MM						
j)	Type of Admission	Emergency		Planned		Day Care		Maternity			
k)	If Maternity	i. Date of Delivery	DD / MM / YYYY	ii. Gravida Status							
l)	Status at time of discharge	Discharge to home		Discharge to another hospital		Deceased					
m)	Total Claimed Amount	₹									

DETAILS OF AILMENT DIAGNOSED (PRIMARY)											
a)		ICD 10 Codes	Description								
	i. Primary Diagnosis										
	ii. Additional Diagnosis										
	iii. Co-morbidities										
	iv. Co-morbidities										
b)		ICD 10 Codes	Description								
	i. Procedure 1										
	ii. Procedure 2										
	iii. Procedure 3										
	iv. Details of Procedure										
c)	Present ailment is a complication of PED?	Yes		No		(If Yes, specify details)					
d)	Pre-authorization obtained	Yes		No							
e)	Pre-authorization Number										
f)	If authorization by network hospital not obtained, give reason										
g)	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										

CLAIM DOCUMENTS SUBMITTED - CHECK LIST					
Claim Form duly signed		Operation Theatre notes		Doctor's reference slip for investigation	
Original Pre-authorization request		Hospital main bill		ECG	
Copy of the Pre-authorization approval letter		Hospital break-up bill		Pharmacy bills	
Copy of photo ID card of patient verified by hospital		Investigation reports		MLC report & Police FIR	
Hospital Discharge summary		CT/MR/USG/HPE investigation reports		Original death summary from hospital where applicable	
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																													
	City																													
	State																					Pin Code								
b)	Phone No.											c) Registration No.																		
	Date of Registration	DD / MM / YYYY									Expiry date of Registration														DD / MM / YYYY					
	Name of the Registering Authority																													
d)	PAN													e) Number of Inpatient beds																
f)	Facilities available in the hospital									i. OT			Yes		No		ii. ICU		Yes		No									
	iii. Others																													

DECLARATION BY THE HOSPITAL (PLEASE READ VERY CAREFULLY)
We 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 false or untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited. The signature of the insured is taken on this form after Claim Form B is fully filled up by us. Hospital have required infrastructure to fulfill the hospital definition as per IRDA guideline, which is reproduced below: • Has at least 10 inpatient beds, in those towns having a population of less than 10,00,000 and 15 inpatient beds in all other places • Has fully qualified nursing staff under its employment round the clock • Has fully qualified doctor(s) in charge round the clock • Has a fully equipped operation theatre of its own where surgical procedures are carried out. • Maintains daily Medical records of patients and will make these accessible to the Company's authorized personnel.

Place: _____ **Date:** DD/MM/YYYY **Signature of Insured/Claimant** **Signature and Seal of the Hospital Authority**