# Reimbursement Claim Form

**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**
**Please include the original pre-authorisation request form in lieu of PART A**

(To be filled in BLOCK LETTERS)

## DETAILS OF THE HOSPITAL

**Name of the hospital**
**Hospital ID** **Type of hospital** Network Non-network (If non-network, fill Section E)
**Name of the treating doctor**
**Qualification** **Registration No. with state code**
**Phone No.**

## DETAILS OF THE PATIENT ADMITTED

**Name of the patient** FIRST LAST
**IP registration No.** **Gender** Male Female **Age** Years Months
**Date of birth** DDMMYEAR **Date of admission** DDMMYEAR **Time** MMHH
**Date of discharge** DDMMYEAR **Time** MMHH **Type of admission** Emergency Planned Day Care
Maternity If Maternity, date of delivery DDMMYEAR Gravida Status
**Status at the time of discharge** Discharge to home Discharge to another hospital Deceased

## DETAILS OF THE AILMENT DIAGNOSED (PRIMARY)

| ICD 10 quotes | Description | CD 10 PCS | Description |
|---|---|---|---|
| i. Primary diagnosis | | i Procedure 1 | |
| ii Additional diagnosis | | ii Procedure 2 | |
| iii Co-morbidities | | iii Procedure 3 | |
| iv Morbidities | | iv Details of procedure | |
| | | | |

**Present ailment is a complication of PED?** Yes No (If Yes, specify details)
**Pre-authorisation obtained** Yes No **Pre-authorisation No.**
**If authorisation by network hospital not obtained, give reasons**
**Hospitalisation due to injury** Yes No If yes, give cause Self-inflicted Road traffic accident Substance abuse/Alcohol consumption
**If injury due to substance abuse/alcohol consumption. Test conducted to establish this** Yes No (If Yes, attach reports)
**If Medico legal** Yes No **Reported to police** Yes No **FIR No.**
**If not reported to police, give reasons**

## CLAIM DOCUMENTS SUBMITTED-CHECK LIST

- **Claim Form Duly Signed**
- **Original pre-authorisation request**
- **Copy of pre-authorisation approval letter**
- **Copy of photo ID card of patient verified by hospital**
- **Hospital discharge summary**
- **Operation theatre notes**
- **Hospital main bills**
- **Hospital break-up bills**
- **Investigation reports**
- **CT/MR/USH/HPE Investigation reports**
- **Doctors reference slip for investigation**
- **ECG**
- **Pharmacy bills**
- **MLC report and police FIR**
- **Original death summary from hospital where applicable**
- **Any other, please specify**

## DETAILS IN CASE OF NON-NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)

**Address of the hospital** BUILDING

ROAD NAME/NO.

DISTRICT/TALUK LANDMARK 1

CITY/VILLAGE LANDMARK 2

STATE

**Pincode** LANDLINE

**Registration No.** **PAN Card No.**

**No. of inpatient beds** **Facilities available at the hospital** **OT** Yes No **ICU** Yes No **Others**

## DECLARATION BY THE INSURED (PLEASE READ VERY CAREFULLY)

I hereby declare that the information furnished in this claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact, my right to claim reimbursement shall be forfeited. I also consent & authorise 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-hospitalisation claim, if any.

**Date** DDMMYEAR **Place**

**Signature of the Insured**

## 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. This signature of the insured is taken on this form after claim Form B is fully filled up by us.

**Date** DDMMYEAR **Place**

**Signature of the Insured**

| GUIDANCE FOR FILLING THE CLAIM FORM PART B (to be filled in by the Hospital) | | |
|---|---|---|
| **DATA ELEMENT** | **DESCRIPTION** | **FORMAT** |
| **SECTION A DETAILS OF HOSPITAL** | | |
| a) Name of the hospital | Enter the name of the hospital | Name of the hospital |
| b) Hospital ID | Enter ID number of the hospital | As allocated by the TPA |
| c) Type of the hospital | Indicate whether in network or non-network hospital | Tick the right option |
| d) Name of the treating doctor | Enter the name of the treating doctor | Name of the doctor in full |
| e) Qualification | Enter the qualifications of the treating doctor | Abbreviation of educational qualification |
| f) 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 |
| g) Phone No. | Enter the phone number of the doctor | Include STD code with telephone number |
| **SECTION B DETAILS OF THE PATIENT ADMITTED** | | |
| a) Name of the patient | Enter the name of the patient | Name of the patient in full |
| b) IP Registration No. | Enter insurance provider registration number | As allotted by the insurance provider |
| c) Gender | Indicate gender of the patient | Tick Male or Female |
| d) Age | Enter age of the patient | Number of years and month |
| e) Date of admission | Enter the date of admission | Use dd-mm-yy format |
| f) Time | Enter the time of admission | Use hh-mm format |
| g) Date of discharge | Enter the date of discharge | Use dd-mm-yy format |
| h) Time | Enter the time of discharge | Use hh-mm format |
| i) Type of admission | Indicate type of admission of patient | Tick the right option |
| j) If Maternity | | |
| Date of delivery | Enter the date of delivery, if maternity | Use dd-mm-yy format |
| Gravida Status | Enter Gravida Status, if maternity | Use standard format |
| k) Status at the time of discharge | Indicate the status of the patient at time of discharge | Tick the right option |

| GUIDANCE FOR FILLING THE CLAIM FORM PART B (to be filled in by the Hospital) | | |
|---|---|---|
| **DATA ELEMENT** | **DESCRIPTION** | **FORMAT** |
| **SECTION C DETAILS OF AILMENT DIAGONISED (PRIMARY)** | | |
| a) ICD 10 Code | | |
| Primary diagnosis | Enter the ICD 10 Code and description of the primary diagnosis | Standard format and open text |
| Additional diagnosis | Enter the ICD 10 Code and description of the additional diagnosis | Standard format and open text |
| Co-morbidities | Enter the ICD 10 Code and description of the co-morbidities | Standard format and open text |
| b) ICD 10 PCS | | |
| Procedure 1 | Enter the ICD 10 PCS and description of the first procedure | Standard format and open text |
| Procedure 2 | Enter the ICD 10 PCS and description of the second procedure | Standard format and open text |
| Procedure 3 | Enter the ICD 10 PCS and description of the third procedure | Standard format and open text |
| Details of the procedure | Enter the details of the procedure | Open text |
| c) Present ailment is a complication of PED | Indicate whether present ailment is a complication of some pre-existing disease | Tick Yes or No |
| d) Pre-authorisation obtained | Indicate whether pre-authorisation is obtained | Tick Yes or No |
| e) Pre-authorisation number | Enter pre-authorisation number | As alloted by TPA |
| f) If authorisation by network hospital not obtained, give reasons | Enter reason for not obtaining pre-authorisation number | Open text |
| g) Hospitalisation due to injury | Indicate whether hospitalisation is due to injury | Tick Yes or No |
| Cause | Indicate cause of injury | Tick the right option |
| If injury due to substance abuse/alcohol consumption, test conducted to establish this | Indicate whether test conducted | Tick Yes or No |
| Medico legal | Indicate whether injury was Medico legal | Tick Yes or No |
| Reported to police | Indicate whether police report was filed | Tick Yes or No |
| FIR No. | Enter the first information report number | As issued by the police authorities |
| If not reported to police, give reason | Enter the reason for not reporting it to police | Open text |
| **SECTION D CLAIM DOCUMENTS SUBMITTED - CHECK LIST** | | |
| Indicate which supporting documents are submitted | | |
| **SECTION E DETAILS IN CASE OF NON NETWORK HOSPITAL** | | |
| a) Address | Enter the full Postal address | Include Street, City & Pin Code |
| b) Phone No. | Enter the phone number of the hospital | Include STD code with telephone number |
| c) Registration No. | Enter registration number of the patient | As allotted by the hospital |
| d) PAN Card No. | Enter the permanent account number | As allotted by the Income Tax department |
| e) Number of in patient beds | Enter the number of in patient beds | Digits |
| f) Facilities available at the hospital | Indicate facilities available at the hospital | Tick the right option. If others, please specify |
| **SECTION F DECLARATION BY THE INSURED** | | |
| Read Declaration carefully and mention date in (dd/mm/yy format), place (open text) & sign. | | |
| **SECTION G DECLARATION BY THE HOSPITAL** | | |
| Read Declaration carefully and mention date in (dd/mm/yy format), place (open text), sign & stamp. | | |