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 Hospital Authority (with Hospital stamp)

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.		