हैल्थ इन्श्योरेंस टीपीए ऑफ इन्डिया लिमिटेड
HEALTH INSURANCE TPA OF INDIA LTD.

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

The issue of this Form is not to be taken as an admission of liability

(To be Filled in block letters)

DETAILS OF PRIMARY INSURED:

SECTION A

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

c) Company/TPA ID No.:

d) Name: SURNAME FIRST NAME NAME

e) Address:

City: State:

Pin Code: Phone No.: Email ID:

DETAILS OF INSURANCE HISTORY:

SECTION B

a) Currently covered by any other Mediclaim / Health Insurance: Yes No b) Date of commencement of first Insurance without break: D D M M Y Y Y Y

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: M M Y Y

Diagnosis: e) Previously covered by any other Mediclaim/Health insurance: Yes No

e) If yes, company name:

DETAILS OF INSURED PERSON HOSPITALIZED::

SECTION C

a) Name: SURNAME FIRST NAME NAME

b) Gender Male Female c) Age years Y Y Months M M d) Date of Birth D D M M Y Y Y Y

e) Relationship to primary Insured: Self Spouse Child Father Mother Other (Please Specify)

f) Occupation Service Self Employed Home Maker Student Retired Other (Please Specify)

g) Address (if diffrent from above) :

City: State:

Pin Code Phone No.: Email ID:

DETAILS OF HOSPITALIZATION::

SECTION D

a) Name of Hospital where Admited:

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: D D M M Y Y Y Y

e) Date of admission: D D M M Y Y f) Time: H H M H g) Date of Discharge: D D M M Y Y h) Time: H H M H

I) If injury give cause: Self inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption I) If medical legal Yes No

ii) Reported to Police Yes No iii) MLC Report & Police FIR attached Yes No j) System of Medicine:

DETAILS OF CLAIM:

SECTION E

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 parid: 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 Theater Notes
- ECG
- Doctor's request for investigation
- Investigation Reports (Including CT / MRI / USG / HPE)
- Doctor's Prescription
- Others

DETAILS OF BILLS ENCLOSED:

SECTION F

Sl. No.	Bill No.	Date	Issued by	Towards	Amount (Rs)
1.		D D M M Y Y		Hospital mail Bill	
2.		D D M M Y Y		Pre-hospitalization Bills: Nos	
3.		D D M M Y Y		Post-hospitalization Bills: Nos	
4.		D D M M Y Y		Pharmacy Bills	
5.		D D M M Y Y			
6.		D D M M Y Y			
7.		D D M M Y Y			
8.		D D M M Y Y			
9.		D D M M Y Y			
10.		D D M M Y Y			

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT::

SECTION G

a) Pan: b) Account Number:

c) Bank Name and Branch:

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

(IMPORTANT: PLEASE TURN OVER)

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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 preauthorization request form in lieu of PART A

(To be Filled in block letters)

SECTION 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)

c) Name of the treating doctor: SURNAME FIRST NAME MIDDLE NAME

e) Qualification: f) Registration No. with State Code: g) Phone No.

SECTION B

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient: SURNAME FIRST NAME MIDDLE NAME

b) IP Registration Number: c) Gender: Male ☐ Female ☐ d) Age: Years: YY Months MM e) Date of birth: DD MM YY

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

j) Type of Admission Emergency ☐ Planned ☐ Day Care ☐ Maternity ☐ k) If Maternity i)Date of Delivery: DD MM YY ii) Gravida Status:

l) Status at time of discharge: Discharge to home ☐ Discharge to another hospital ☐ Deceased ☐ m) Total claimed amount

SECTION C

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a)	ICD 10 Codes	Description	b)	ICD 10 Codes	Description
I. Primary Diagnosis			I. Procedure 1:		
ii. Additional Diagnosis:			ii. Procedure 2:		
iii. Co-morbidities			iii. Procedure 3:		
iv. Co-morbidities			iv. Details of procedure:		

c) Pre-authorization obtained: ☐ Yes ☐ No d) Pre-authorization Number:

e) If authorization by network hospital not obtained give reason:

f) 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:

SECTION D

CLAIM DOCUMENTS SUBMITTED - CHECK LIST

- ☐ Claim Form duty signed
- ☐ Original Pre-authorization request
- ☐ Copy of the Pre-authorization approval letter
- ☐ Copy of Photo ID Card of patient Verified by hospital
- ☐ Hospital Discharge summary
- ☐ Operation Theatre Notes
- ☐ Hospital main bill
- ☐ Hospital break-up bill
- ☐ Investigation reports
- ☐ CT/MR/USG/HPE investigation reports
- ☐ Doctor's reference slip for investigation
- ☐ ECG
- ☐ Pharmacy bills
- ☐ MLC reports & Police FIR
- ☐ 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. with State Code:

d) Hospital PAN: e) Number of impatient beds f) Facilities available in the hospital I. OT ☐ Yes ☐ No ii. ICU ☐ Yes ☐ No

iii. Others:

SECTION F

DECLARATION BY THE HOSPITAL

We hereby declare 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.

Date: DD MM YY

Place:

Signature and Seal of the Hospital Authority:

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HEALTH INSURANCE TPA OF INDIA LTD.

Registered and corporate office :Health Insurance TPA of India Ltd.,2nd Floor, Majestic Omnia Building, A-110, Sector 4 Noida, Uttar Pradesh - 201301.

CONSENT FORM

From:

Patient's Name and address:

Policy no:

Hospital IPD no:

To:

Hospital Name:

Madam/Sir,

I hereby authorize TPA representatives/Investigator free and unlimited access to seek medical information (Indoor case papers, reports, documents, including photocopies thereof pertaining my admission / treatment) from any hospital / medical practitioner from which or whom I have at any time sought or shall seek medical attention concerning any disease/ sickness, ailment or injury, which affects my physical or mental health.

Yours faithfully

Signature of the Patient/Insured