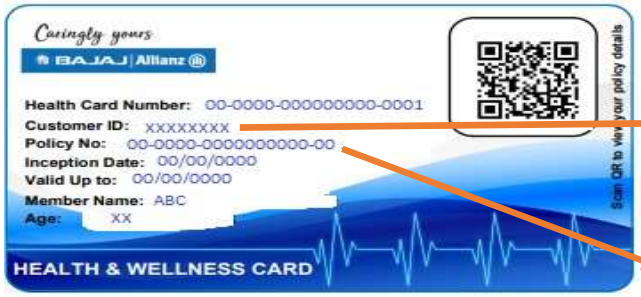
Sample Claim form-Reimbursement



Enter your Policy Number

(To be filled in block letters)

ACCIDENT – PART A

The issue of this for n admission of liability

DETAILS OF PRIMARY INSURED

a) Policy No: b) Sl. No/Certificate No:
c) Company TPA ID No: d) Customer ID:
e) Company Name: f) Employee No:
g) Name:
h) Address:
City: Pin Code:
Phone No: Email ID:

Enter Health ID card Number of Policy Holder

As On Policy Documents

Your employee code no Applicable only For Corporate Customers

DETAILS OF INSURANCE HISTORY

a) Currently covered by any other Mediclaim / Health Insurance Yes No
b) date of commencement of first insurance without break
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: D D M M Y Y Y Y
Diagnosis
e) Previously covered by any other Mediclaim / Health Insurance: Yes
f) If yes, Company Name

In case you have another health insurance

Mentioned Name of the Member Hospitalized

SECTION B

DETAILS OF INSURED PERSON HOSPITALIZED

a) Name of the Patient:
b) Health ID card no of the Patient:
c) Gender: Male Female d) Age: years months e) Date of Birth D D M M Y Y Y Y
f) Relationship of Primary insured: Self Spouse Child Father Mother Other (Please Specify)
g) Occupation: Service Self Employed Homemaker Student Retired Other (Please Specify)
h) Address (if different from above)
City: State: Pin Code:
I) Phone No: J) Email ID:

Mentioned Health ID card number of Hospitalized Member

SECTION C

DETAILS OF HOSPITALIZATION

a) Name of Hospital where Admitted:
b) Room Category occupied: Day Care Single occupancy Twin sharing 3 or more beds per room
c) Hospitalisation 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 Y Y f) Time H H : M M g) Date of Discharge D D M M Y Y Y Y
I) Name of treating doctor Diagnosis
j) If injury give cause: Self inflicted Road Traffic Accident Substance Abuse /Alcohol Consumption
i) If Medico legal: Yes No ii) Reported to police: Yes No
iii) MLC report and Police FIR attached: Yes No j) System of Medicine

Type of hospitalization Details

If it was a medico legal case.

Allopathy?
Ayurveda?
Homeopathy?
Etc.

Sample Claim form-Reimbursement

Expenses incurred before and after Hospitalization

Total hospitalization bill

DETAILS OF CLAIM

a) Details of the treatment expenses claimed:

I. Pre-Hospitalisation Expenses:	Rs.	ii. Hospitalisation Expenses	Rs.
iii. Post-Hospitalisation Expenses:	Rs.	iv. Health checkup cost	Rs.
v. Ambulance Charges:	Rs.	vi. Others (code)	Rs.
		Total	Rs.
vii. Pre-Hospitalisation period:	days	viii. Post Hospitalisation period:	days

In case medical treatment taken at home

b) Claim for Domiciliary Hospitalisation: Yes ☐ No ☐ (If yes, provide details in annexure)

In case you have benefit based plan

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 hospitalisation lump sum benefit	Rs.	vi. Others	Rs.
		Total	Rs.

SECTION E

Claim Documents Submitted – Check List

- ☐ Claim Form Duly Signed
- ☐ Copy of claim intimation if any
- ☐ Original Hospital Main Bill
- ☐ Original Hospital Breakup Bill
- ☐ Original Hospital Bill Payment Receipt
- ☐ Original Hospital Discharge
- ☐ Operation Theater Notes
- ☐ ECG
- ☐ Original Doctor's Prescription
- ☐ Original Doctors request for investigation reports (including CT/MRI/USG/HPE)
- ☐ Others
- ☐ Cancelled blank cheque leaf with payee name printed. If name of the payee is not printed on the cheque leaf please attach copy of the first page of the bank passbook.

List of documents to be attached with this claim form

DETAILS OF BILLS ENCLOSED

Enter all the bills incurred before, during & after hospitalization

Sr.No	Bill No	Date	Issued by	Towards	Amount (Rs)
1		D D M M Y Y		Hospitalisation Main Bill	
2		D D M M Y Y		Pre-Hospitalisation Bills:__Nos	
3		D D M M Y Y		Post-Hospitalisation 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			

SECTION F

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

SECTION G

Very important payment details (Mandatory)

a) Name of the Account Holder (As per Bank Account):_____

b) Account no (As appearing in the cheque book):

B) Account number XXXXXXXXXXX

c) Bank Name :_____

d) Branch Name & Address:_____

e) Account Type : Saving ☐ Current ☐ Cash Credit ☐

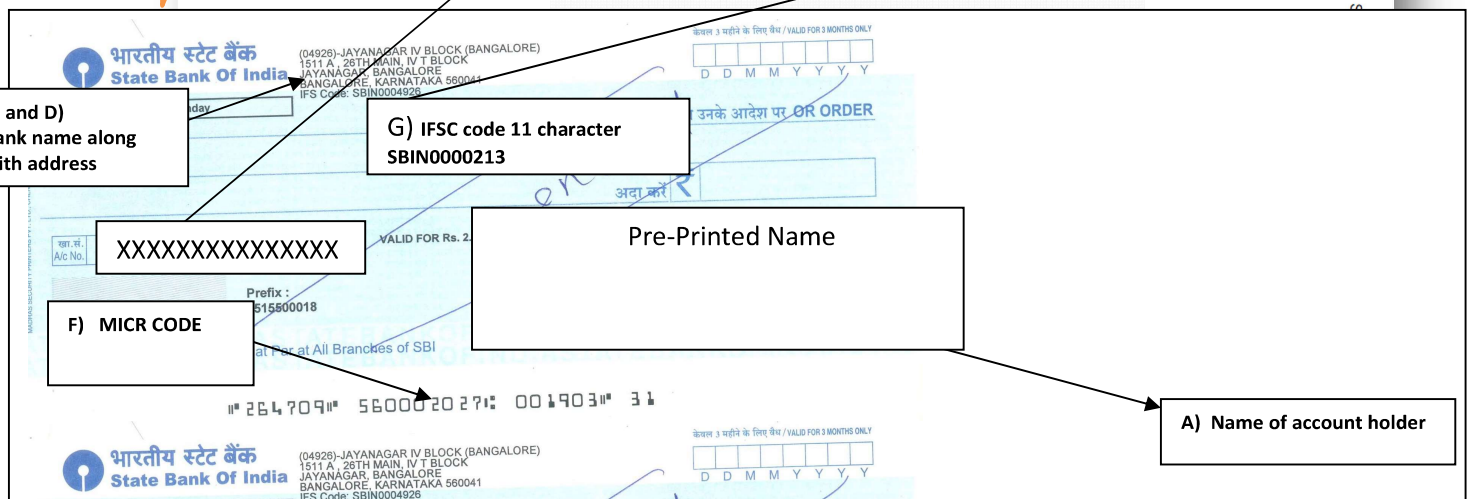
E) Account type

f) MICR No.

IFSC Code:

h) PAN:

i) Cheque / DD Payable Details:



C) and D) Bank name along with address

G) IFSC code 11 character SBIN0000213

XXXXXXXXXXXXXX

Pre-Printed Name

F) MICR CODE

A) Name of account holder

BAJAJ Allianz

Bajaj Allianz General Insurance Company Limited.

Regd. & Head Office : GE Plaza, Airport Road, Yerawada, Pune 411 006

Email id: customercare@bajajallianz.co.in, **Toll free no.** 1800-209-5858, 020-30305858

CLAIM FORM- PART B

TO BE FILLED IN BY THE HOSPITAL

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

Please include the original preauthorization request form in lieu of PART-A

(To be filled in block letters)

To be filled by the hospital in Concern

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)

d) Name of treating doctor: _____

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

SECTION B

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: D D M M Y Y

f) Date of admission: D D M M Y Y g) Time : H H M M h) Date of discharge : D D M M Y Y i) Time: H H M M

j) Type of Admission : Emergency ☐ Planned ☐ Day Care ☐ Maternity ☐ k) If Maternity i) Date of delivery D D M M Y Y 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 PCS	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:		

d) Pre-Authorization Obtained: Yes ☐ No ☐ e) Pre-Authorization Number: ☐☐☐☐☐☐☐☐☐☐

f) If authorization by network hospital no 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)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 -CHECK LIST

- ☐ Claim form duly signed
- ☐ Original Pre-Authorization request
- ☐ Copy of Pre-Authorization letter
- ☐ Copy of photo ID card of patient verified by hospital
- ☐ Hospital discharge summary
- ☐ Operation theatre notes
- ☐ Hospital main bill
- ☐ Hospital break up bill
- ☐ Ingestion reports
- ☐ CT/MR/USG/HPE investigation report
- ☐ Doctor's reference slip for investigation
- ☐ ECG
- ☐ Pharmacy bills
- ☐ MLC report & Police FIR
- ☐ Original death summary from hospital where applicable
- ☐ Any other, please specify

SECTION E

ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON NETWORK HOSPITAL)

a) Address of hospital _____

City: _____ State: _____ Pin Code: _____ Phone No: _____ c) Registration no with State Code: _____

d) Hospital PAN: _____ e) Number of Inpatient beds: ☐☐ Facilities available in hospital: i) OT: Yes ☐ No ☐ ii) ICU: Yes ☐ No ☐

iii) Others: _____

SECTION F

DECLARATION BY THE HOSPITAL: (PLEASE READ VERY CAREFULLY)

We hereby declare that the information furnished in the Claim Form is true and correct to the best of our knowledge and belief. If we have made any false and untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited.

Date : D D M M Y Y

Place : _____

Signature and Seal of the Hospital Authority