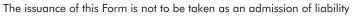
CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT - PART A TO BE FILLED IN BY THE INSURED

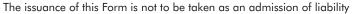




SECTION A - DETAILS	OF	PRI	IMA	۱RY	'IN	ISU	REI	D: (1	To l	oe fi	illec	l ir	n blo	oc	k le	ttei	rs)																
a) Policy No:			П											1	b) :	SI.	No/	Cert	ifico	ate l	Vo:	Γ					\top		П				
c) Company/ TPA ID No:		Ī	Ħ	Ī				Ť	Ť	i		T		ĺ	,							_										I	
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Email ID:																																	
Alternate Email ID:																																	
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SECTION B - DETAILS														ļ											Ļ								
a) Currently covered by any	oth	er ۸	∧ed	icla	im ,	/ He	alth	ı Insı	Jrai	nce:		Y	'es	L		lo			b) It	ye	s, P	olic	у Ту	pe:	L		ndiv	vidu	al	L	(Gro	υр
Company Name:																			F	Polic	yΝ	lo.:								Ш			
c) Date of commencement	of fir	st Ir	ารบา	anc	e w	vitho	ut k	reak	:: [d) S	um	Ins	ure	ed (F	Rs.):	: [
Have you been hospitalise	ed in	the	e la	st fo	our	yec	ırs s	since	in	cept	ion	of	the c	co	ntra	ct?			Yes			N	0										
Diagnosis:																																	
f) Previously covered by any	othe	er N	۱edi	iclai	im /	/ He	alth	Insu	ırar	nce:		,	Yes		N	lo																	
g) If yes, Company Name:																																	
SECTION C - DETAIL	S O	FΙΙ	NS	URI	ED	PEF	RSC) N	НС	SPI	TAL	ISE	D:	i																			
a) Name:		T	\equiv	T			1		T			Τ		Τ		T				T	T	T	T	Т	Т	Т	T	Π		П	\exists		一
b) Gender:	H	Mo	ale	Ī	T	Fen	nale		c)	 Age	: Ye	ars	Y	1	Y	٨	Nont	hs /	ИΛ	Λ	d)	Do	ite c	of B	irth	: D	D	M	М	Υ	Y	Υ	Y
e) Relationship to Primary Ir	ISUTE	_	_	Sel	 f			use		_	hild		\vdash	Fo	∸ athei			Moth	er		- ·						cify)		2 7 4				Ħ
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g) Occupation:		Sai	rvice			ام؟	Em	 ploy	 _d	$\overline{\Box}$	Ho	ne	 mak		r	St	uder	, t	 7 _R ₄	etire	ч [—	\dashv		L her	(Pl	2000	e sp	 cif	Τ_		_		╡
h) Name of Employer/ Firm's Name:								Pioy														I											
i) Address of the Employer/Firm:																											I						
SECTION D - DETAIL	s o	FF	10	SPI	TAI	LISA	TIC	DN:						i																			
a) Name & Address of Hospital where Admitted:			\exists							Ι	Ι		Ι			I				Ι				Ι	Ι		Ι						
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b) Room Category occupied:	Н	Do	ay c	are	Г		ina			oand	_		Twir	n «	shar	ina	Ī	3.6	or m	ore	he	'ye	ner	roc	nm.								
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c) Hospitalisation due to:	Н		ury	-	_	llne			٨٨٥	ıtern	ity																_		_		_		
d) Date of Injury / Date D	icoa		,								,	[Б			A A	V \	/ \	V	1													
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e) Date of Admission:	<u> </u>	<i>□</i>	.~ r	14/	. I		1) D	TIME	. L √ L			/V\]	IIV C					_	urg	e. [/V\ /	Ψĺ	1		h) 1	111116	ž. [115		/V\	14/
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j) If injury give cause:	ш с		lf-ir				닉		a I	raffi						_	ubsta		Abı			ICO	1		nsu	mpt	ion						
	I) If				_			Yes	L	_	اه ا		1		orte	1	pol	ice:		Ye	S		No)									
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k) System of Medicine:														l																ıl			

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CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT - PART A TO BE FILLED IN BY THE INSURED





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S.N.	Cover Name	Amount (in Rs)	S.N.	Cover Name	Amount (in Rs)
	Pre Hospitalization Expenses			Green channel benefit claim against Health wearable device	
	Post Hospitalization Expenses			Compassionate Visit in case of Cl	
	Ambulance Cover			Vaccination for new born	
	Organ Donor Expenses			Out-patient Cover	
	Green channel benefit claim against Non payable expenses			Air Ambulance	

b) Details of Lump sum / cash benefit claimed

S.N.	Cover Name	Claimed	S.N.	Cover Name	Claimed
	Hospital Cash	Yes No		Companion Benefit	Yes No
	Loss of income benefit	Yes No		Convalescence Benefit	Yes No
	Enhanced Daily cash benefit	Yes No		Benefit under Critical Illness optional Cover, if opted	Yes No
	Home treatment additional daily Cash benefit	Yes No		Benefit under Personal Accident optional Cover, if opted	Yes No

Amount as per above covers, if claimed by you, will be paid as per the terms and conditions of the Policy plan.

C	neck	List of	Clain	1 Docur	nents to	be su	bmitte	d (In o	riginal	I)* - PI	ease (√) †ı	ck rele	evant	box
(F	or H	ospital	Cash	benefit,	photoco	pies of	f claim	docun	nents a	ire acc	eptabl	e)			

Claim Form duly filled and signed	Copy of the Claim Intimation, if any	Hospital Bill Payment receipt
Hospital Main Bill	Hospital Break-up Bill	Doctor's request for investigation
Hospital Discharge Summary	Pharmacy Bill	Operation Theatre Notes
] Investigation Reports (Including CT	/ MRI / USG / HPE / ECG)	Test report and prescription relating to first consultation for the Illness
Doctor's prescription for medicines investigation done outside hospital	purchased outside the hospital and	FIR / MLC in case of accident injury and English translation of the same if it is in any other language
KYC document (Address proof, ID p	roof only for claims exceeding ₹1 Lakh)	Original Death Summary (Wherever applicable)
Cancelled cheque leaf of the bank	account held in the name of the	Any Other

SECTION F - DETAILS OF BILLS ENCLOSED:

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

Note: If there are more bills, please attach additional sheets with this claim form giving the bill details in same format as below.

Hospital Main Bill Payment Receipts only

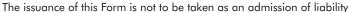
Receipt No.	Date	Amount (Rs)	Please (√) Tick Relevant Box
			Advance Receipt Final Receipt
			Advance Receipt Final Receipt
			Advance Receipt Final Receipt
			Advance Receipt Final Receipt

Note: Please attach separate sheet if necessary

[•] For new born baby cover, separate claim form to be filled & submitted. • For Fitness Reward points, please fill separate form "Fitness reward earning claim form" available on our website. • Benefits under Cumulative Bonus, Early joining Benefit, Restoration of Sum Insured will be provided automatically. You need not file a claim separately for these.

^{*}Please retain copy of complete set of claim documents for your records

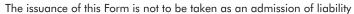
CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT - PART A TO BE FILLED IN BY THE INSURED





IF THE CLAIM IS FOR ACCIDENTAL INJURIES, PLEASE PROVIDE DETAILS OF DATE, TIME AND CIRCUMSTANCES OF ACCIDENT EVENT AND OTHER DETAILS AS RELEVANT: Date: Circumstances of Accident event and other details: SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT: PLEASE PROVIDE YOUR BANK DETAILS: (PLEASE ATTACH CANCELLED CHEQUE LEAF OF BANK ACCOUNT IN THE NAME OF PRIMARY INSURED WITHOUT FAIL) a) PAN: b) Account Number: c) Bank Name and Branch: d) IFSC Code: e) Cheque/DD Payable Details: SECTION H - DECLARATION BY THE INSURED: 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, suppressed or concealed any material fact with respect to questions asked in relation to this claim, 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 the person for 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 pre/post hospitalization claim and for additional covers, if any. Date: Place: Signature of the Insured: Please send this duly filled and signed claim form to our TPA at below address: Family Health Plan Insurance TPA Limited Srinilaya - cyber spazio suite, 101,102,Ground Floor, Road No. 2, Banjara Hills, Hyderabad, Telangana 500034 GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled in by the insured) DATA ELEMENT **DESCRIPTION FORMAT** SECTION A - DETAILS OF PRIMARY INSURED a) Policy No. Enter the policy number As allotted by the insurance company b) SI. No/ Certificate No. Enter the social insurance number or the certificate As allotted by the organisation number of social health insurance scheme c) Company TPA ID No. Enter the TPA ID No. License number as allotted by IRDA and printed in TPA documents. Enter the full name of the policyholder Surname, First name, Middle name d) Name e) Address Enter the full postal address Include Street, City and Pin Code SECTION B - DETAILS OF INSURANCE HISTORY a) Currently covered by any other Mediclaim / Indicate whether currently covered by another Tick Yes or No Health Insurance? Mediclaim / Health Insurance b) i. Company Name Enter the full name of the insurance company Name of the organisation in full b) ii. Policy No. Enter the policy number As allotted by the insurance company c) Date of Commencement of first Insurance Enter the date of commencement of first Use dd-mm-yy format without break insurance d) Sum Insured Enter the total sum insured as per the policy In rupees Have you been Hospitalised in the last four years Indicate whether hospitalised in the last four years Tick Yes or No since inception of the contract? f) Date Enter the date of hospitalisation Use mm-yy format g) Diagnosis Enter the diagnosis details Open Text h) Previously Covered by any other Mediclaim/ Indicate whether previously covered by another Tick Yes or No Mediclaim / Health Insurance Health Insurance? i) Company Name Enter the full name of the insurance company Name of the organisation in full

CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT - PART A TO BE FILLED IN BY THE INSURED





GUIDANCE FOR FILLING CLAIM FORM	- PART A (To be filled in by the insured)							
DATA ELEMENT	DESCRIPTION	FORMAT						
SECTIO	DN C - DETAILS OF INSURED PERSON HOSPIT,	ALIZED						
a) Name	Enter the full name of the patient	Surname, First name, Middle name						
b) Gender	Indicate gender of the patient	Tick Male or Female						
c) Age	Enter age of the patient	Number of years and months						
d) Date of Birth	Enter Date of Birth of patient	Use dd-mm-yy format						
e) Relationship to primary Insured	Indicate relationship of patient with policyholder	Tick the right option. If others, please specify						
f) Address	Enter the full postal address	Include Street, City and Pin Code						
Phone No.	Enter the phone number of patient	Include STD code with telephone number						
E-mail ID	Enter e-mail address of patient	Complete e-mail address						
g) Occupation	Indicate occupation of patient	Tick the right option. If others, please specify						
i) Address of the Employer	Complete address of the employer of the Insured	Include Street, City and Pin Code						
SECTION D	- DETAILS OF HOSPITALISATION FOR CLAIM E	BEING FILED						
a) Name of hospital where admitted	Enter the name of hospital	Name of hospital in full						
b) Room category occupied	Indicate the room category occupied	Tick the right option						
c) Hospitalisation due to	Indicate reason of hospitalisation	Tick the right option						
d) Date of injury / Date disease first detected/ Date of delivery	Enter the relevant date	Use dd-mm-yy format						
e) Date of admission	Enter date of admission	Use dd-mm-yy format						
f) Time	Enter time of admission	Use hh:mm format						
g) Date of discharge	Enter date of discharge	Use dd-mm-yy format						
h) Time	Enter time of discharge	Use hh:mm format						
i) In case of maternity								
I. Date of delivery	Enter date of delivery	Use dd-mm-yy format						
ii. Gravida Status	Enter Gravida Status	Use standard format						
j) If Injury give cause	Indicate cause of injury	Tick the right option						
i. If Medico Legal	Indicate whether injury is Medico Legal	Tick Yes or No						
ii. Reported to Police	Indicate whether police report was filed	Tick Yes or No						
iii. MLC Report & Police FIR attached	Indicate whether MLC report and Police FIR attached	Tick Yes or No						
k) System of Medicine	Enter the system of medicine followed in treating the patient	Open Text						
	SECTION E - DETAILS OF CLAIM							
a) Details of Treatment Expenses	Enter the amount claimed as treatment expenses	In rupees (Do not enter paise values)						
b) Claim for Domiciliary Hospitalisation	Indicate whether claim is for domiciliary hospitalization	Tick Yes or No						
c) Details of Lump sum/ Cash Benefit claimed	Enter the amount claimed as lump sum/ cash benefit	In rupees (Do not enter paise values)						
d) Claim Documents Submitted-Check List	Indicate which supporting documents are submitted	Tick the right option						
	SECTION F - DETAILS OF BILLS ENCLOSED							
Indicate which bills are enclosed with the amounts	n rupees							
SECTION	G - DETAILS OF PRIMARY INSURED'S BANK AG	CCOUNT						
a) PAN	Enter the permanent account number	As allotted by the Income Tax department						
b) Account Number	Enter the bank account number	As allotted by the bank						
c) Bank Name and Branch	Enter the bank name along with the branch	Name of the Bank in full						
d) IFSC Code	Enter the IFSC code of the bank branch	IFSC code of the bank branch in full						
	SECTION H - DECLARATION BY THE INSURED							
Read declaration carefully and mention date (in dd								

The issuance 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



SEC	TION A - DETAILS	OF I	HOS	SPITA	L (T	o be	e fille	ed i	n b	loc	ck le	ette	rs)																					
a) N	ame of the hospital:		\Box								T																		П					
b) H	ospital ID:		İ					ĺ	j				c)	Тур	e c	of H	losp	oital	: [Ne	wo	rk		No	on-N	Vet	wor	k (F	or (office	e us	e or	ıly)
d) N	ame of the treating d	locto	r: [
e) Q	Qualification:		\perp																															
f) Re	gistration No. with St	ate C	Code:	: 🔲																g) Pł	non	e N	lo.:										
CE	CTION B DETAILS	` O [7110	- DAT	TIENI	IT A			.D																									
	CTION B - DETAILS		IFIE	PAI	IEN	II A	DMI		:ט																									
,	ame of the Patient:	\vdash	\dotplus			$\frac{\perp}{}$		<u> </u>		<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>		<u> </u>	<u> </u>	<u></u>	L_,	\Box	Ц.					1	Ļ		Щ		Ш			
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SE	CTION C - DETAILS	S OF	· AIL	MEN	IT D	IAG	SNO	SEL) (P	PRI	MAI	RY)																						
a)		ICD	10 (Code	s		D	esci	ripti	on				a)								ICI	O 1	0 P	CS	Cod	des)es	crip	tior	1	
1	Primary Diagnosis:													1		Prod	cedu	ure 1	:															
2	Additional Diagnosis:													2		Prod	cedu	ure 2	2:															
3	Co-morbidities:													3		Prod	cedu	ure 3	3:															
4	Co-morbidities:													4	+			of P		adu.	ro:							H						
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1	High or low blood pre	essure	e. che	st pai	n. or	anv	other	car	diad							C3 /	140	<u>'</u>							D01	uno	11 111	yec	ii Q	1110	111113			
	disorder			o. pa.	, 0.	,																												
2	Tuberculosis, asthma, disorder	bron	chitis	or an	ny oth	ner lu	ing / i	esp	oirato	ory																								
3	Ulcer (stomach / duod any other digestive tro				all b	ladd	er dis	orde	er or	r																								
4	Kidney failure, stone i	n kidı	ney o	r urin				ate																										\dashv
5	Stroke, epilepsy (fits), (brain, spinal cord, etc.	paral	lysis o	r any				syst	em																									

The issuance 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



		Yes / No Duration in year & months
6	Diabetes, Impaired glucose tolerance (Pre-diabetes), Thyroid/Pituitary Disorder or any other endocrine disorder	
7	Tumor (swelling)-benign or malignant, any external ulcer / growth / cyst / mass anywhere in the body	
8	Arthritis, spondylosis or any other disorder of the muscle / bone / joint	
9	Diseases of the ear / nose / throat / teeth / eye (please mention dioptres in case of refractory error)	
10	HIV / AIDS or sexually transmitted diseases or any immune system disorder	
11	Anaemia, leukaemia, lymphoma or any other blood / lymphatic system disorder	
12	Psychiatric / mental illnesses or sleep disorder	
13	Uterine fibroid, fibroadenoma breast or any other gynaecological (female reproductive system) / breast disorder	
14	Any other illness or injury not mentioned above (other than common cold)	
If Yes h) His	the ailment a complication / sequel of a pre-existing disease o , please give details: story of alcoholism Yes No If yes: No of years: story of smoking / tobacco chewing: Yes No If Yes	Quantity consumed per day Units consumed per day Units consumed per day
SFC	CTION D - CLAIM DOCUMENTS SUBMITTED - CHECK	LIST
屵	Claim Form duly signed	Investigation reports
H	Original pre-authorisation request	CT/MR/USG/HPE investigation reports
$\frac{\sqcup}{\vdash}$	Copy of the pre-authorisation approval letter	Doctor's reference slip for investigation
\perp	Copy of photo ID card of patient verified by hospital	ECG
\vdash	Hospital discharge summary	Pharmacy bills
$\frac{\sqcup}{\vdash}$	Operation theatre notes	MLC report & Police FIR
	Hospital main bill	Original death summary from hospital where applicable
Ш	Hospital break-up bill	Other, please specify
SEC	CTION E - ADDITIONAL DETAILS IN CASE OF NON-NET	WORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)
a) Ad	dress of the hospital:	
City:		State:
Pinco	de: b) Phone No:	
c) Reg	gistration No. with State Code:	d) Hospital PAN:
e) Nu	umber of Inpatient beds:	
	cilities available in the hospital: i. OT: Yes No ii. IC	U: Yes No iii. Round the clock Doctor / Nurses: Yes No
,	iv. Maintains daily record of po	
SEC	CTION F - DECLARATION BY THE HOSPITAL (PLEASE R	EAD VERY CAREFULLY)
		n is true & correct to the best of our knowledge and belief. If we have naterial fact, our right to claim under this claim shall be forfeited.
Date:		
Place		Signature and Seal of the Hospital Authority:
	ease send this duly filled and signed claim form to our TPA at be mily Health Plan Insurance TPA Limited	low address:

Srinilaya - cyber spazio suite, 101,102,Ground Floor, Road No. 2, Banjara Hills, Hyderabad, Telangana 500034

The issuance 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



Authorisation Letter (Mandatory)		Date: DDMMYYYYY
From:		
To: The Manager / Medical Superintendent, Medical	Records	
DearSir		
	Reg: Authorisation Letter.	
Name of the Patient:		
IP Number	(First admission) in	Hospital
IP Number	(Second admission) in	Hospital
IP Number	(Third admission) in	Hospital
hospital and share copies of indoor case sheets of	al Insurance Co. Limited and their Authorised Servicend such other relevant medical records and / or medical records and	eet / obtain statement from the Medical Practitioner
Thanking you,		
Yours sincerely,		and the Deliver
Signature of the Proposer	Sid	anature of the Patient

DATA ELEMENT	DESCRIPTION	FORMAT
DATA ELEMENT		FORMAI
	SECTION A - DETAILS OF HOSPITAL	
a) Name of Hospital	Enter the name of hospital	Name of hospital in full
b) Hospital ID	Enter ID number of hospital	As allocated by the TPA
c) Type of Hospital	Indicate whether In network or non-network hospital	Tick the right option
d) Name of treating doctor	Enter the name of the treating doctor	Name of doctor in full
e) Qualification	Enter the qualifications of the treating doctor	Abbreviations of educational qualifications
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 doctor	Include STD code with telephone number
	SECTION B - DETAILS OF THE PATIENT ADMITTE	ED .
a) Name of Patient	Enter the name of hospital	Name of hospital in full
b) IP Registration Number	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 months
e) Date of Birth	Enter date of admission	Use dd-mm-yy format
f) Date of Admission	Enter date of admission	Use dd-mm-yy format
g) Time	Enter time of admission	Use hh:mm format
h) Date of Discharge	Enter date of discharge	Use dd-mm-yy format
I) Time	Enter time of discharge	Use hh:mm format
j) Type of Admission	Indicate type of admission of patient	Tick the right option
k) If Maternity	Tick the right option	Tick the right option
Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format
Gravida Status	Enter Gravida Status if maternity	Use standard format
I) Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
m) Total amount claimed	Indicate the total amount claimed	In rupees (Do not enter paise values)

The issuance 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



GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled in by the Insured)				
DATA ELEMENT	DESCRIPTION	FORMAT		
SECTION C - DETAILS OF AILMENT DIAGNOSED (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 Procedure	Enter the details of the procedure	Open text		
c) Whether pre-authorisation obtained	Indicate whether pre-authorisation obtained	Tick Yes or No		
d) Pre-authorisation Number	Enter pre-authorisation number	As allotted by TPA		
e) If authorization by network hospital not obtained, give reason	Enter reason for not obtainingpre-authorisation number	Open text		
f) Hospitalization due to injury	Indicate if 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 is Medico Legal	Tick Yes or No		
Reported To police	Indicate whether police report was filed	Tick Yes or No		
FIR No.	Enter first information report number	As issued by police authorities		
If not reported to the police, give reason	Enter reason for not reporting to the police	Open text		
g) Complaints / Symptoms	Indicate the date when the symptom / complaint	Use dd-mm-yy format		
h) Previous medical history	Enter the medical history	Open text		
i) Specific diseases	State Yes or No	Duration should be in years and months		
j) Complication of pre-existing diseases	Indicate whether present ailment is a complication that existed prior to policy inception	Open text		
k) Alcoholism	Indicate Yes or No. If 'yes' state quantity consumed	Open text		
I) Smoking of tobacco	Indicate Yes or No. If 'yes' state units consumed	Open text		
SECTION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST				
Indicate which supporting documents are submitted.				
SECTIO	n e - Details in case of non-network h	OSPITAL		
a) Address	Enter the full postal address	Include Street, City and Pin Code		
b) Phone No.	Enter the phone number of hospital	Include STD code with telephone number		
c) 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		
d) Hospital PAN	Enter the Permanent Account Number	As allotted by the Income Tax department		
e Number of Inpatient beds	Enter the number of inpatient 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 HOSPITAL				
Read the declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign and stamp				
, , , , , , , , , , , , , , , , , , ,				