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 (To be Filled in block letters) The issue of this Form is not to be taken as an admission of liablity Company name -DETAILS OF PRIMARY INSURED: b) SI. No/ Certificate no. a) Policy No.: Employee Code; d) Name: e) Address: Pin Code DETAILS OF INSURANCE HISTORY: a) Currently covered by any other Mediclaim / Health Insurance: Yes No b) Date of commencement of first Insurance without break: D D Policy No. Date: Y Sum insured (Rs.) d) Have you been hospitalized in the last four years since inception of the contract? e) Previously covered by any other Mediclaim /Health insurance : : Diagnosis: f) If yes, company name: DETAILS OF INSURED PERSON HOSPITALIZED: S U R N A M E FIRST NAME M I D D L E Months M M d) Date of Birth D D M M b) Gender c) Age years Y Y Self Child Father Mother Other (Please Specify) e) Relationship to Primary insured: SECTION Home Maker (Please Specify) f) Occupation Self Employed Student Other State: DETAILS OF HOSPITALIZATION: a) Name of Hospital where Admited: Single occupancy Day care Twin sharing 3 or more beds per room b) Room Category occupied: Injury Illness Maternity \_\_\_\_ d) Date of injury / Date Disease first detected /Date of Delivery: D D M M c) Hospitalization due to: h) Time: H H e) Date of Admission: M f) Time H H g) Date of Discharge: D D M M Road Traffic Accident Substance Abuse / Alcohol Consumption I) If Medico legal Yes No I) If injury give cause: Self inflicted iii. MLC Report & Police FIR attached Yes No i) System of Medicine: ii) Reported to Police DETAILS OF CLAIM: a) Details of the Treatment expenses claimed Claim Documents Submitted - Check List: I. Pre -hospitalization expenses ii. Hospitalization expenses Claim form duly signed Copy of the claim intimation, if any Rs iii. Post-hospitalization expenses iv. Health-Check up cost Hospital Main Bill v. Ambulance Charges: vi. Others (code): Rs Hospital Break-up Bill Total Hospital Bill Payment Receipt vii. Pre -hospitalization period: viii. Post -hospitalization period: Hospital Discharge Summary Yes No b) Claim for Domiciliary Hospitalization: (If yes, provide details in annexure) Pharmacy Bill Operation Theater Notes c) Details of Lump sum / cash benefit claimed: ECG ii. Surgical Cash: i. Hospital Daily cash: Doctor's request for investigation iii Critical Illness benefit: iv Convalescence Investigation Reports (Including CT П MRI / USG / HPE) v. Pre/Post hospitalization Lump sum benefit: Rs. vi. Others: Doctor's Prescriptions Others DETAILS OF BILLS ENCLOSED: SI. No. Bill No. Date Issued by Towards Amount (Rs) Hospital main Bill M 1. M Pre-hospitalization Bills: Nos 2. 3. D D M Post-hospitalization Bills: Nos Pharmacy Bills 4. D M 7. D M M D M 8. M D D M 9. 10. D D M DETAILS OF PRIMARY INSURED'S BANK ACCOUNT: a) PAN: b) Account Number: c) Bank Name and Branch: e) IFSC Code: <u>G</u> d) Cheque / DD Payable details:

## DECLARATION BY THE INSURED:

I hereby declare that the information furnished in the claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealent of any material fact with respect to questions asked in relation to this claim, my right to claim reimbrusement shall be forfeited, I also consent & authorize 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-hospitalization claim, if any.

Date D D	M	YYYY	Place:		Signature of the Insured	

SECTION H

	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 number of	As allotted by the oraganization
υ) —	Si. No/ Certificate No.	social health insurance scheme	Licence number as allotted by IRDA and printed
c)	Company TPA ID No.	Enter the TPA ID No.	in TPA documents.
d)	Name	Enter the full name of the policyholder	Surname, First name, Middle 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 / Health Insurance?	Indicate whether currently covered by another Mediclaim / Health Insurance	Tick Yes or No
b)	Date of commencement of first Insurance without break	Enter the date of commencement of first Insurance	Use dd-mm-yy-forrmat
c)	Company Name	Enter the full name of the Insurance Company	Name of the organization in full
	Policy No.	Enter the policy number	As allotted by the Insurance Company
	Sum insured	Enter the total sum insured as per the policy	In rupees
d)	Have you been Hospitalized in the last four years since	Indicate whether hospitalized in the last four years	Tick Yes or No
	Inception of the contract?		
	Date	Enter the date of Hospitalization	Use mm-yy format
- \	Diagnosis	Enter the diagnosis details	Open Text
∍)	Previously covered by any other Mediclaim / Health Insurance?	Indicate whether previously covered by another mediclaim / Health Insurance	Tick Yes or No
f)	Company Name	Enter the full name of the Insurance Company	Name of the organization in full
	SEC1	TION C -DETAILS OF INSURED PERSON HOSPITALIZED	
a)	Name	Enter the full name of the patient	Surname, First name, Middle name
o)	Gender	Indicate Gender of the patient	Tick Male or Female
<del></del>	Age	Enter age of the patient	Number of years and months
<u>(</u> t	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)	Occupation	indicate occupation of patient	Tick the right option. If others, please specify.
g)	Address	Enter the full postal address	Include Street, City and Pin code
h)	Phone No	Enter the phone number of patient	Include STD code with telephone number
1)	E-mail ID	Enter e-mail address of patient	Complete e-mail address
		SECTION D - DETAILS OF HOSPITALIZATION	,
a)	Name of Hospital where admited	Enter the name of hospital	Name of hospital in full
b)	Room category occupied	indicate the room category occupied	Tick the right option
c)	Hospitalization due to	indicate reason of hospitalization	Tick the right option
d)	Date of injury/Date Disease first detected / Date of	Enter the relevant date	Use dd-mm-yy format
	Delivery	Litter the relevant date	
e)	Date of admission	Enter date of admission	Use dd-mm-yy format
)	Time	Enter time of admission	Use hh-mm- format
g)	Date of discharge	Enter date of discharge	Use dd-mm-yy format
1)	Time	Enter time of discharge	Use hh-mm- format
)	If injury give cause	indicate cause of injury	Tick the right option
	If 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
	MLC Report & Police FIR attached	indicate whether MLC report and Police FIR attached	Tick Yes or No
)	System of Medicene	Enter the system of medicine followed in treating the patient	Open Text
		SECTION E - DETAILS OF CLAIM	
a)	Details of Treatment Expences	Enter the amount claimed as treatment expences	In rupees (Do not enter paise values)
b)	Claim for Domiciliary Hospitalization	indicate whether claim is for domiciliary hospitalization	Tick Yes or No
c)	Details of Lump sum/ Cash benifit 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	
ndi	cate which bills are enclosed with the amount in rupees		
	SECTIO	N G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT	
٠, -	PAN	Enter the permanent account number	As allotted by the Income Tax Department
a)	Account Number	Enter the Bank account number	As allotted by the Bank
		Enter the Bank name along with the branch	Name of the Bank in full
a) b) c)	Bank Name and Branch	Ziner the Zamename along was the Station	
b)		Enter the name of the beneficiary the cheque / DD should be	Name of the individual / organization in full
b)	Bank Name and Branch Cheque/ DD payable details IFSC Code		Name of the individual / organization in full  IFSC code of the Bank branch in full

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)

DETAILS OF HOSPITAL						
a) Name of the hospital:  a) Hospital ID:  c) Type of Hospital:  Network:  Non Network:  (if non network fill section E)						
c) Name of the treating doctor: SURNAME FIRE	ST NAME MIDDLE NAME S					
e) Qualification: f) Registration No. with State Code:	g) Phone No.					
DETAILS OF THE PATIENT ADMITTED						
a) Name of the Patient: SURNAME FIRE b) IP Registration Number: C) Gender: Male Female	d) Age: Years Y Y Months M M e) Date of birth: D D M M Y Y W					
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 Mater	nity i) Date of Delivery: D D M M Y Y ii) Gravida Status:					
I) Status at time of discharge: Discharge to home Discharge to another hospital Deceased	m) Total claimed amount					
DETAILS OF AILMENT DIAGNOSED (PRIMARY)						
a) ICD 10 Codes Description	b) ICD 10 PCS Description					
a) ICD 10 Codes Description  I. Primary Diagnosis	b) ICD 10 PCS Description 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:	lumber:					
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:	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:						
CLAIM DOCUMENTS SUBMITTED - CHECK LIST						
Claim Form duly signed   Investigation reports   CT/MR/USG/HPE investigation reports   CT/MR/USG/HPE investigation reports   Doctor's reference slip for investigation reports   Copy of the Pre-authorization approval letter   Doctor's reference slip for investigation   ECG   Hospital Discharge summary   Pharmacy bills   Pharmacy bills   MLC reports & Police FIR   Hospital main bill   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:						
iii. Others:						
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 our right to claim under this claim shall be forfeited.	If we have made any false or untrue statement, suppression or concealment of any material fact,					
	SEC.					
Date: D D M M Y Y						
Place: Signature and Seal of the Ho	spital Authority:					

DESCRIPTION   FORMAT	GUIDANCE FOR FILLING CLAIM FORM - PART B (To be filled in by the hospital)					
Beautiful December   Extended   Extended   Extended   An estimated   An estimat						
Reciption   Comment   Co						
Comment of the period of the	a)	Name of the hospital:	Enter the name of hospital	Name of the hospital in full		
Secretary   Secr	b)	Hospital ID	Enter ID number of hospital	As allocated by the TPA		
Enter the qualification of the treating score   Abstraction of substance auxilifications   Enter the registration number of the abstract acting with the state could be part of the country of the part of the country	c)	Type of Hospital	Indicate whether in network or non network hospital	Tick the right option		
Enter the regulation nountry of the doctor along with the state code gill Phono No.  Enter the pregulation number of Declore  SECTION B. DETAILS OF THE APPLIETY ADMITTED  SECTION B. DETAILS OF THE APPLIETY ADMITTED  As allocated by the Medical Counted in India Name of Patient  Enter the name of patient gill Pregulation Number  Enter the name of patient Gender  Indicate Gender of the patient Gender  Indicate	c)	Name of treating doctor	Enter the name of the treating doctor	Name of doctor in full		
SECTION B - DETAILS OF THE PATIENT ADMITTED    Name of Patient   Section B - DETAILS OF THE PATIENT ADMITTED   Pregatation Number   Section B - DETAILS OF THE PATIENT ADMITTED   Pregatation Number   Section B - DETAILS OF THE PATIENT ADMITTED   Pregatation Number   Section B - DETAILS OF THE PATIENT ADMITTED   Name of patient in full   Section B - DETAILS OF THE PATIENT ADMITTED   Section B - DETAILS OF THE PATIENT ADMITTED   Name of patient in full   Section B - DETAILS OF THE PATIENT ADMITTED   Name of patient in full   Section B - DETAILS OF THE PATIENT ADMITTED   DETAILS OF	e)		Enter the qualification of the treating doctor	Abbreviations of educational qualifications		
Name of Patient   Error the name of patient	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		
Name of Paliant   Enter the name of patient   Name of patient in ful	g)	Phone No.	Enter the phone number of doctor	Include STD code with telephone number		
Enter insurance provider registration Number    Gender		SEC	TION B - DETAILS OF THE PATIENT ADMITTED			
Gender	a)	Name of Patient	Enter the name of patient	Name of patient in full		
Age	b)	IP registration Number	Enter insurance provider registration number	As allotted by the insurance provider		
Date of Girth  Date of Johnson  Enter date of Johnson  Enter date of Admission  Date of Olscharge  Enter date of Admission  Date of Olscharge  Enter date of Decharge  Date of Olscharge  Enter date of Decharge  Use of Ammy format  Date of Olscharge  Enter date of Decharge  Use of Ammy format  Tick the right cydino  Indicate byte of Johnson  Indicate Open of Johnson  Section C - Details Soft Authority  Permany Diagnosis  Enter the ICD 10 Code and description of the primary diagnosis  Additional Diagnosis  Enter the ICD 10 Code and description of the Co-morbidities  Co-morbidities  Enter the ICD 10 Code and description of the Section Open Open Interest and Open text  Procedure 2  Enter the ICD 10 Code and description of the Section Open Interest and Open text  Procedure 2  Enter the ICD 10 Code and description of the Section Open Interest and Open text  Details of Procedure  Procedure 2  Enter the ICD 10 Code and description of the Section Open Interest and Open text  Details of Procedure  Procedure 3  Enter the ICD 10 Code and description of the Section Open Interest and Open text  Details of Procedure  Procedure 3  Enter the ICD 10 Code and description of the Section Open Interest and Open text  Details of Procedure  Procedure 3  Enter the ICD 10 Code and description of the Section Open Interest Andrews Open Interest	c)	Gender	Indicate Gender of the patient	Tick Male or Female		
Date of Admission   Enter date of admission   Use dis-many format	d)	Age	Enter age of the patient	Number of years and months		
Time	e)	Date of Birth	Enter date of birth	Use dd-mm-yy format		
Enter time of Discharge Use 64mm-yy format    Time   Enter time of Discharge   Use httmm format	f)	Date of Admission	Enter date of admission	Use dd-mm-yy format		
Enter date of Discharge  Enter time of Discharge  Enter time of Discharge  Use did-mm-yy format  Use htmmn format  Indicate type of admission of patient  Tick the right option  If Maternity  Load of Dislivery  Enter Date of Delivery if maternity  Use standard format  Convention of Status  Enter Gravids status in maternity  Use standard format  Indicate status of patient at time of discharge  Indicate status of patient at time of discharge and patient at time of discharge and patient at time of discharge and patient at tim	g)	Time	Enter Time of admission	Use hh:mm format		
Type of Admission   Indicate type of admission of patient   Tick the right option		Date of Discharge	Enter date of Discharge	Use dd-mm-yy format		
Type of Admission   Indicate type of admission of patient   Tick the right option	i)	Time	Enter time of Discharge			
Maternaty	j)	Type of Admission	•	Tick the right option		
Enter Date of Delivery Enter Date of Delivery if maternity Use standard format Cardida Status Enter Gravida Status of instamply Use standard format Use standard format Indicate the total claimed amount Indicate the total Code and description of the primary diagnosis Sandard Format and Open text Sandard Format and Open text Indicate The ICD 10 Code and description of the foreign conclusion Indicate The ICD 10 Code and description of the first procedure Indicate The ICD 10 Code and description of the first procedure Indicate The ICD 10 Code and description of the first procedure Indicate The ICD 10 Code and description of the first procedure Indicate The ICD 10 Code and description of the first procedure Indicate The ICD 10 Code and description of the first procedure Indicate The ICD 10 Code and description of the first procedure Indicate The ICD 10 Code and description of the first procedure Indicate The ICD 10 Code and description of the first procedure Indicate The ICD 10 Code and description of the first procedure Indicate The ICD 10 Code and description of the first procedure Indicate The ICD 10 Code and description of the first procedure Indicate The ICD 10 Code and description of the first procedure Indicate The ICD 10 Code and description of the first procedure Indicate The ICD 10 Code and description of the first procedure Indicate The ICD 10 Code and description of the first procedure Indicate The ICD 10 Code Indicates The ICD 10 Code I		••		<u> </u>		
ii. Gravida Status  Enter Gravida Status if maternity  Indicate status of material indicates status of patient at time of discharge  Tick the right option  Indicate status of patient at time of discharge  Tick the right option  Indicate the total claimed amount  SECTION C - DETAILS OF AILMENT DIAGNOSED (PRIMARY)  a) ICD 10 Code  Privary Diagnosis  Enter the ICD 10 Code and description of the primary diagnosis  Standard Format and Open text  Co-morbidities  Enter the ICD 10 Code and description of the additional diagnosis  Standard Format and Open text  Enter the ICD 10 Code and description of the first procedure  Procedure 1  Enter the ICD 10 Code and description of the first procedure  Standard Format and Open text  Enter the ICD 10 Code and description of the first procedure  Standard Format and Open text  Enter the ICD 10 Code and description of the first procedure  Standard Format and Open text  Enter the ICD 10 Code and description of the first procedure  Details of Procedure 2  Enter the ICD 10 Code and description of the first procedure  Standard Format and Open text  Enter the ICD 10 Code and description of the first procedure  Standard Format and Open text		·	Enter Date of Delivery if maternity	Use dd-mm-yy format		
Total claimed amount   Indicate the total claimed amount   In rupees (Do not enter paise values)		•	· · ·			
Total claimed amount   Indicate the total claimed amount   In rupees (Do not enter paise values)	1)	Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option		
SECTION C - DETAILS OF AILMENT DIAGNOSED (PRIMARY)  a) ICD 10 Code  Primary Diagnosis  Enter the ICD 10 Code and description of the primary diagnosis  Additional Diagnosis  Enter the ICD 10 Code and description of the additional diagnosis  Standard Format and Open text  Standard						
ICD 10 Code	,			in rapece (20 net citter pales values)		
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 Combridities Enter the ICD 10 Code and description of the Co-morbidities Standard Format and Open text Standard Format and Open text Standard Format and Open text Procedure 1 Enter the ICD 10 Code and description of the Co-morbidities Standard Format and Open text Procedure 1 Enter the ICD 10 Code and description of the first procedure Standard Format and Open text Procedure 2 Enter the ICD 10 Code and description of the first procedure Standard Format and Open text Procedure 3 Enter the ICD 10 Code and description of the third procedure Standard Format and Open text Procedure 3 Enter the details of the procedure Open text Open te	<i>a)</i>		DEFINITE OF FULL PLANTS OF THE PROPERTY OF THE			
Additional Diagnosis  Enter the ICD 10 Code and description of the additional diagnosis  Co-morbidities  Enter the ICD 10 Code and description of the Co-morbidities  Standard Format and Open text  Co-morbidities  Enter the ICD 10 Code and description of the Co-morbidities  Standard Format and Open text  Enter the ICD 10 Code and description of the first procedure  Procedure 1  Enter the ICD 10 Code and description of the first procedure  Standard Format and Open text  Enter the ICD 10 Code and description of the second procedure  Standard Format and Open text  Open text  Open text  Open text  Indicate whether pre-authorization obtained  Indicate whether pre-authorization byte in the procedure  Open text  Indicate whether pre-authorization number  As allotted by TPA  Indicate if hospitalization is due to injury  Tick Yes or No  Cause  Indicate whether the cause of injury  Tick Yes or No  Indicate outself in hospitalization is due to injury  Tick Yes or No  Indicate outself in his indicate outself injury  Tick Yes or No  Indicate outself injury is medico legal  Reported to Police  Indicate whether injury is medico legal  Tick Yes or No  Indicate whether police report was filed  Tick Yes or No  Enter first information report number  As issued by police authrities  Indicate whether police report was filed  Tick Yes or No  Enter first information report number  As issued by police authrities  Indicate whether police report was filed  Tick Yes or No  Enter first information report number  As issued by police authrities  Indicate whether police report was filed  Tick Yes or No  Cause  Indicate whether police report was filed  Tick Yes or No  Enter the first information report number  As issued by police authrities  Procedure 1  Enter the first information report number  As issued by police authrities  Indicate which supporting documents are submitted  Enter the full	a)		Enter the ICD 10 Code and description of the primary diagnosis	01-1-151-101-1		
Co-morbidities		· ·		•		
Procedure 1		<u> </u>	<u> </u>	'		
Procedure 1 Enter the ICD 10 Code and description of the first procedure Standard Format and Open text Procedure 2 Enter the ICD 10 Code and description of the second procedure Standard Format and Open text Procedure 3 Enter the ICD 10 Code and description of the third procedure Standard Format and Open text Details of Procedure Enter the details of the procedure Open text Open text Open text Open text Open text Indicate whether pre-authorization obtained Tick Yes or No Pre-authorization Number Enter reason for not obtaining pre-authorization number As allotted by TPA If authorization by network hospital not obtained, give reason Enter reason for not obtaining pre-authorization number Open text If injury due to substance abuse/alcohol consumption test conducted to establish this Indicate whether rest conducted If injury due to substance abuse/alcohol consumption test conducted to establish this Indicate whether prolice report was fled Tick Yes or No Reported to Police Indicate whether prolice report was fled Tick Yes or No If not reported to police, give reason Enter reason for not reporting to police  SECTION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST Indicate which supporting documents are submitted  SECTION E - DETAILS IN CASE OF NON NETWORK HOSPITAL  a) Address b) Phone No. Enter the flul postal address Enter the preparation number of thospital Include Street, City and Pin Code Iner the registration number of thospital Include Street, City and Pin Code Include Street, City and Pin Code Iner the registration number of thospital Include Street, City and Pin Code Iner the registration number of thospital Include Street, City and Pin Code Inter the registration number of thospital Include Street, City and Pin Code Inter the registration number of thospital Include Street, City and Pin Code Inter the registration number of thospital Include Street, City and Pin Code Inter the registration number of thospital Include Street, City and Pin Code Inter the registration number of thospital Include Street, City and Pin C			Enter the ICD 10 Code and description of the Co-morbidities	Standard Format and Open text		
Procedure 2 Enter the ICD 10 Code and description of the second procedure Procedure 3 Enter the ICD 10 Code and description of the third procedure Details of Procedure Enter the details of the procedure Open text Ope	b)	ICD 10 PCS				
Procedure 3 Enter the ICD 10 Code and description of the third procedure Standard Format and Open text  Details of Procedure Enter the details of the procedure Open text  C) Pre-authorization obtained Indicate whether pre-authorization obtained Tick Yes or No  d) Pre-authorization Number Enter pre-authorization number As allotted by TPA  e) If authorization by network hospital not obtained, give reason Enter reason for not obtaining pre-authorization number Open text  f) Hospitalization due to injury Indicate if hospitalization is due to injury Tick Yes or No  Cause 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 authrities  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 STD code with telephone number of hospital Include STD code with telephone number of No. Enter the phone number of hospital Include STD code with telephone number of No. With State Code like City Corporation / Municipality  d) Hospital PAN Enter the permanent account number As allocated by the City Corporation / Municipality  Indicate savailable in the hospital Include STD code with telephone number of inpatient beds Digits  File of the permanent account number of inpatient beds Digits  Procedure 3 Section F - DECLARATION BY THE HOSPITAL  SECTION F - DECLARATION BY THE HOSPITAL		Procedure 1	Enter the ICD 10 Code and description of the first procedure	Standard Format and Open text		
Details of Procedure Enter the details of the procedure Open text  c) Pre-authorization obtained Indicate whether pre-authorization obtained Tick Yes or No  d) Pre-authorization Number Enter pre-authorization number As allotted by TPA  e) If authorization by network hospital not obtained, give reason Enter reason for not obtaining pre-authorization number Open text  f) Hospitalization due to injury Indicate if hospitalization is due to injury Tick Yes or No  Cause Indicate cause of injury Tick Yes or No  Gause Indicate cause of injury Tick Yes or No  Medico Legal Indicate whether test conducted Tick Yes or No  Medico Legal Indicate whether injury is medico legal Tick Yes or No  FIR No. Enter first information report number As issued by police authrities  Indicate which supporting documents are submitted  SECTION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST  Indicate which supporting documents are submitted  Enter the full postal address Indicated Security Corporation / Municipality  d) Hospital PAN Enter the reportant Description Indicated for the premanent account number As allocated by the Income Tax Department  e) Number of Inpatient beds Enter the number of inpatient beds Digits  First the right option. If others, please specify  SECTION F - DECLARATION BY THE HOSPITAL  Tick the right option. If others, please specify  SECTION F - DECLARATION BY THE HOSPITAL		Procedure 2	Enter the ICD 10 Code and description of the second procedure	Standard Format and Open text		
c) Pre-authorization obtained Indicate whether pre-authorization obtained Tick Yes or No d) Pre-authorization Number Enter pre-authorization number As allotted by TPA e) If authorization by network hospital not obtained, give reason Enter reason for not obtaining pre-authorization number Open text f) Hospitalization due to injury Indicate if hospitalization 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 authrities Indicate which supporting documents are submitted  SECTION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST Indicate which supporting documents are submitted  SECTION E - DETAILS IN CASE OF NON NETWORK HOSPITAL  a) Address Include Street, City and Pin Code b) Phone No. Enter the full postal address Include STD code with telephone number of hospital c) Registration No. with State Code Enter the registration number of the Hospital obtained from local body like (City Corporation / Municipality Wile Corporation / Municipality As allocated by the City Corporation / Municipality Phone No. Enter the registration number of the permanent account number As allocated by the Income Tax Department e) Number of Inpatient beds Enter the number of inpatient beds Digits f) Facilities available in the hospital Indicate facilities available in the hospital Tick the right option. If others, please specify  SECTION F - DECLARATION BY THE HOSPITAL		Procedure 3	Enter the ICD 10 Code and description of the third procedure	Standard Format and Open text		
Pre-authorization Number   Enter pre-authorization number   As allotted by TPA   e) If authorization by network hospital not obtained, give reason   Enter reason for not obtaining pre-authorization number   Open text   f) Hospitalization due to injury   Indicate if hospitalization is due to injury   Tick Yes or No   Cause   Indicate cause of injury   Tick Yes or No   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 injury is medico legal   Tick Yes or No   FIR No.   Enter first information report number   As issued by police authrities   If not reported to police, give reason   Enter reason for not reporting 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 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 Hospital obtained from local body like City Corporation / Municipality   d) Hospital PAN   Enter the permanent account number   As allocated by the Income Tax Department   e) Number of Inpatient beds   Enter the number of inpatient beds   Digits   f) Facilities available in the hospital   Indicate facilities available in the hospital   Tick the right option. If others, please specify    SECTION F - DECLARATION BY THE HOSPITAL		Details of Procedure	Enter the details of the procedure	Open text		
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Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign. and stamp						