CHOLAMANDALAM MS GENERAL INSURANCE COMPANY LIMITED
Claims Processing Centre: Shaw Wallace Building, New No. 319, Old No.154,
2nd Floor, Thambu Chetty Street, Parrys, Chennai- 600001
Toll Free Ph No.: 1800 200 5544, Toll Free Fax No.: 1800 425 2200
Pre Authorization Request: faxhealth@cholams.murugappa.com;
Queries & Complaints: customercare@cholams.murugappa.com
www.cholainsurance.com

Chola MS GENERAL INSURANCE

TUV NABCB QM 002

CLAIM FORM – PART A
TO BE FILLED IN BY THE INSURED

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

All reimbursement claims either from network / non-network hospitals has to be intimated immediately to us at the earliest (before discharge) to our customer care through Toll Free number 18002005544 or by an e-mail to help@choalms.murugappa.com Claim documents should be submitted to us within 30 days from the date of discharge. The issuance of this form does not imply Admission of Liability. Please answer questions completely. Use additional sheet, if required. Please attach the documents required as indicated. Please note that the list of documents mentioned is an indicative list, We may ask for any other documents to process the claim.

(To be filled in block letters)

SECTION A

DETAILS OF PRIMARY INSURED:

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

c) **Membership Number:**

d) Name : SURNAME FIRST MIDDLE LAST NAME

e) Address :

City: State:

Pin Code: Phone No: Email ID :

SECTION B

Additional details in case of Non Network Hospital

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 (Copies of Policies to be attached)

c) If yes, company name: Policy No.

Sum Insured (Rs.) d) Have you been hospitalized in the last 4 years? Yes No Date: M M Y Y Diagnosis:

e) Previously covered by any other Mediclaim / Health insurance : Yes No f) If yes, Company Name

SECTION C

DETAILS OF INSURED PERSON HOSPITALIZED:

a) Name: SURNAME FIRST MIDDLE LAST NAME

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

e) Relationship to Primary insured: Self Spouse Child Father Mother Other (Please Specify)

f) Occupation: Service Self Employed Homemaker Student Retired Other (Please Specify)

g) Address (if different from above):

City: State:

Pin Code: Phone No: E-mail ID:

SECTION D

DETAILS OF HOSPITALIZATION:

a) Name of Hospital where Admitted:

b) Room Category occupied: Day care **Suite** **Deluxe Room** Single occupancy Twin sharing 3 or more beds per room Others

c) Hospitalization due to: Injury Illness Maternity d) Date of Injury / Date Disease first detected /Date of Delivery: D D M M Y Y

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

i) 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 & Police FIR attached: Yes No j) System of Medicine:

k) Type of hospitalization: Emergency / Planned

SECTION E

DETAILS OF CLAIM:

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. External aids: **Rs.**
vii. OPD dental: **Rs.**
viii.OPD: **Rs.**
ix.Eye check up cost: **Rs.**
x. Minor accompaniment daily cash **Rs.**
xi. Others (code): **Rs.**
Total **Rs.**
vii. Pre-hospitalization period: 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:

- Filled claim form duly signed
- **Copy of the claim intimation**
- **Final Hospital Bill with detailed break-up**
- **Hospital bill payment receipt**
- **Detailed hospital discharge summary**
- **Pharmacy / medical bills which supporting doctor prescription**
- **Investigation / lab reports supporting the diagnosis.**
- **Operation theatre notes for surgical cases**
- **Invoice / sticker for the implants used in the treatment**
- **External Aids vendors supported by the proper prescription from Doctor.**
- **Home Hospitalization treatment - Certificate from treating doctor specifying reasons for Home Hospitalization**
- **Obstetric History for maternity claims (GPAL Status)**
- **Copy of MLC / FIR / in case of road traffic accidents (RTA)**
- **AML documents (Proof of Identity with photo, Address proof) for above 1 lac claims**

SECTION F

DETAILS OF BILLS ENCLOSED:

Sl. No	Bill No	Date	Issued by	Towards	Amount (Rs)
1.		D D M M Y Y		Hospital Main 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			

SECTION G

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT:

a) PAN: b) Aadhaar No. /

c) Aadhaar Enrollment No. / : d) Account Number:

e) Bank Name and Branch:

g) Cheque/ DD Payable details: f) IFSC Code:

Note : PAN & Aadhaar No. Mandatory for as per IRDAI. In case of Non availability of PAN CARD – FORM 60 as per the annexure need to be provided.
If applied for Aadhaar, kindly provide Enrolment ID. Please enclose a copy of Pan Card, Aadhaar Card and Cancelled cheque of Insured.

(IMPORTANT: PLEASE TURN OVER)

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, 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 suppression or concealment of any material fact, my right to claim reimbursement shall be forfeited. I also consent & authorize TPA / insurance company, to seek necessary 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.

SECTION H

Date: D D M M Y Y Place: Signature of the Insured

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 number of social health insurance scheme	As allotted by the organization
c) Company TPA ID No.	Enter the TPA ID No	License number as allotted by IRDA and printed 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 format
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 4 years	Indicate whether hospitalized in the last 4 years	Tick Yes or No
Date	Enter the date of hospitalization	Use mm-yy format
Diagnosis	Enter the diagnosis details	Open Text
e) 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
SECTION C - DETAILS OF INSURED PERSON HOSPITALIZED		
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) 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
i) E-mail ID	Enter e-mail address of patient	Complete e-mail address
SECTION D - DETAILS OF HOSPITALIZATION		
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) Hospitalization due to	Indicate reason of hospitalization	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) 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
j) 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 Hospitalization	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 in rupees		
SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT		
a) PAN	Enter the permanent account number	As allotted by the Income Tax department
b) Aadhar Card (Mandatory)	Enter the 16 digit Aadhar Number	As provided by Govt. Of India.
c) Aadhaar Card Enrollment No	Enter the Aadhaar Enrollment No as per your sheet	As provided by Govt. Of India.
d) Account Number	Enter the bank account number	As allotted by the bank
e) Bank Name and Branch	Enter the bank name along with the branch	Name of the Bank in full
f) Cheque/ DD payable details	Enter the name of the beneficiary the cheque/ DD should be made out to	Name of the individual/ organization in full
g) 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:mm:yy format), place (open text) and sign.		

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 | SECTION B | SECTION C | SECTION D | SECTION E | SECTION F | SECTION G

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 the treating doctor: SURNAME FIRST NAME MIDDLE NAME
e) Qualification: f) Registration No. with State Code: g) Phone No.

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 ☐

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:		

c) Present ailment is a complication of PED? ☐ Yes ☐ No (If Yes, specify details)

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

f) If authorization by network hospital not 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. 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
- ☐ 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 report & 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.:
d) PAN: e) Number of Inpatient beds f) Facilities available in the hospital: i. OT : ☐ Yes ☐ No ii. ICU : ☐ Yes ☐ No
iii. 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 & 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: DD MM YY 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. The signature of the insured is taken on this form after Claim Form B is fully filled up by us.

Date: DD MM YY

Place: Signature and Seal of the Hospital Authority:

GUIDANCE FOR FILLING CLAIM FORM – PART B (To be filled in by the hospital)		
DATA ELEMENT	**DESCRIPTION**	**FORMAT**
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 nospital	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 ADMITTED		
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 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) Type of Admission	Indicate type of admission of patient	Tick the right option
j) If Maternity		
Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format
Gravida Status	Enter Gravida status if maternity	Use standard format
k) 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	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) 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-authorization obtained	Indicate whether pre-authorization obtained	Tick Yes or No
e) Pre-authorization Number	Enter pre-authorization number	As allotted by TPA
f) If authorization by network hospital not obtained, give reason	Enter reason for not obtaining pre-authorization number	Open text
g) 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 authorities
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.	Enter the registration number of patient	As allocated by the Hospital
d) 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 in the hospital	Indicate facilities available in 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) and sign.		
SECTION G - DECLARATION BY THE HOSPITAL		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign and stamp		

Income-tax Rules, 1962

FORM NO. 60

[See second proviso to rule 114B]

Form for declaration to be filed by an individual or a person (not being a company or firm) who does not have a permanent account number and who enters into any transaction specified in rule 114B

First Name :	
Middle Name :	
Surname :	
Date of Birth / Incorporation of declarant :	D D M M Y Y Y Y
Father's Name (in case of individual) :	
First Name :	
Middle Name :	
Surname :	
Flat/ Room No. :	Floor No. :
Name of premises :	Block Name/No. :
Road/ Street/ Lane	Area/ Locality
Town/ City	District
State	Pin code
Telephone Number (with STD code)	Mobile Number
Amount of transaction (Rs.)	
Date of transaction	D D M M Y Y Y Y
In case of transaction in joint names, number of persons involved in the transaction	
Mode of transaction: ☐ Cash, ☐ Cheque, ☐ Card, ☐ Draft/Banker's Cheque, ☐ Online transfer, ☐ Other	
Aadhaar Number issued by UIDAI (if available)	
If applied for PAN and it is not yet generated enter date of application and acknowledgement number	D D M M Y Y Y Y
If PAN not applied, fill estimated total income (including income of spouse, minor child etc. as per section 64 of Income-tax Act, 1961) for the financial year in which the above transaction is held	
a. Agricultural income (Rs.)	
b. Other than agricultural income (Rs.)	

Details of document being produced in support of identify in Column 1 *(Refer Instruction overleaf)*	Document code	Document identification number	Name and address of the authority issuing the document
Details of document being produced in support of address in Columns 4 to 13 *(Refer Instruction overleaf)*	Document code	Document identification number	Name and address of the authority issuing the document

Verification

I, _____ do hereby declare that whatis stated above is true to the best of my knowledge and belief. I further declare that I do not have a Permanent Account Number and my/ our estimated total income (including income of spouse, minor child etc. as per section 64 of Income-tax Act, 1961) computed in accordance with the provisions of Income-tax Act, 1961 for the financial year in which the above transaction is held will be less than maximum amount not chargeable to tax.

Verified today, the _____ day of _____ 20_____

Place: _____ (Signature of declarant)