સુમાહિતગાર રહેવાથી જરૂરિયાતના સમયે મોટો ફરક પડી શકે છે

મુસીબત આવે ત્યારે, ચીજો વિશે અજાણ રહેવાથી સરળતાથી તમને કશુંક ગુમાવ્યાનો અહેસાસ થાય છે. આ કારણે જ અમે તમારી **રિએમ્બર્સમેન્ટ દાવા પ્રક્રિયા** વિશે કેટલીક અગત્યની માહિતી જણાવી રહ્યા છીએ.

યાદ રાખવાના મુદ્દા

- ☑ ઝડપી પ્રક્રિયા માટે ક્લેમ ફોર્મમાંની તમામ અનિવાર્ય વિગતો ભરો:
  - ક્લેમ ફોર્મમાં એનઇએફટી સંબંધિત વિગતો ભરશો નહીં અને તેના બદલે ઓરિજિનલ પર્સનલાઇઝ્ડ કેન્સલ કરેલો ચેક અથવા એનઇએફટી મેન્ડેટ ફોર્મ જોડવું.
  - પર્સનલાઈઝ કેન્સલ ચેક પ્રપોઝરના નામે હોવો જોઈએ.
- ☑ ડિસ્ચાર્જ સમરી/ ડિસ્ચાર્જ પ્રમાણપત્ર/ મૃત્યુની સમરીની સાથે સર્જિકલ અને એનેસ્થેટિક નોંધની અસલ નકલો.
- ☑ સર્જિકલ ચાર્જિસ, સર્જનની ફી, ઓટી ચાર્જિસ વગેરેના બ્રેક-અપ સાથેનું અસલ અંતિમ હોસ્પિટલ બિલ.
  - અંતિમ હોસ્પિટલ બિલની સામે નાણાં ચૂકવ્યાની અસલ રસીદ.
- ☑ કરાવેલા ટેસ્ટ/ એક્સ-રે/ એમઆરઆઈ/ સીટી સ્કેન સહિતના લેબોરેટરીના બિલ (જો લાગુ પડતું હોય તો).
  - કરાવેલી તપાસના ઇન્વેસ્ટિગેશન રિપોર્ટ

- ☑ ઇન્ડોર કેસ પેપરની પ્રમાણિત નકલ.
- ☑ વર્તમાન બીમારી માટેનો પ્રથમ પ્રમાણ પત્ર.
- ☑ ઈમ્પ્લાન્ટ સર્જરીના સંજોગોમાં, ઈન્વોઈસ અને સ્ટીકર.
- ☑ જો દાવો કરાયેલી રકમ ૧ લાખથી વધુ હોય, તો નીચે વર્ણવેલા કેવાયસી દસ્તાવેજો રજૂ કરવા ફરજિયાત છે-
  - પ્રપોઝરનો તાજેતરનો પાસપોર્ટ સાઈઝનો ફોટો
  - પ્રપોઝરનું પાન કાર્ડ
  - રુહેઠાણનો પૂરાવો (પાસપોર્ટ, વોટર આઈડી, વીજળીનું બિલ, ટેલિફોન બિલની નકલ) જે પોલીસી દસ્તાવેજમાં ઉલ્લેખ કરાયેલા સરનામા સાથે મેળ ખાવું જોઈએ.

Checklist

Original Discharge Card

Photo Id Proof of Patient & policy Holder
(If minor ,Birth Certificate required)

Original Cheque with Printed Name marking Cancel or Plz Attached Passbook Copy with latest Entry in case Name not printed on cheque

Policy Copy

Intimation Number

1st Consultation Report from Treating Doctor with indicating Line of Treatment COMPULSORY

Treating Doctor Certificate with Stating proper Reason for need of Hospitalization-From Hospital

Indore Case Paper Copy with Hospital stamp compulsory

All Medical Bills along with prescription with Doctor Sign & Stamp

All Test Reports with Prescription With Doctor Sign & Stamp

For Non Network Hospital- Hospital Registration details & Copy

Bill Sheet with proper detailing

In Accident Case Only:
MLC Report from Hospital
Non Alcohol Cerificate
Police FIR If any done
Driving license of Driving/Riding person Compulsory.
(If Driver does not have Valid License then Claim will not submit anyhow)

Important Point:

We Will Not Accept File if any document or Signature Missing on above checklist docs.

Plz Carry whole File Xerox Copy as original will not returned in any manner after submitting claim whether claim will settled or not.

If Client Having Any Pre Existing Illness Before Purchased Policy Then Claim will not be Submit before 4 yr as Exclusion.

Claimant Name:			Intimation No:	
Policy No:				
S.No	**Date**	**Bill No**	**Hospital Name/Medical Store Name**	**Amount**
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
Total				
In Word:				

HEALTH INSURANCE

Claim Form - 'CARE'

Part A

1. To be filled in by the Insured.
2. The issue of this Form is not to be taken as an admission of liability.
3. To be filled in block letters.

Claim Intimation No.:_____

Section A - Details of Primary Insured

a) Policy No. :

b) SL No./Certificate No.: c) Company/TPA ID No.:

d) Name :
(Surname) (First Name) (Middle Name)

e) Address :

City :

State : Pin Code :

Phone Number :

E-mail :

Section B - Details of Insurance History

a) Currently covered by any other Mediclaim/Health Insurance : Yes No

b) Date of commencement of first insurance without break : / / (DD/MM/YYYY)

c) If yes, Company Name :

Policy Number : Sum Insured (Rs.):

d) Have you ever been hospitalized in the last 4 years since inception of the contract? Yes No

- Date: / / (DD/MM/YYYY)
- Diagnosis: _____

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

f) If yes, Company Name :

Section C - Details of Insured Person Hospitalised

Title : Mr. Ms.

a) Name :
(Surname) (First Name) (Middle Name)

b) Gender : M F c) Age : / (YY/MM) d) Date of Birth : / /

e) Relationship with Primary Insured : Self Spouse Child Father Mother
Others (Please Specify) _____

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

g) Address : (if different from above)

City :

State : Pin Code :

h) Phone Number :

i) E-mail :

Section D - Details of Hospitalisation

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 : / / (DD/MM/YYYY)

e) Date of Admission : / / (DD/MM/YYYY) f) Time of Admission : : (HH:MM)

g) Date of Discharge : / / (DD/MM/YYYY) h) Time of Discharge : : (HH:MM)

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 : _____

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) 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.

d) Claim Documents Submitted - Checklist

(i) Claim Form Duly signed : ☐
(ii) Copy of the claim intimation, if any : ☐
(iii) Hospital Main Bill : ☐
(iv) Hospital Break-up Bill : ☐
(v) Hospital Bill Payment Receipt : ☐
(vi) Hospital Discharge Summary : ☐
(vii) Pharmacy Bill : ☐
(viii) Operation Theatre Notes : ☐
(ix) ECG : ☐
(x) Doctor's request for investigation : ☐
(xi) Investigation Reports (Including CT/MRI/USG/HPE) : ☐
(xii) Doctor's Prescriptions : ☐
(xiii) Others ☐ _____

Section F - Details of Bills Enclosed

S No.	Bill No.	Date	Issued by	Towards	Amount (INR)
1		(DD/MM/YYYY)		Hospital Main Bill	
2		(DD/MM/YYYY)		Pre-hospitalization Bills: ____Nos	
3		(DD/MM/YYYY)		Post-hospitalization Bills: ___Nos	
4		(DD/MM/YYYY)		Pharmacy bills	
5		(DD/MM/YYYY)			
6		(DD/MM/YYYY)			
7		(DD/MM/YYYY)			
8		(DD/MM/YYYY)			
9		(DD/MM/YYYY)			
10		(DD/MM/YYYY)			

In case of more details, please attach a separate sheet.

Section G - Details of Primary Insured's Bank Account

a) PAN :

b) Account Number :

c) Bank Name & Branch :

d) Cheque/DD payable details :

e) IFSC Code :

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, suppression or concealment of any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent & authorize TPA/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/YYYY)

Signature of the Insured : _____

Place : _____

Claim Form - 'CARE'

Part B

1. To be filled in by the hospital.
2. The issue of this Form is not to be taken as an admission of liability.
3. Please include the original pre-authorization request form in lieu of PART A.
4. 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)

d) Name of the treating doctor :
(Surname) (First Name) (Middle Name)

e) Qualification :

f) Registration No. with State Code :

g) Contact No. :

Section B - Details of the Patient Admitted

a) Name of the Patient:
(Surname) (First Name) (Middle Name)

b) IP Registration No. :

c) Gender : ☐ M ☐ F d) Age : / (YY/MM) e) Date of Birth : / /

f) Date of Admission : / / (DD/MM/YYYY) g) Time of Admission : : (HH:MM)

h) Date of Discharge : / / (DD/MM/YYYY) i) Time of Discharge : : (HH:MM)

j) Type of Admission : ☐ Emergency ☐ Planned ☐ Day Care ☐ Maternity

k) If Maternity,

(i) Date of Delivery : / / (DD/MM/YYYY) (ii) Gravida Status : ______________________

l) Status at the time of discharge : ☐ Discharge to home ☐ Discharge to another hospital ☐ Deceased

m) Total Claimed Amount :

Section C - Details of Ailment Diagnosed (Primary)

a) (i) Primary Diagnosis : ICD 10 Code : Description : ______________________

(ii) Additional Diagnosis : ICD 10 Code : Description : ______________________

(iii) Co-morbidities : ICD 10 Code : Description : ______________________

(iv) Co-morbidities : ICD 10 Code : Description : ______________________

b) (i) Procedure 1 : ICD 10 Code : Description : ______________________

(ii) Procedure 2 : ICD 10 Code : Description : ______________________

(iii) Procedure 3 : ICD 10 Code : Description : ______________________

(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 no. :

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 : _____

Section D - Claim Documents Submitted - Checklist

(I)	Duly signed Claim Form	: ☐	(ix)	Investigation Report	: ☐
(ii)	Original Pre-authorization request	: ☐	(x)	CT/ MRI/ USG /HPE investigation reports	: ☐
(iii)	Copy of Pre-authorization approval letter	: ☐	(xi)	Doctor's reference slip for investigation	: ☐
(iv)	Copy of photo ID card of patient verified by hospital	: ☐	(xii)	ECG	: ☐
(v)	Hospital Discharge Summary	: ☐	(xiii)	Pharmacy Bills	: ☐
(vi)	Operation Theatre notes	: ☐	(xiv)	MLC report & Police FIR	: ☐
(vii)	Hospital Main Bill	: ☐	(xv)	Original death summary from hospital where applicable:	☐
(viii)	Hospital Break-up Bill	: ☐	(xvi)	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 the Hospital :

City :

State : Pin Code :

b) Contact No. : -

c) Registration No. with State Code :

d) Hospital PAN : e) No. of inpatient beds :

f) Facilities available in the 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 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 facts, our right to claim under this claim shall be forfeited.

Date : / / (DD/MM/YYYY) Signature & Seal of the Hospital Authority : _____

Place : _____