



redefining / general insurance

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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

Important Note

Issuance of this form not to be taken as an admission of liability

Please fill this form in Block Letters and Tick the Boxes where appropriate and do not leave any column unanswered.

If any detail or information is not readily available, please do not delay despatch of this report and such particulars may be sent later.

1 Details of Hospital

(To be filled in block letters)

a) Name of the hospital
b) Hospital ID (in case of networked hospital)
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.

2 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 Months 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 Maternit Date of Delivery DD MM YY Gravida Status
l) Status at time of discharge: Discharge to home Discharge to another hospital Deceased m) Total claimed amount

3 Details of Ailment Diagnosed (primary)

Table with 2 columns: ICD 10 Codes, Description. Rows for Primary diagnosis, Procedure done with Anastasia, Treatment given if no surgery.

c) Pre-authorization obtained: Yes No d) Pre-authorization Number:
e) If authorization by network hospital not obtained, give reason:
f) Hospitalization due to Injury: Yes No If Yes, give cause Self-inflicted Road Traffic Accident Substance abuse / alcohol consumption
If Injury due to Substance abuse / alcohol consumption, Test Conducted to establish this: Yes No (If Yes, attach reports) If Medico legal: Yes No
FIR no. If not reported to police give reason:

SECTION A
SECTION B
SECTION C

4 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. with State Code: _____

d) Hospital PAN: _____ e) Number of Inpatient beds _____ f) Facilities available in the hospital: OT : Yes No

ICU : Yes No Others : _____

5 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.

Data Privacy Notice:

I/We hereby provide consent to the Company for collecting/retaining any information relating to Me/Us including Sensitive Personal Information ("hereinafter cumulatively referred to as "INFORMATION"), that is either available with the Company or disclosed by Me/Us while obtaining the policy of Insurance from the company or otherwise. I/We further understand that the Company may use the INFORMATION for servicing the Insurance policy obtained by Me/Us and for same may share the INFORMATION with any reinsurer, insurance association, medical authorities, other Insurers, statutory authorities, court, governmental body, regulator etc., or with services provider(s) engaged by the Company for servicing the Insurance policy, underwriting the risk, settlement of claim etc. without obtaining our specific consent for such sharing and we hereby provide our consent to Company for same.

I/We understand that whenever I/We would like to update/correct the INFORMATION, we will intimate the Company for the same, so as to enable the Company to amend/correct the INFORMATION accordingly. Further in the event I/We would like to withdraw My/Our consent provided herein, I/We would intimate the Company of the same in writing and also understand that, in the event of such withdrawal by Me/Us, the Company reserves the right to not provide Me/Us the Services for which it has sought the INFORMATION.

Date

Place _____

Signature and Seal of the Hospital Authority



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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 b) Hospital ID c) Type of Hospital d) Name of treating doctor e) Qualification f) Registration No. with State Code g) Phone No.	Enter the name of hospital Enter ID number of hospital Indicate whether In network or non network hospital Enter the name of the treating doctor Enter the qualifications of the treating doctor Enter the registration number of the doctor along with the state code Enter the phone number of doctor	Name of hospital in full As allocated by the TPA Tick the right option Name of doctor in full Abbreviations of educational qualifications As allocated by the Medical Council of India Include STD code with telephone number
SECTION B – DETAILS OF THE PATIENT ADMITTED		
a) Name of Patient b) IP Registration Number c) Gender d) Age e) Date of Birth f) Date of Admission g) Time h) Date of Discharge i) Time j) Type of Admission k) If Maternity Date of Delivery Gravida Status l) Status at time of discharge m) Total claimed amount	Enter the name of hospital Enter insurance provider registration number Indicate Gender of the patient Enter age of the patient Enter date of admission Enter date of admission Enter time of admission Enter date of discharge Enter time of discharge Indicate type of admission of patient Enter Date of Delivery if maternity Enter Gravida status if maternity Indicate status of patient at time of discharge Indicate the total claimed amount	Name of hospital in full As allotted by the insurance provider Tick Male or Female Number of years and months Use dd-mm-yy format Use dd-mm-yy format Use hh:mm format Use dd-mm-yy format Use hh:mm format Tick the right option Use dd-mm-yy format Use standard format Tick the right option In rupees (Do not enter paise values)
SECTION C – DETAILS OF AILMENT DIAGNOSED (PRIMARY)		
a) ICD 10 Code Primary Diagnosis Additional Diagnosis Co-morbidities b) ICD 10 PCS Procedure 1 Procedure 2 Procedure 3 Details of Procedure c) Pre-authorization obtained d) Pre-authorization Number e) If authorization by network hospital not obtained, give reason f) Hospitalization due to injury Cause If injury due to substance abuse/alcohol consumption, test conducted to establish this Medico Legal Reported To Police FIR No. If not reported to police, give reason	Enter the ICD 10 Code and description of the primary diagnosis Enter the ICD 10 Code and description of the additional diagnosis Enter the ICD 10 Code and description of the co-morbidities Enter the ICD 10 PCS and description of the first procedure Enter the ICD 10 PCS and description of the second procedure Enter the ICD 10 PCS and description of the third procedure Enter the details of the procedure Indicate whether pre-authorization obtained Enter pre-authorization number Enter reason for not obtaining pre-authorization number Indicate if hospitalization is due to injury Indicate cause of injury Indicate whether test conducted Indicate whether injury is medico legal Indicate whether police report was filed Enter first information report number Enter reason for not reporting to police	Standard Format and Open text Standard Format and Open text Standard Format and Open text Standard Format and Open text Standard Format and Open text Standard Format and Open text Open text Tick Yes or No As allotted by TPA Open text Tick Yes or No Tick the right option Tick Yes or No Tick Yes or No Tick Yes or No As issued by police authorities 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 b) Phone No. c) Registration No. with State Code d) Hospital PAN e) Number of Inpatient beds f) Facilities available in the hospital	Enter the full postal address Enter the phone number of hospital Enter the registration number of the doctor along with the state code Enter the permanent account number Enter the number of inpatient beds Indicate facilities available in the hospital	Include Street, City and Pin Code Include STD code with telephone number As allocated by the Medical Council of India As allotted by the Income Tax department Digits Tick the right option. If others, please specify
SECTION F - DECLARATION BY THE HOSPITAL		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign and stamp		

CLAIM FORM/HOSPITAL/THINQ/01-16. Insurance is the subject matter of solicitation.



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