MediRaksha

Claim Form

TATA AIG INSURANCE
WITH YOU ALWAYS

Tata AIG General Insurance Company Limited: A-501, 5th Floor, Building No.4, Infinity Park, Gen. A.K. Vaidya Marg, Dindoshi, Malad (East), Mumbai 400 097

IMPORTANT:
The Issue of this Form is not to be taken as an admission of liability

Part A (To be filled in by the Insured)

SECTION A - DETAILS OF PRIMARY INSURED

Policy No

Sl. No/ Certificate No:

Company/ TPA ID No:

Name
First Name Middle Name Surname

Address

City

State PIN

Phone (O) (R)

Fax Mobile

E-mail

Date of Birth D D M M Y Y Y Y Occupation

(Please be available at this place where our representative may call on you)

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 D D M M Y Y Y Y

c) If Yes, Company Name _____

Policy No.

Sum Insured Rs.

d) Have you been hospitalized in the last four years since inception of the contract Yes No D D M M Y Y 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 HOSPITALISED

Name
First Name Middle Name Surname

Relationship (Self/Spouse/Child/Father/Mother/Other)

Date of Birth D D M M Y Y Y Y Age mths/yrs

Address
(If different than above)

Gender Male Female Occupation Service/Self employed/Homemaker/Student/ Retired/ Others _____

Phone (O) (R)

Fax Mobile

E-mail

SECTION D - DETAILS OF HOSPITALISATION

Name of the Hospital where admitted

Room Category occupied — Daycare/Single Occupancy/Twin Sharing/ 3 or more beds per room

Hospitalization due to — Illness / Injury / Maternity

Date of Injury/ Date of disease first detected/ Date of delivery — D D M M Y Y Y Y

Date of admission — D D M M Y Y Y Y Time H H M M

Date of discharge — D D M M Y Y Y Y Time H H M M

If injury, give cause — Self Inflicted/Road Traffic Accident/ Substance Abuse/ Alcohol Consumption

If Medico legal — Yes ☐ No ☐

Reported to police? — Yes ☐ No ☐

MLC Report & Police FIR attached? — Yes ☐ No ☐

System of medicine — Allopathic/Other systems of medicine

SECTION E - DETAILS OF CLAIM

Details of the treatment expenses claimed

Pre-hospitalisation Expenses	Rs. _____	Hospitalisation Expenses	Rs. _____
Post-hospitalisation Expenses	Rs. _____	Health-Check up Cost	Rs. _____
Ambulance Charges	Rs. _____	Others (code)	Rs. _____
		Total	Rs. _____
Pre-hospitalisation Period	Days _____	Post -hospitalisation Period	Days _____

Claim for Domiciliary Hospitalization — Yes ☐ No ☐ (if yes, please provide details i9n annexure

Details of Lumpsum/cash benefit claimed

Hospital Daily Cash	Rs. _____	Surgical Cash	Rs. _____
Critical Illness Benefit	Rs. _____	Convalescence	Rs. _____
Pre / Post hospitalisation	Rs. _____	Others	Rs. _____

lumpsum benefit: _____

Claim Documents Submitted- Check List:

Duly filled and signed Claim Form	☐	Copy of intimation letter, if any	☐
Hospital Main Bill	☐	Hospital Break Up bill	☐
Hospital Bill Payment Receipt	☐	Hospital Discharge Summary	☐
Pharmacy Bill	☐	Operation Theater Notes	☐
ECG	☐	Doctor's Request for Investigation	☐
Investigation Reports (Including CT, MRI/USG/HPE)	☐	Doctor's Prescription	☐
Others	☐	_____	☐

SECTION - F DETAILS OF BILLS ENCLOSED

Sr.No.	Bill No.	Date	Issued By	Towards	Amount (Rs.)
		D D M M Y Y Y Y			

SECTION - G DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

PAN

Account Number

Bank Name/ Branch

Payable details: Cheque / DD

IFSC Code

* Please attach a cancelled cheque pertaining to the same

MICR No.

* Please attach a cancelled cheque pertaining to the same

Note:

It is agreed that the Policyholder/Claimant will intimate in writing to TATA-AIG General Insurance Co. Ltd. about any change in bank account details. In an event Insured person bears expenses for treatment please provide account details of Insured Persons in the above format along with proof of incurring such expenses.

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 / 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: Place Signature of Insured

GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled in by the insured)

DATA ELEMENT	DESCRIPTION	FORMAT
SECTION A - DETAILS OF PRMARY INSURED		
a) Policy No.	Enter the policy number	As allotted by the insurance company
b) Sl. 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 Health	Indicate whether currently covered by another Mediclaim / Health Insurance	Tick Yes or Noother Mediclaim /
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	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) 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) 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
e) 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.		

MediRaksha

Claim Form

TATA AIG INSURANCE
WITH YOU ALWAYS

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 preauthorisation request form in lieu of PART A

Part B

SECTION A - DETAILS OF HOSPITAL

Name of the Hospital where treated

Hospital ID

Type of Hospital ☐ Network ☐ Non Network (If non network fill form section E)

Name of the treating Doctor

Qualification

Registration No. with state Code

Phone No.

SECTION B - DETAILS OF PATIENT ADMITTED

Name of the patient

IP Registration Number

Gender: ☐ Male ☐ Female

Age ☐☐ yrs.

Date of Birth D D M M Y Y Y Y

Date of Admission D D M M Y Y Y Y

Time of Admission H H M M

Date of Discharge D D M M Y Y Y Y

Time of Discharge H H M M

Type of Admission ☐ Emergency ☐ Planned ☐ Daycare ☐ Maternity

If Maternity Date of Delivery D D M M Y Y Y Y

Gravida Status _____

Status at time of discharge ☐ Discharged to Home ☐ Discharged to another Hospital ☐ Deceased

Total Claimed Amount Rs. _____

SECTION C - DETAILS OF AILMENTS DIAGNISED (PRIMARY)

ICD 10 Code ☐ Primary Diagnosis ☐ Additional Diagnosis ☐ Co-morbidities

Details procedure/s done _____

ICD 10 PCS ☐ Procedure 1 ☐ Procedure 2 ☐ Procedure 3

Pre-authorization obtained ☐ Yes ☐ No Pre-authorization ☐ No

If authorization by network hospital not obtained, give reason _____

Hospitalisation due to Injury ☐ Yes ☐ No If yes, give cause _____

Self inflicted? ☐ Yes ☐ No Road Traffic Accident ☐ Yes ☐ No

Substance Abuse /Alcohol Consumption ☐ Yes ☐ No

If Injury due to Substance abuse / alcohol consumption, Test Conducted to establish this: ☐ Yes ☐ No

(If yes, attach reports)

Medico Legal ☐ Yes ☐ No Reported to Policy ☐ Yes ☐ No

FIR No. ☐☐☐☐ If not reported to Policy give reasons _____

_____

SECTION D - CLAIM DOCUMENTS SUBMITTED - CHECKLIST

- ☐ Claim form duly filled and signed
- ☐ Investigation reports
- ☐ Original Pre authorization Request
- ☐ CT/MRI/USG/HPE investigation Report
- ☐ Copy of Pre-authorization approval Letter
- ☐ Doctor's reference slip for Investigation
- ☐ Copy of photo ID card of patient verified by Hospital
- ☐ ECG
- ☐ Hospital Discharge Summary
- ☐ Pharmacy Bills
- ☐ Operation Theatre Notes
- ☐ MLC Report & Police FIR
- ☐ Hospital Main Bill
- ☐ Original death summary from hospital where applicable
- ☐ Hospital break up Bill
- ☐ Any other, Pl specify

SECTION E – DETAILS IN CASE OF NON NETWORK HOSPITAL

Address of the Hospital

Phone No.

Registration No. with State Code

Hospital PAN

No. of in-patient Beds

Facilities available in Hospital OT ☐ Yes ☐ No ICU ☐ Yes ☐ No Others _____

SECTION F - DECLARATION BY HOSPITAL

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.

Date: D D M M Y Y Y Y

Place: _____

_____

Signature and seal of the Hospital Authority

GUIDANCE FOR FILLING CLAIM FORM - PART B (To be filled in by the hospital)

DATA	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 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 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

CHECK LIST OF ENCLOSURES FOR SUBMISSION OF CLAIM

Note:

1. When original bills, receipts, prescriptions, reports and other documents are submitted to the other insurer or to the reimbursement provider, verified photocopies attested by such other organisation/provider have to be submitted.
2. If original bills, receipts, prescriptions, reports and other documents are submitted to Us and Insured Person requires same for claiming from other organisation/provider, then on request from the Insured Person We will provide attested copies of the bills and other documents submitted by the Insured Person.

In-patient Treatment / Day Care Procedures

☐ Duly filled and signed Claim Form.
☐ Photocopy of ID card / Photocopy of current year policy.
☐ Original Detailed Discharge Summary with date of admission & discharge, clinical history, past history / procedure details/ Day care summary from the hospital.
☐ Original consolidated hospital bill with break up of each Item, duly signed by the insured.
☐ Original payment Receipt of the hospital bill.
☐ First Consultation letter and subsequent Prescriptions.
☐ Original bills, original payment receipts and Reports for investigation.
☐ Original medicine bills and receipts with corresponding Prescriptions.
☐ Original invoice/Sticker of implants/bills for Implants (viz. Stent/PHS Mesh/IOL etc.) with original payment receipts.

Road Traffic Accident

In addition to the In-patient Treatment documents:

☐ Copy of the First Information Report from Police Department / Copy of the Medico-Legal Certificate.

<u>In Non Medico legal cases</u>

☐ Treating Doctor's Certificate giving details of injuries (How, when and where injury sustained)

<u>In Accidental Death cases</u>

☐ Copy of Post Mortem Report & Death Certificate (If conducted)

For Death Cases

In addition to the In-patient Treatment documents:

- ☐ Original Death Summary from the hospital.
- ☐ Copy of the Death certificate from treating doctor or the hospital authority.
- ☐ Copy of the Legal heir certificate, if the claim is for the death of the principle insured.

Pre and Post-hospitalisation expenses

- ☐ Duly filled and signed Claim Form.
- ☐ Photocopy of ID card / Photocopy of current year policy.
- ☐ Original Medicine bills, original payment receipt with prescriptions.
- ☐ Original Investigations bills, original payment receipt with prescriptions and report.
- ☐ Original Consultation bills, original payment receipt with prescription.
- ☐ Copy of the Discharge Summary of the main claim.

Organ Donation/Transplantation

In addition to the documents of general hospitalization

- ☐ Organ Function test / blood test proving organ failure.
- ☐ Treatment Certificate issued by the Transplant Surgeon of the hospital concerned.

Ambulance Benefit

- ☐ Duly filled and signed Claim Form.
- ☐ Photocopy of ID card / Photocopy of current year policy.
- ☐ Original Bill with Original Payment Receipt.
- ☐ Treating Doctor's consultation prescription indicating Emergency Hospitalization.

Customer Identification Procedure (as per KYC norms of IRDA) Please submit the following documents in case of claim amount exceeds Rs. 100,000	
Legal name and any other names used (Any one of the mentioned documents)	Passport/ PAN Card/ Voter's Identity Card/ Driving License/ Letter from a recognized public authority or public servant verifying the identity and residence of the customer Proof of Residence
(Any one of the mentioned documents)	Telephone bill/ Bank account statement/ Letter from any recognized public authority/ Electricity bill/ Ration card