MediSenior

# 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:**
1. Issuance of this form is not an admission of Liability or a waiver of the terms, conditions and exceptions of the insurance contract .
2. No claim will be admitted without a Medical Report (Attending Physician's Statement) as per format (Page 4) to be obtained at claimant's expense.

## Part A

### 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 the treatment expenses 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 | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
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| | | | | | |
| | | | | | |

## 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. | | |

MediSenior

# 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 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 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)**<br>Please submit the following documents in case of claim amount exceeds Rs. 100,000 | |
|---|---|
| Legal name and any other names used<br>(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<br>Proof of Residence |
| (Any one of the mentioned documents) | Telephone bill/ Bank account statement/ Letter from any recognized public authority/ Electricity bill/ Ration card |