

**Claim Form - 'CARE'**
**To be filled by the insured. Please fill in CAPITAL only.**

 Pre Authorization obtained :  Yes  No If Yes, Pre Authorization No.: \_\_\_\_\_ If No, Claim Intimation No.: \_\_\_\_\_

**Details of Primary Insured**

Policy No. :	<input type="text"/>																																											
Name :	<input type="text"/>														<input type="text"/>																													
	(First Name)														(Last Name)																													
Address :	<input type="text"/>																																											
	<input type="text"/>																																											
	<input type="text"/>														City :	<input type="text"/>																												
State :	<input type="text"/>														Pin Code :	<input type="text"/>																												
Landline :	<input type="text"/>														-	<input type="text"/>														Mobile :	<input type="text"/>													
E-mail :	<input type="text"/>																																											

**Insurance History**

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

If yes, Insurer's Name :

Policy Number :  Sum Insured :

Date of commencement of the above specified insurance, without any break :  /  /  (DD/MM/YYYY) (Attach Policy Copy)

Have you been hospitalized in the last 4 years :  Yes  No

- Date :  /  /  (DD/MM/YYYY)
- Illness/Treatment : \_\_\_\_\_

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

Insurer's Name :

**Details of the Insured Person Hospitalized**

Title :	<input type="checkbox"/> Mr.	<input type="checkbox"/> Mrs.																																										
Name :	<input type="text"/>																																											
Member ID :	<input type="text"/>																																											
Age (in years/mm) :	<input type="text"/>	(YY/MM)	Gender :	<input type="checkbox"/> M	<input type="checkbox"/> F																																							
Date of Birth :	<input type="text"/>	/	<input type="text"/>	/	<input type="text"/>	(DD/MM/YYYY)																																						
Relationship with Primary Insured :	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Son	<input type="checkbox"/> Daughter	<input type="checkbox"/> Father	<input type="checkbox"/> Mother																																						
	<input type="checkbox"/> Others	Specify _____																																										
Occupation :	<input type="checkbox"/> Service	<input type="checkbox"/> Self Employed	<input type="checkbox"/> Student	<input type="checkbox"/> Retired																																								
Address :	<input type="text"/>																																											
	<input type="text"/>																																											
	<input type="text"/>														City :	<input type="text"/>																												
State :	<input type="text"/>														Pin Code :	<input type="text"/>																												
Landline :	<input type="text"/>														-	<input type="text"/>														Mobile :	<input type="text"/>													
E-mail :	<input type="text"/>																																											

**Religare Health Insurance Company Limited**

GYS Global, Plot No. A3, A4, A5, Sector - 125, Noida, U.P. - 201301

Website : www.religarehealthinsurance.com E-mail : customerfirst@religarehealthinsurance.com Call us : 1800-200-4488 Fax : 1800-200-6677

## Details of Hospitalization

Hospital Name :

Room Category :  Day Care  Single Occupancy  Twin Sharing  3 or more beds

Hospitalization due to :  Injury  Illness  Maternity

Date of Injury/Detection of Disease/Delivery :  /  /  (DD/MM/YYYY)

Date of Admission :  /  /  (DD/MM/YYYY)

Time of Admission :  :  (HH:MM)

Date of Discharge :  /  /  (DD/MM/YYYY)

Time of Discharge :  :  (HH:MM)

If Injury, specify cause :  Self inflicted  Road Traffic Accident  Substance Abuse/Alcohol Consumption

Medico Legal Case :  Yes  No

Reported to Police :  Yes  No

MLC Report & Police FIR attached :  Yes  No

System of Medicine : \_\_\_\_\_

## Details of Claim

### a. Details of the treatment expenses claimed

- Pre-hospitalization Expenses :
- Hospitalization Expenses :
- Post-hospitalization Expenses :
- Others \_\_\_\_\_ :
- Others \_\_\_\_\_ :
- Others \_\_\_\_\_ :
- Others \_\_\_\_\_ :
- Others \_\_\_\_\_ :
- Total :

### b. Pre-hospitalization period (Days) :

### c. Post-hospitalization period (Days) :

### d. Claim for domiciliary hospitalization : Yes No (If yes, provide the details in annexure)

### e. Details of Lump sum/cash benefit claimed

- Hospital Daily Cash :
- Surgical Cash :
- Critical Illness Benefit :
- Convalescence Benefit :
- Accidental Death :
- Permanent Total Disability :
- Others (code)  :
- Total :

### Original Claim Documents submitted ñ checklist

• Duly signed Claim Form : <input type="checkbox"/>	• Operation Theater notes : <input type="checkbox"/>
• Hospital Bill : <input type="checkbox"/>	• ECG : <input type="checkbox"/>
• Hospital Break-up Bill : <input type="checkbox"/>	• Doctor's request for investigation : <input type="checkbox"/>
• Hospital Bill Payment Receipt : <input type="checkbox"/>	• Investigation Reports (Including CT/MRI/USG/HPE) : <input type="checkbox"/>
• Hospital Discharge Summary : <input type="checkbox"/>	• Doctor's prescriptions : <input type="checkbox"/>
• Pharmacy Bill : <input type="checkbox"/>	• Others _____ : <input type="checkbox"/>

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### Details of Bills Enclosed

S No.	Bill No.	Date	Issued by	Towards	Amount (INR)
1				Hospital bill	
2				Pre-hospitalization bills	
3				Post-hospitalization bills	
4				Pharmacy bills	
5					
6					

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

### Primary Insured's Bank Details

Bank :

Account Number :

Branch :

PAN :

Cheque/DD No. :

IFSC/Swift Code :

Preferred Payment Mode :  Cheque  NEFT (If NEFT, please fill the NEFT mandate form attached in the end)

To be filled by the Hospital. Please fill in **CAPITAL** only.

### Hospital Details

Hospital Name :

Hospital ID :

Type of Hospital :  Network  Non-network

Name of treating doctor :

Qualification :

Registration No. with State Code :

Contact No. :

### Details of Patient Admitted

Patient name :

IP Registration No. :

Gender :  M  F

Age (in years/mm) :  /

Date of Birth :  /  /  (DD/MM/YYYY)

Date of Admission :  /  /  (DD/MM/YYYY)

Time of Admission :  :  (HH:MM)

Date of Discharge :  /  /  (DD/MM/YYYY)

Time of Discharge :  :  (HH:MM)

Type of Admission :  Emergency  Planned  Day Care  Maternity

If Maternity,

- Date of Delivery :  /  /  (DD/MM/YYYY)
- Gravida Status : \_\_\_\_\_

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

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### Details in case of Non-Network Hospital

Hospital Address :

City :

State :  Pin Code:

Contact No. :  -

Registration No. :

PAN :

No. of inpatient beds :

Facilities available in the hospital : OT :  Yes  No  
 ICU :  Yes  No  
 Others : \_\_\_\_\_

### 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, my right to claim reimbursement shall be forfeited. I also consent & authorize the TPA/insurance company to seek necessary medical information / documents from any hospital/medical practitioner who has attended to me. I hereby declare that I have included all the bills/receipts for the purpose of this claim and that I will not be making any supplementary claim except pre/post hospitalization claim, if any.

Date :  /  /  (DD/MM/YYYY) Signature of the Insured : \_\_\_\_\_

Place : \_\_\_\_\_

### Declaration by the 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 shall be forfeited. Signature of the insured is taken on this claim form after Part – B is fully filled up by us.

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

Place : \_\_\_\_\_