

Claim Form - 'CARE'

To be filled by the insured. Please fill in <u>CAPITAL</u> only.	
Pre Authorization obtained : Yes No If Yes, Pre Authorization No.: If No, C	Claim Intimation No.:
Details of Primary Insured	
Policy No. :	
Address : Cate Name)	
City:	
State : Pin C	Code:
Landline : Mobile :	
E-mail :	
Insurance History	
Currently covered by any other Mediclaim/Health Insurance : Yes No	
If yes, Insurer's Name :	
Policy Number : Sum Insured : Sum Insured :	
	/MM/YYYY) (Attach Policy Copy)
Have you been hospitalized in the last 4 years: Yes No	
• Date:/	
Illness/Treatment:	
Previously covered by any other Mediclaim/Health Insurance : Yes No	
Insurer's Name :	
Details of the Insured Person Hospitalized	
Title : Mr. Mrs.	
Name :	
Member ID :	
Age (in years/mm) : (YY/MM) Gender : M	
Date of Birth : / / (DD/MM/YYYY)	
Relationship with Primary Insured : Self Spouse Son Daughter	Father Mother
Others Specify	
Occupation : Service Self Employed Student Retired	
Address :	
City:	
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Landline : Mobile :	
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Details of Hospitalization		
Hospital Name :		
Room Category : Day Care Sin	ngle Occupancy Twin Sharing 3 or more beds	
Hospitalization due to : Injury Illn	ness 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		
• 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	res res (if yes, provide the details in a mexare)	
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	: Operation Theater notes :	
Hospital Bill	:	一
Hospital Break-up Bill	: Doctor's request for investigation :	_
Hospital Bill Payment Receipt	: Investigation Reports (Including CT/MRI/USG/HPE) :	\dashv
Hospital Discharge Summary	Doctor's prescriptions :	\dashv
		_
 Pharmacy Bill 	: : : :	

Cheque/DD No. :																																
IFSC/Swift Code :																																
Preferred Payment : Chequ Mode	ie				NEF	=T		_	(If N	EFT,	, plea	se fi	ll the	NEI	T ma	andate	e forr	n atta	ache _	d in :	the e	end)		_	_	_				_	_	
To be filled by the Hospital. Pl	ease	fill	in (CAI	PIT	AL	only	7.																								
Hospital Details																																
Hospital Name	: [
Hospital ID	: [
Type of Hospital	:		Ne	etwo	ork				No	n-r	netw	vorl	k																			
Name of treating doctor	: [
Qualification	:																															
Registration No. with State Code	:																															
Contact No.	:																													\perp		
Details of Patient Admit	ted																															
Patient name	: [T										Τ		
IP Registration No.	: [\Box		
Gender	: [Μ				F																									
Age (in years/mm)	:			/																												
Date of Birth	:			/			/					(D	D/N	1M/`	(YY)	()																
Date of Admission	:			/			/					(D	D/N	1M/`	/YY)	()																
Time of Admission	:			:			(HH	l:M	1)																							
Date of Discharge	:			/			/					(D	D/N	1M/	/YY)	()																
Time of Discharge	:			:			(HH	l:M	1)																							
Type of Admission	:		Em	nerg	enc	y				Pla	anne	ed] D	ay C	are					Μ	ater	nit	У						
If Maternity,																																
Date of Delivery	:			/			/					(D	D/M	1M/`	/YY)	()																
Gravida Status	:																															
Status at the time of discharge	: [Dis	scha	arge	to h	ome						Dis	 scha	ırge :	to ar	noth	er h	OSE	ital						D	ece	ase	d			
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Details of Bills Enclosed

Bill No.

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

Primary Insured's Bank Details

Date

Issued by

Towards

Pre-hospitalization bills

Post-hospitalization bills

Hospital bill

Pharmacy bills

Amount (INR)

S No.

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Bank

Branch PAN

Account Number :

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Details of Ailment Diagnosed	
Primary Diagnosis : ICD 10 Code : Description :	
Additional Diagnosis : ICD 10 Code : Description :	
Co-morbidities : ICD 10 Code : Description :	
Co-morbidities : ICD 10 Code : Description :	
Procedure I : ICD 10 Code : Description :	
Procedure 2 : ICD 10 Code : Description :	
Procedure 3 : ICD 10 Code : Description :	
Details of Procedure :	
a. Present ailment is a complication of PED : Yes No	
If yes, specify details :	
b. Pre-authorization obtained : Yes No	
c. Pre-authorization no. :	
d. If authorization by network hospital not obtained, give reason :	
e. Hospitalization due to Injury : No	
If yes, give reason : Self inflicted Road Traffic Accident Substance Abuse/Alcohol Consumption	
If Injury due to Substance abuse/Alcohol consumption, Test conducted to establish this : Yes (If yes, attach reports)	
Medico Legal Case : Yes No	
Reported to Police : Yes No	
FIR No. :	
If not reported to Police, give reason :	
Claim Documents Submitted - Checklist	
Duly signed Claim Form :	
Original Pre-authorization request :	
Copy of Pre-authorization approval letter :	
Copy of photo ID card of patient verified by hospital :	
Hospital Discharge Summary :	
Operation Theatre notes :	
Hospital Bill :	
Hospital Break-up Bill :	
Hospital Bill Payment Receipt :	
• Investigation Reports :	
CT/MRI/USG/HPE investigation reports :	
Doctor's request for investigation :	
• ECG :	
Pharmacy Bills :	
MLC report & Police FIR :	
Original death summary from hospital where applicable :	
Others, please specify	

Details in case of N	on _'	-Ne	etw	or!	k H	los	pita	ıl																							
Hospital Address	:																														
City	:																														
State	:																						Pin	Coc	e:		Ī				
Contact No.																															
Registration No.	:																														
PAN	:									Ť	İ					Ť				T	T	Ť		T		T	T	T	T		
No. of inpatient beds	:									Ť	İ					T					T	Ť				Ī	Ī	T	T		
Facilities available in the hosp	ital	:	ОТ	-					: [7	Yes					No	1														
			ICL	J					:] \	Yes					No															
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