Royal Sundaram

HEALTH INSURANCE CLAIM FORM

FOR OFFICE USE ONLY

Issuing office :_____

Date of Issue :_____

ROYAL SUNDARAM ALLIANCE INSURANCE COMPANY LIMITED

Sundaram Towers, 45-46, Whites Road, Chennai-600 014. Ph : +91-44-28517387 - 90 Fax:+91-44-2851 5500

E-mail : customer.services@royalsundaram.in, Customer Service Helpline : 1860 425 0000

THE ISSUE OF THIS FORM IS NOT TO BE TAKEN AS AN ADMISSION OF LIABILITY

Please ensure that all questions are answered in capital letters.

Policy Certificate Number

Membership Number
(As appearing in the health card. This is applicable for policies serviced by TPA only)

1. INSURANCE DETAILS

Details of Proposer

Name of the Proposer/Policy Holder

Occupation and Designation

Work address / Business address

Details of the Patient

Name of the Patient

Date of Birth of patient

Occupation and Designation of the Patient

Work address / Business address

Communication Details

Address for Correspondence with Pincode

In case the policy address is not same as the communication address, would you like to change the same?

Yes ☐ No ☐

Contact Details

Telephone Number - landline

Mobile Number (Mandatory)

Email ID

2.DETAILS OF THE INJURY / ILLNESS

Date of Injury / illness D D M M Y Y Y Y

Nature of Injury / illness

In the event of injury, please give full details as to the circumstances of the accident (If the space provided is inadequate attach a separate sheet)

3. HOSPITAL DETAILS

Details of the Hospital/Nursing Home

Name of the Hospital/Nursing Home

Address & Telephone number

Date of Admission D D M M Y Y Y Y

Time of Admission am / pm

Date of discharge D D M M Y Y Y Y

Time of discharge am / pm

4. AMOUNT CLAIMED

Please mention all Royal Sundaram Policy Nos under which claim is lodged

Policy No	Certificate No	Amount Claimed			Daily Benefit	Any other Benefit	Total
		Hospitalization	Pre Hospitalization	Post Hospitalization			

5.OTHER INSURANCE DETAILS (With any other Insurance Company)

Is the claimant covered under any other health insurance scheme Yes ☐ No ☐

If Yes , please give full details below

Company Name	Policy Number	Sum Insured	Cumulative Bonus	Total Sum Insured	Period of Insurance

6. CLAIMS HISTORY

Company Name	Policy Number	Date of Admission	Date of Discharge	Claim Number	Nature of illness/injury	Amount Settled

7. DECLARATION

I hereby warrant the truth of the above particulars in every respect. I agree that if I have made, or will make any false statement, suppression or concealment, my right to claim under the policy shall be forfeited.

I consent and authorise Royal Sundaram to seek medical information along with indoor case paper from any Hospital / Medical practitioner who has at any time attended on the insured person.

Date : D D M M Y Y Y Y

Place : _____

_____

Signature or thumb impression of the Insured (Policy Holder)

Please Enclose (Originals required only for claims on reimbursement basis. For Hospital Cash claims photo copies will do)

- ☐ Test Reports and prescriptions relating to First / Previous consultations for the same or related illness
- ☐ Case history / Admission-discharge summary describing the nature of the complaints and its duration, treatment given, advice on discharge etc issued by the Hospital
- ☐ Hospital receipts / bills / cash memos in original (Including advance & final receipts)(Not required for Hospital Cash / Daily benefit policies)
- ☐ All test reports for X-rays, ECG, Scan, MRI, Pathalogy etc (The Original reports will be returned on request). Please do not send the Original CD/DVD of the procedure undergone by the patient, unless specifically called for.
- ☐ Doctor's prescriptions with cash bills for medicines purchased outside (Cash bills, however not required for Hospital Cash / Daily benefit policies)
- ☐ FIR in the case of accidental injury and English translation of the same, if in any other language.
- ☐ For maternity claims, ante-natal prescription mentioning LMP, EDD & Gravida (Wherever applicable)

TO BE FILLED IN BY ATTENDING PHYSICIAN

1. Name and address of the patient
2. Age of the patient
3. Name and address of the Surgeon / Physician
4. When did the patient start suffering with the complaint ?
5. Date of first consultation (prior to hospitalisation) — D D M M Y Y Y Y
6. Why was the patient admitted ? (specify complaint)
7. a. Date of admission — D D M M Y Y Y Y b. Time of admission — am / pm
8. a. Date of discharge — D D M M Y Y Y Y b. Time of discharge — am / pm
9. Diagnosis
10. a) Please give previous medical history of the patient

    b) Is the patient suffering from any of the following diseases

	Say Yes /No	If "yes" Please mention the duration below	
		Duration in Year	Duration in month
I. Bronchial Asthma			
II. Chronic Obstructive Pulmonary disease			
III. Hypertension			
IV. Diabetes			
V. Heart ailment			
VI. Osteoarthritis			
VII. Cerebro vascular attack			
VIII. Seizure disorder			
IX. Renal / Kidney Disorder			
X. Any other			

11. Is the ailment a complication of a pre-existing disease or condition ?
If Yes , please give details

12. History of alcoholism :
If yes : No of years :
Quantity consumed per day :

Tick Yes/ No

History of Smoking/ Tobacco chewing :
If yes : No of years :
Units consumed per day :

Tick Yes/ No

13. Nature of surgery or treatment given for present ailment

14. For maternity claims,

LMP

EDD

Gravida

Number of living children
(Including the new born Baby)

15. Is the Hospital / Nursing Home registered ?
If Yes , please give registration number.

16. How many inpatient beds does the Hospital have (including ICU) ?

17. Does the hospital have a fully equipped operation theatre and qualified nurses and doctors round the clock ?

18. Any other remarks you wish to make.

I hereby declare that the contents of information furnished and declared by me on the patient's treatment is true and correct to best of my knowledge and belief. I shall be held personally liable in case any of above information is found incorrect.

Doctor's Name

Qualification

Doctor's Registration No.

Seal

Signature of Doctor

Date D D M M Y Y Y Y

Authorization Letter (Mandatory)

Date:

From:

To:

The Manager/ Medical Superintendent,
Medical Records

Dear Sir

Reg : Authorization Letter.

Name of the Patient:_____

IP Number_____ (First admission) in _____Hospital

IP Number_____ (Second admission) in _____Hospital

IP Number_____(Third admission) in _____Hospital

I consent and authorize M/s Royal Sundaram Alliance Insurance Company and their Authorized Service Providers to seek medical information from your hospital and share copies of indoor case sheets and such ther relevant medical records and / or meet the Medical Practitioner who has at any time attended on the patient for the hospitalization dated ..... to .....

Thanking you,

Yours sincerely,

Signature of the Proposer

Signature of the Patient

Visit 1: Request made for Hospital Internal Case Records of the patient/ Other medical Records

Response :

Signature of Hospital Authority (with seal & date):

Visit 2 : Request made for Hospital Internal Case Records of the patient/ Other medical Records

Response :

Signature of Hospital Authority (with seal & date):

Visit 3: Request made for Hospital Internal Case Records of the patient/ Other medical Records

Response :

Signature of Hospital Authority (with seal & date):