Claim Form

MediPrime

TATA AIG INSURANCE
WITH YOU ALWAYS

PART A

TO BE FILLED IN BY THE INSURED
The issue of this Form is not to be taken as an admission of liability

Policy No. **Sl. No. /Certificate No.**

Name of the TPA:

Insured / Claimant Details (In block letters)

1. Name & Address of the Policyholder

Name

Address

City State

Pin Code

Contact Information Mobile Phone

Email

2. Details of the Hospitalised Person

Name

Relationship Date of Birth D D M M Y Y Y Y

Address

City State

Pin Code

Gender ☐ Male ☐ Female Occupation

Contact Information Mobile Phone

Email

3. Hospitalisation due to ☐ Illness ☐ Injury ☐ Others

Details

Date of Injury sustained D D M M Y Y Y Y

Disease first detected / Last Menstrual Period D D M M Y Y Y Y

If injury, how did it occur ?

If injury, whether is it a Medico Legal Case (MLC) ☐ YES ☐ NO

If MLC, whether reported to police? ☐ YES ☐ NO

System of medicine : ☐ Allopathic ☐ Other systems of medicine

4. Insurance History

Name of the Company & Policy Name :

Date of commencement of first Insurance for the person (without break) D D M M Y Y Y Y

Are you presently covered with any other Mediclaim / Health Insurance Policy? ☐ YES ☐ NO

If Yes, give details - Company / Policy No. / Sum Insured (copies of policies to be attached)

5. Name of the Hospital where admitted

Room Category occupied ☐ Day care ☐ Single occupancy ☐ Twin sharing ☐ 3 or more

6. Past Hospitalisation History

a) Have you been hospitalised in the last 4 years? ☐ YES ☐ NO

b) If Yes, Diagnosis

c) Month and Year of Diagnosis M M Y Y Y Y

7. Is this claim for Domiciliary Hospitalisation? ☐ YES ☐ NO

(If yes, please provide details of annexures attached) :

8. Policyholder's Bank Account particulars

a) Policyholders PAN No. | e) IFSC Code

b) Account No. | f) MICR No.

c) Payable details: ☐ Cheque ☐ DD ☐ NEFT (* Please attach a cancelled cheque pertaining to the same)

d) Bank Name / Branch*

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.

9. Details of the treatment expenses claimed

a) Pre-hospitalisation Expenses Rs. _____ b) Hospitalisation Expenses Rs. _____

c) Post-hospitalisation Expenses Rs. _____ d) Health-Check up Cost Rs. _____

e) Ambulance Charges Rs. _____ f) Organ donor Rs. _____

g) Domiciliary hospitalisation Rs. _____ h) Others Rs. _____

10. Details of bills enclosed

Sl. No	Bill No	Date	Issued by	Towards	Amount (Rs.)

11. For details of Claim Documents to be submitted to the TPA, please refer to the CHECK LIST

Declaration by the Insured

I hereby declare that the information furnished in this Claim Form is true and correct to the best of my knowledge and belief. If I have made any false or untrue statement or suppressed or concealed any material fact with respect to the queries raised in the proposal form and claim form, my right to claim reimbursement shall be forfeited.

I also consent and authorize TPA / Insurance Company, to seek necessary medical information / documents from any hospital / Medical Practitioner / Insurer 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/Hospitalization / event and that I will not be making any further claims under this inpatient hospitalization for the illness / injury except the Pre / Post - hospitalization claim, if any.

I hereby also agree that in the event of the death of Policyholder or an Insured Person, the claim payment will be made to the Nominee (as named in the Schedule) or the legal heir in case not mentioned on the Schedule.

Place : _____

Date D D M M Y Y Y Y

_____

Signature of the Insured / Policyholder / Claimant

Communication details of TPA (kindly submit the dully filled & signed claim form along with original documents at following address)
Family Health Plan (TPA) Ltd - Claims Department **Tata AIG General Insurance Company (TAGIC)**
Ground Floor, Srinilaya – Cyber Spazio, Road No: 2, Banjara Hills, Hyderabad 500 034 • FHPL Toll Free No: **1800 425 4090**

CHECK LIST OF ENCLOSURES FOR SUBMISSION OF CLAIM

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 / 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 or.
- ☐ Original bills, payment receipts and reports investigations.
- ☐ Original medicine bills and receipts with corresponding prescriptions.
- ☐ Original invoice / 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.

In Non Medico Legal Cases:

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

In Accidental Death cases:

- ☐ Copy of post mortem report (if conducted).
- ☐ Copy of Death Certificate.

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.
- ☐ Original medicine bills, payment receipt with prescriptions.
- ☐ Original investigations bills, payment receipt with prescriptions and investigation report.
- ☐ Original consultation bills & payment receipt.

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

- ☐ Original bill with payment receipt.
- ☐ Treating Doctor's consultation prescription indicating emergency hospitalization.

Annual Health Check up

- ☐ Duly filled and signed Claim Form.
- ☐ Photocopy of ID card.
- ☐ Original investigation bills & payment receipts with investigation report.
- ☐ Original consultation bills and payment receipts with prescription.

Daily Cash Benefit

- ☐ Duly filled and signed Claim Form.
- ☐ Photocopy of ID card.

Outpatient Benefit / Accidental & Post Bite Vaccination

- ☐ Duly filled and signed Claim Form.
- ☐ Photocopy of ID card.
- ☐ Original Medicine bills & payment receipt.
- ☐ Original Investigations bills & payment receipt with investigation report.
- ☐ Original consultation bills & payment receipt with prescription.
- ☐ Details of any outpatient procedures.
- ☐ Dental X-ray film.

PART B

For Office Use Only (Refer IRDA / TAC Master for codes wherever applicable)

1) TPA Code
2) Insurer Code
3) Product Code
4) Policy Number
5) Policy Start Date (D D M M Y Y Y Y)
6) Policy End Date (D D M M Y Y Y Y)
7) Sum Insured
8) Bonus Sum Insured
9) Master Claim ID
Accrued, if any
10) Diagnosis Code
Primary Diagnosis
Additional Diagnosis
Co-morbidities
11) Procedure Code
Procedure 1
Procedure 2
Procedure 3
12) Details of Claim Paid

Indemnity Benefit

a. Room & Nursing Charges
b. ICU Charges
c. OT Charges
d. Medicine & Consummable Charges
e. Professional Fees' Charges
f. Investigation Charges
g. Ambulance Charges
h. Miscellaneous Charges
13) Total Claim Paid
14) Total Rejected Amount
15) Reason for Rejection of Claim
16) Reason for Reduction of Claim
17) Whether claim paid was for PED
18) If Yes, PED Code
19) Whether claim paid under alternate medicine ☐ Yes ☐ No
20) Amount of co-payment / deductible applicable
21) Corporate Buffer Utilized, if any
22) Date of Payment (D D M M Y Y Y Y)
23) Payment Reference Number
24) Date of Claim Intimation (D D M M Y Y Y Y)
25) Date of receipt of complete claim documents (D D M M Y Y Y Y)

PART C (TO BE FILLED IN BY THE HOSPITAL)

The insurance of this Form is not to be taken as an admission of liability
Please include the original pre-authorisation request form in lieu of PART A

1. **Name of the Hospital where treated**
2. **Hospital ID :** _____
3. **Type of Hospital :** Network ☐ Non Network ☐
4. **In case of Non Network, please provide below details**

Address of the Hospital

City State Pin Code

Telephone No. (with STD) Registration No.

No.of Inpatient beds Hospital PAN No.

Other facilities available in the hospital :

i) OT ☐ YES ☐ NO

ii) ICU ☐ YES ☐ NO

iii) Others : _____

5. **Details of the patient admitted**

Name of the patient

IP Registration No.

Gender : ☐ Male ☐ Female

Date of Birth (D D M M Y Y Y Y)

Date of Admission (D D M M Y Y Y Y) Time AM / PM

Date of Discharge (D D M M Y Y Y Y) Time AM / PM

6. Ailment Diagnosed (Primary)

ICD 10 Code | Primary Diagnosis

Additional Diagnosis | Co-morbidities

Details of Procedure/s done : _____

ICD 10 PCS : _____ Procedure 1 : _____ Procedure 2 : _____ Procedure 3 : _____

7. Type of Admission

☐ Emergency ☐ Planned Day-care Others : _____

Date of delivery, if maternity D D M M Y Y Y Y Gravida Status : _____

8. Is the treatment for an injury? If, yes, give details

a) Was it self inflicted? ☐ YES ☐ NO

b) Whether Road Traffic Accident ☐ YES ☐ NO

c) If Medico Legal Certificate (MLC), whether notified to police - ☐ YES ☐ NO

d) MLC / FIR No.: _____

e) If MLC not notified, give reasons : _____

9. Was the Injury/ disease caused due to Substance abuse / Alcohol consumption ☐ YES ☐ NO

If Yes whether any test was conducted to establish this? If Yes please attach Report ☐ YES ☐ NO

10. Whether the present ailment is a complication of any illness suffered in the past ☐ YES ☐ NO

If Yes, specify details _____

11. Whether Pre-authorisation obtained ☐ YES ☐ NO

a) If Yes, Pre Auth No.: _____

b) If authorisation by network hospital not obtained, give reason : _____

12. Details of the Treating Doctor

a) Name of the Treating Doctor

b) Registration No. with state code

c) Mobile No.

d) Qualification : _____

13. For details of Claim Documents to be submitted to the TPA, please refer to the Capital

Declaration by the hospital

We hereby declare that the information furnished in this Claim Form is true and correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppressed or concealed any material fact, our right to claim under this claim shall be forfeited.

_____

Seal & Signature Of The Hospital Authority

Date D D M M Y Y Y Y

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) identity and residence of the customer	Passport/ PAN Card/ Voter's Identity Card/ Driving License/ Letter from a recognized public authority or public servant verifying the
Proof of Residence (Any one of the mentioned documents)	Telephone bill/ Bank account statement/ Letter from any recognized public authority/ Electricity bill/ Ration card