L&T Insurance

my:health Group Medisure Insurance Claim Form

GUIDELINES TO FILL THE FORM

1. Please fill the form in BLOCK LETTERS. Please answer all questions fully and correctly. All details with * are mandatory.
2. Please leave one box blank between two words while writing the ADDRESS.
3. Kindly contact the Company's Office or TPA for any doubts or clarifications on the claim form.

PLEASE USE ONLY ORIGINAL CLAIM FORM. PHOTO COPIES WILL NOT BE ACCEPTED BY THE COMPANY.

CLAIM FORM FOR GROUP HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT
PART A (TO BE FILLED IN BY THE INSURED)
The issue of this Form is not to be taken as an admission of liability

DETAILS OF PRIMARY INSURED:

a) Policy No: b) Sl. No/ Certificate No:

c) Company/TPA ID No:

d) Name : F I R S T M I D D L E L A S T

e) Address:

City State

Pin Code Phone No Email ID

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

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 Date: M M Y Y

Diagnosis: e) Previously covered by any other Mediclaim / Health insurance : ☐ Yes ☐ No

f) If yes, Company Name

DETAILS OF INSURED PERSON HOSPITALIZED:

a) Name : F I R S T M I D D L E L A S T

b) Gender: ☐ Male ☐ Female c) Age: Y Y years M M months d) Date of Birth: D D M M Y Y

e) Relationship to Primary insured: ☐ Self ☐ Spouse ☐ Child ☐ Father ☐ Mother ☐ Other (Please Specify)

f) Occupation: Service ☐ Self Employed ☐ Homemaker ☐ Student ☐ Retired ☐ Other (Please Specify)

g) Address (if different from above):

City State

Pin Code Phone No Email ID

DETAILS OF HOSPITALIZATION:

a) Name of Hospital where Admitted:

b) Room Category occupied: ☐ Day care ☐ Single occupancy ☐ Twin sharing ☐ 3 or more beds per room

c) Hospitalization due to: ☐ Injury ☐ Illness ☐ Maternity d) Date of Injury / Date Disease first detected /Date of Delivery:

e) Date of Admission: D D M M Y Y f) Time: H H : M M g) Date of Discharge: D D M M Y Y h) Time: H H : M M

i) If Injury give cause: ☐ Self inflicted ☐ Road Traffic Accident ☐ Substance Abuse/Alcohol Consumption j. If Medico legal: ☐ Yes ☐ No

ii. Reported to police: ☐ Yes ☐ No iii. MLC Report & Police FIR attached: ☐ Yes ☐ No k) System of Medicine:

DETAILS OF INSURED HOSPITALIZATION:

a) Details of the treatment expenses claimed

Hospitalization expense

Add on Covers

Total Rs.

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Document Check List for Hospitalization Claim

Basic Claim Documents

1. Claim Form Duly filled with requisite information and signed by Insured & Hospital
2. Copy of the claim intimation
3. Original Hospital Main Bill
4. Original Hospital Bill break up (Where issued by the Hospital)
5. Original Hospital Bill Payment Receipt
6. Hospital Discharge Card/Summary
7. Original Pharmacy Bill with supporting prescriptions
8. Medical Investigation report: ECG/X-Ray/USG/CT/MRI/Histopathology/pathological and all other medical investigation report in support of diagnosis as advised by the treating doctor.
9. All doctors' consultation note: confirming provisional & final diagnosis/advise for admission/medical complication/proposed line of treatment/past medical history
10. Original bills and receipts for claiming Ambulance charges (if any)

Pre & post hospitalization Claim documents:

1. Duly filled claim form(s) (If claimed Separately)
2. Pharmacy Bills with supporting prescriptions
3. Medical investigation test reports and payment receipts with doctor's advice note for such investigations
4. All doctors' consultation note with original bills and receipts for claiming doctors' fees

Domiciliary hospitalization Claims documents

1. Duly filled claim form(s)
2. Original bills from chemists supported by proper prescription
3. Original Investigation test reports and payment receipts
4. Original bills and receipts for claiming doctor's fees
5. Certificate from treating doctor stating the reason for domiciliary treatment

By signing the claim form you are authorizing us to collect the following documents from the Hospital. If you have obtained these documents, then please submit the same

a) Operation Theatre Notes in surgical cases

b) Bar code sticker & Invoice for implants and prosthesis (if used)

c) In case of Accidental Injuries, Medico Legal Certificate and/ or First information Report, where applicable and self statement giving description of the incident

d) Indoor case papers

Know Your Customer (KYC) documents viz. (address proof of claimant (nominee) and photo ID) would be required for all admissible Claims more than Rs. 100000/-

Details of Bill Enclosed

Sr. No.	Bill No.	Bill No.	Issued By	Towards	Amount (Rs)

my:health Group Medisure Insurance UIN No. IRDA/NL-HLT/L&TGI/P-H/V.I/329/13-14

e) Previously Covered by any other Mediclaim/ Health insurance?	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.		

e) Previously Covered by any other Mediclaim/ Health insurance?	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.		

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CLAIM FORM-PART B

(To be filled in by the Hospital)

The issue of this form is not taken as an admission of liability

(To be filled in block letters)

a) Name of the hospital:

b) Hospital ID: c) Type of Hospital: ☐ Network ☐ Non Network (If non network, fill section E)

d) Name of the treating doctor: F I R S T M I D D L E L A S T

e) Qualification: f) Registration No. with State Code: g) Ph. No.

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient: F I R S T M I D D L E L A S T

b) IP Registration Number: c) Gender: ☐ M ☐ F d) Age: Y Y years M M months e) Date of Birth: D D M M Y Y

f) Date of Admission: D D M M Y Y g) Time: H H : M M h) Date of Discharge: D D M M Y Y i) Time: H H : M M

j) Type of Admission: ☐ Emergency ☐ Planned ☐ Day Care ☐ Maternity k) If maternity i. Date of Delivery: D D M M Y Y ii. Gravida Status: ☐

l) Status at time of discharge: ☐ Discharge to home ☐ Discharge to another hospital ☐ Deceased m) Total claimed amount

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a) ICD 10 Codes	Description
i. Primary Diagnosis:	
ii. Additional Diagnosis:	
iii. Co-morbidities: 1:	
iv. Co-morbidities: 2:	

b) ICD 10 PCS	Description
i. Procedure 1:	
ii. Procedure 2:	
iii. Procedure 3:	
iv. Details of Procedure:	

d) Pre-authorization obtained: ☐ Yes ☐ No e) Pre-authorization Number:

f) If authorization by network hospital not obtained, give reason:

g) Hospitalization due to Injury: ☐ Yes ☐ No i. If Yes, give cause ☐ Self-inflicted ☐ Road Traffic Accident ☐ Substance abuse/alcohol consumption ☐

ii. If Injury due to Substance abuse/alcohol consumption, Test Conducted to establish this: ☐ Yes ☐ No (If Yes, attach reports)

iii. If Medico legal: ☐ Yes ☐ No iv. Reported to Police: ☐ Yes ☐ No v. FIR no.

vi. If not reported to police give reason:

CLAIM DOCUMENTS SUBMITTED - CHECK LIST

- Claim Form duly signed
- Original Pre-authorization request
- Copy of the Pre-authorization approval letter
- Copy of photo ID card of patient verified by hospital
- Hospital Discharge summary
- Operation Theatre notes
- Hospital main bill
- Hospital break-up bill
- Investigation reports
- CT/MR/USG/HPE investigation reports
- Doctor's reference slip for investigation
- ECG
- Pharmacy bills
- MLC report & Police FIR
- Original death summary from hospital where applicable
- Any other, please specify

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L&T Insurance is the brand of L&T General Insurance Company Limited Registered Office: L&T House, N.M. Marg, Ballard Estate, Mumbai - 400001

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ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)

a) Address of the Hospital:

City State

Pin Code Ph. No. Registration No. with state Code:

d) Hospital PAN: e) Number of Inpatient beds f) Facilities available in the hospital: i. OT : ☐ Yes ☐ No

ii. ICU : ☐ Yes ☐ No iii. Others :

DECLARATION BY THE HOSPITAL (PLEASE READ VERY CAREFULLY)

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

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 Birth	Enter date of admission	Use dd-mm-yy format
f) Date of Admission	Enter date of admission	Use dd-mm-yy format
g) Time	Enter time of admission	Use hh:mm format
h) Date of Discharge	Enter date of discharge	Use dd-mm-yy format
i) Time	Enter time of discharge	Use hh:mm format
j) Type of Admission	Indicate type of admission of patient	Tick the right option
k) 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
l) Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
m) Total claimed amount	Indicate the total claimed amount	In rupees (Do not enter paise values)
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

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DATA ELEMENT	DESCRIPTION	FORMAT
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) Pre-authorization obtained	Indicate whether pre-authorization obtained	Tick Yes or No
d) Pre-authorization Number	Enter pre-authorization number	As allotted by TPA
e) If authorization by network hospital not obtained, give reason	Enter reason for not obtaining pre-authorization number	Open text
f) 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. with State Code	Enter the registration number of the doctor along with the state code	As allocated by the Medical Council of India
d) Hospital 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 HOSPITAL		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign and stamp		

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