Claim Form

ApolloMunich HEALTH INSURANCE

10th Floor, Building No. 10, Tower B, DLF City Phase II, DLF Cyber City, Gurgaon-122002

CLAIM FORM

(The issue of this Form is not to be taken as an admission of liability)

PART A

TO BE FILLED IN BY THE INSURED

SECTION A - DETAILS OF PRIMARY INSURED

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

c) Company/ TPA ID No :

d) Name :

e) Address :

Phone No. : Email ID :

SECTION B - DETAILS OF INSURANCE HISTORY

a) Currently covered by any other mediclaim health insurance Yes ☐ / No ☐

b) Date of commencement of first Insurance for the person (without break) : (DD/MM/YYYY) : D D M M Y Y Y Y

c) If Yes, Company Name :

Policy No. : Sum Insured :

d) Have you been hospitalized in the last four years since inception of the contract? Yes ☐ / No ☐ (DD/MM/YYYY) : D D M M Y Y Y Y

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

f) If Yes, Company Name :

SECTION C - DETAILS OF THE INSURED PERSON HOSPITALISED :

a) Name :

b) Relationship : Self ☐ / Spouse ☐ / Child ☐ / Father ☐ / Mother ☐ / Other ☐ c) Date of Birth : D D M M Y Y Y Y

d) Age (YY/MM) : Y Y M M e) Gender: Male ☐ / Female ☐

f) Address: (If different than above)

g) Occupation : Service ☐ / Self employed ☐ / Homemaker ☐ / Student ☐ / Retired ☐ / Others

h) Telephone No : Mobile No :

i) E-mail ID, if any :

SECTION D - DETAILS OF HOSPITALISATION :

a) Name of the Hospital where admitted :

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

c) Hospitallisation due to Illness ☐/ Injury ☐/ Maternity ☐ : Details :

d) Date of Injury/ Date of disease first detected/ Date of delivery : (DD/MM/YYYY) : D D M M Y Y Y Y

e) Date of admission : (DD/MM/YYYY) : D D M M Y Y Y Y f) Time : (HH/MM) : H H M M

g) Date of discharge : (DD/MM/YYYY) : D D M M Y Y Y Y h) Time : (HH/MM) : H H M M

i) If injury, give cause : Self Inflicted ☐ / Road Traffic Accident ☐ / Substance Abuse ☐ / Alcohol Consumption ☐

i) If Medico legal Yes ☐ / No ☐ ii) Reported to police? Yes ☐ / No ☐ iii) MLC Report, & Police FIR attached? Yes ☐ / No ☐

j) System of medicine : Allopathic ☐ / Other systems of medicine ☐

SECTION E - DETAILS OF CLAIM :

a) Details of the treatment expenses claimed :

i)	Pre-hospitalisation Expenses	Rs.	ii)	Hospitalisation Expenses	Rs.
iii)	Post-hospitalisation Expenses	Rs.	iv)	Health-Check up Cost	Rs.
v)	Ambulance Charges	Rs.	vi)	Others (code)	Rs.
	Total	**Rs.**			

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vii) Pre-hospitalisation Period Days ☐☐☐ viii) Post -hospitalisation Period Days ☐☐☐

b) Claim for Domiciliary Hospitalization : Yes ☐ / No ☐ (if yes, please provide details in annexure)

c) Details of Lumpsum / cash benefit claimed :

i) Hospital Daily Cash Rs. ☐☐☐☐☐☐☐☐☐ ii) Surgical Cash Rs. ☐☐☐☐☐☐☐☐☐

iii) Critical Illness Benefit Rs. ☐☐☐☐☐☐☐☐☐ iv) Convalescence Rs. ☐☐☐☐☐☐☐☐☐

v) Pre/Post hospitalisation lumpsum benefit: Rs. ☐☐☐☐☐☐☐☐☐ vi) Others Rs. ☐☐☐☐☐☐☐☐☐

Claim Documents Submitted- Check List:

- ☐ Duly filled and signed Claim Form
- ☐ Hospital Main Bill
- ☐ Hospital Bill Payment Receipt
- ☐ Pharmacy Bill
- ☐ ECG
- ☐ Investigation Reports (Including CT, MRI/USG/HPE)
- ☐ Others
- ☐ Copy of intimation letter, if any
- ☐ Hospital Break Up bill
- ☐ Hospital Discharge Summary
- ☐ Operation Threater Notes
- ☐ Doctor's Request for Investigation
- ☐ Doctor's Prescription

SECTION - F DETAILS OF BILLS ENCLOSED :

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

SECTION - G DETAILS OF PRIMARY INSURED'S BANK ACCOUNT :

a) PAN No : ☐☐☐☐☐☐☐☐☐☐ b) Account No : ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

c) Bank Name : ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Branch : ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

d) Payable details: Cheque ☐ / DD ☐ e) IFSC Code : ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

f) MICR No : ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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SECTION H - 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 with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent & authorize TPA / insurance company, to seek necessary medical information / documents from any hospital / Medical Practitioner 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 & that I will not be making any supplementary claim except the pre/post-hospitalization claim, if any.

Date : D D M M Y Y Y Y Place : Signature of Insured :☑

GUIDANCE FOR FILLING CLAIM FORM - PART A :

DATA ELEMENT	DESCRIPTION	FORMAT
SECTION A - DETAILS OF PRIMARY INSURED		
a) Policy No.	Enter the policy number	As allotted by the insurance company
b) Sl. No/ Certificate No.	Enter the social insurance number or the certificate number of social health insurance scheme	As allotted by the organization