redefining / general insurance

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CLAIM FORM – PART B
TO BE FILLED IN BY THE HOSPITAL
The issue of this Form is not to be taken as an admission of liability
Please include the original preauthorization request form in lieu of PART A

Important Note

Issuance of this form not to be taken as an admission of liability

Please fill this form in **Block Letters** and **Tick the Boxes** ✓ where appropriate and do not leave any column unanswered.

If any detail or information is not readily available, please do not delay despatch of this report and such particulars may be sent later.

1 Details of Hospital

(To be filled in block letters)

a) Name of the hospital

b) Hospital ID (in case of networked hospital)

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

d) Name of the treating doctor SURNAME FIRST NAME MIDDLE NAME

e) Qualification f) Registration No. with State Code g) Phone No.

2 Details of the Patient admitted

a) Name of the Patient SURNAME FIRST NAME MIDDLE NAME

b) IP Registration Number c) Gender Male ☐ Female ☐ d) Age: Years YY Months MM e) Date of birth DD MM YY

f) Date of Admission DD MM YY g) Time: HH : MM h) Date of Discharge: DD MM YY i) Time: HH : MM

j) Type of Admission: Emergency ☐ Planned ☐ Day Care ☐ Maternity ☐ k) If Maternit Date of Delivery DD MM YY Gravida Status ☐☐☐

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

3 Details of Ailment Diagnosed (primary)

	ICD 10 Codes	Description
i) Primary diagnosis		
ii) Procedure done with Anastasia		
iii) Treatment given if no surgery		

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

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

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

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

FIR no. If not reported to police give reason:

SECTION A SECTION B SECTION C

4 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: b) Phone No. c) Registration No. with State Code:

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

ICU : Yes No Others :

5 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.

Data Privacy Notice:
I/We hereby provide consent to the Company for collecting/retaining any information relating to Me/Us including Sensitive Personal Information ("hereinafter cumulatively referred to as "INFORMATION"), that is either available with the Company or disclosed by Me/Us while obtaining the policy of Insurance from the company or otherwise. I/We further understand that the Company may use the INFORMATION for servicing the Insurance policy obtained by Me/Us and for same may share the INFORMATION with any reinsurer, insurance association, medical authorities, other Insurers, statutory authorities, court, governmental body, regulator etc., or with services provider(s) engaged by the Company for servicing the Insurance policy, underwriting the risk, settlement of claim etc. without obtaining our specific consent for such sharing and we hereby provide our consent to Company for same.

I/We understand that whenever I/We would like to update/correct the INFORMATION, we will intimate the Company for the same, so as to enable the Company to amend/correct the INFORMATION accordingly. Further in the event I/We would like to withdraw My/Our consent provided herein, I/We would intimate the Company of the same in writing and also understand that, in the event of such withdrawal by Me/Us, the Company reserves the right to not provide Me/Us the Services for which it has sought the INFORMATION.

Date D D M M Y Y

Place

Signature and Seal of the Hospital Authority

SECTION D

SECTION E

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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
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		

CLAIM FORM/HOSPITAL/THINQ/01-16. Insurance is the subject matter of solicitation.

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