

HDFC ERGO General Insurance Company Limited



CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT

CLAIM FORM – PART A

To be filled in by the Insured

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

(To be filled in block letters)

SECTION A – DETAILS OF PRIMARY INSURED

a) Policy No.:

b) Sl. No/ Certificate No.:

c) Company/ TPA ID No.:

d) Name: SURNAME FIRSTNAME MIDDLENAME

e) Address:

City: State:

Pin Code: 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 without break: DD MM YY YY

c) If Yes, Company Name: d) Policy No.:

e) Sum Insured (Rs): f) Have you been hospitalized in the last four years since inception of the contract : Yes No Date: MM YY

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

h) If Yes, Company Name:

SECTION C- DETAILS OF INSURED PERSON HOSPITALISED

a) Name: SURNAME FIRSTNAME MIDDLENAME

b) Gender: Male Female c) Age: YY MM d) Date of Birth: DD MM YY YY

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:

SECTION D- DETAILS OF HOSPITALIZATION

a) Name of the Hospital where admitted:

b) Room Category occupied: Daycare Single Occupancy Twin Sharing 3 or more beds per room

c) Hospitalisation due to: Illness Injury Maternity d) Date of Injury/ Date of disease first detected/ Date of delivery: DD MM YY YY

e) Date of admission: DD MM YY YY f) Time: HH : MM g) Date of discharge: DD MM YY YY h) Time: HH : MM

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

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

j) System of medicine:

SECTION E- DETAILS OF CLAIM

a) Details of the treatment expenses claimed

i) Pre-Hospitalization Expenses Rs.

ii) Hospitalization Expenses Rs.

iii) Post-Hospitalization Expenses Rs.

iv) Health-Check up Cost Rs.

v) Ambulance Charges Rs.

vi) Others (code) Rs.

Total Rs.

vii) Pre-Hospitalization Period Days

viii) Post -Hospitalization 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 hospitalization Lump sum benefit Rs.

vi) Others Rs.

Total Rs.

Claim Documents Submitted- Check List:

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

SECTION – F DETAILS OF BILLS ENCLOSED

Sr. No.	Bill No.	Date	Issued By	Towards	Amount (Rs)
1.		DD MM YY		Hospital main bill	
2.		DD MM YY		Pre - hospitalization bills - Nos.	
3.		DD MM YY		Post - hospitalization bills - Nos.	
4.		DD MM YY		Pharmacy bills	
5.		DD MM YY			
6.		DD MM YY			
7.		DD MM YY			
8.		DD MM YY			
9.		DD MM YY			
10.		DD MM YY			

GUIDANCE FOR FILLING CLAIM FORM – PART B (To be filled in by the hospital)

DATA ELEMENT	DESCRIPTION	FORMAT
SECTION A - DETAILS OF PRIMARY INSURED		
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 Birth of patient	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 – ADDITIONAL 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) 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
SECTION F - DECLARATION BY THE		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.		

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 with date of admission & discharge, clinical history, past history / procedure details/ 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.
- Original bills, original payment receipts and Reports for investigation.
- Original medicine bills and receipts with corresponding Prescriptions.
- Original invoice/Sticker of implants/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 & Death Certificate (If conducted)

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-Hospitalization expenses

- Duly filled and signed Claim Form.
- Photocopy of ID card / Photocopy of current year policy.
- Original Medicine bills, original payment receipt with prescriptions.
- Original Investigations bills, original payment receipt with prescriptions and report.
- Original Consultation bills, original payment receipt with prescription.
- Copy of the Discharge Summary of the main claim.

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

- Duly filled and signed Claim Form.
- Photocopy of ID card / Photocopy of current year policy.
- Original Bill with Original Payment Receipt.
- Treating Doctor's consultation prescription indicating Emergency Hospitalization.

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

HDFC ERGO General Insurance Company Limited



Consent for Mode of Claim Payment

Name of Insured

Policy Number

Claim Number

Beneficiary Name

Mode of Payment Cheque Fund Transfer

(Please tick for mode of payment)

(All Fields are Mandatory in case of Fund Transfer)

Insured's Name as per Bank Account

Bank Account Number

Branch Name

IFSC Code

Email address

Attachments

In Support of Bank Details

(Please tick the type of proof submitted)

Cancelled Cheque

Bank Passbook Copy

Declaration: I Mr./ Mrs/ Ms. _____

undersigned, legal beneficiary of the above claim, declare that all details mentioned in this form are true and I agree to the mode of payment against the particular claim number mentioned above.

Signature of Beneficiary

Stamp Required in case of Company

Date: