हिंदुस्तानऑर्गेनिककेमिकल्सलिमिटेडHINDUSTAN ORGANIC CHEMICALS LIMITED

(भारतसरकारकाउपक्रमA GOVERNMENT OF INDIA ENTERPRISE)

अंबलमुगल, कोची, एरणाकुलम जिला, केरलAmbalamugal, Kochi, 682 302.Ernakulam Dist., Kerala

कार्मिक एवं प्रशासन P&A/मेडिक्लाइम MEDICLAIM/2023-24/ दिनांकDate : 11.01.2023

विषय: कंपनी के सेवानिवृत्त /वीआरएस कर्मचारियों के लिए समूह मेडिक्लाइम बीमा पॉलिसी संबंधी

SUB : GROUP MEDICLAIM INSURANCE POLICY FOR RETIREDEMPLOYEES OF THE COMPANY

प्रिय महोदय/महोदया Dear Sir/Madam,

हमें आपको यह बताते हुए प्रसन्नता हो रही है कि सेवानिवृत्त कर्मचारियों और जीवनसाथियों के लिए ग्रुप मेडिक्लेम इंश्योरेंस पॉलिसी को 06.01.2023 से 05.01.2024 तक एक वर्ष की अवधि के लिए **मैसर्स न्यू इंडिया एश्यूरन्स कंपनी लिमिटेड**के साथ नवीकरण किया गया है। इसमें प्रति परिवार को प्रतिवर्ष रु.3,00,000/- (केवल तीन लाख रुपए) का कवरेज मिलेगा। वर्तमान थर्डपार्टीएडमिनिस्ट्रेटर (टीपीए) सर्वश्री **फॅमिली हैल्थ प्लान इंश्योरेंस टीपीए लिमिटेड** (एफ़एचपीएल) की सेवा को एक और वर्ष के लिए बढ़ा दी गयी है।आपको चिकित्सा प्रतिपूर्ति से संबंधित दावे टीपीए को प्रस्तुत करना होगा और नकद रहित चिकिसा सुविधा प्राप्त करने के लिए टीपीए को पहले ही सूचित करना होगा। आप अपने शहर में उपलब्ध नेटवर्क अस्पतालों, कैशलेस सुविधा, दावा प्रस्तुत करने की तरीका, निबंधन और शर्तें आदि के बारे में पूरी जानकारी प्राप्त करने के लिए कृपया टीपीए की वेबसाइट https://www.fhpl.net **भी देखें।**

We are pleased to inform you that Group Mediclaim Insurance Policy for Retired Employees and Spouses has been renewed with **M/s NEW INDIA ASSURANCE COMPANY LIMITED** for a period of ONE year from 06.01.2023 to 05.01.2024 for the coverage of sum insured of Rs.3,00,000/-(Rupees Three lakhs only) per family per year. We have extended the service of present Third Party Administrator (TPA) M/s. Family Health Plan insurance TPA Limited (FHPL) for one more year i.e. 06.01.2023 to 05.01.2024. You have to submit claim related documents to TPA for reimbursement and also intimate the TPA in advance for getting cashless facility. You can **also visit website of TPA https://www.fhpl.net for getting full details regarding network hospitals in your city,** cashless facility, claim submission, etc.

सदस्यों कोअस्पताल में भर्ती होने के दावेथर्ड पार्टी एडमिनिस्ट्रेटर (टीपीए) के कोच्ची या तिरुवनन्तापुरम या मुंबई कार्यालय प्रस्तुत कर सकता है और नकद रहित (कैशलेस) सुविधा या चिकित्सा प्रतिपूर्ति के मामले में जिस कार्यप्रणाली का पालन की जानी है इसके साथ संलग्न है।

Members have the option to submit the hospitalisation claims with Third Party Administrator (TPA) Kochi or Trivandrum or Mumbai office. For getting cashless facility or reimbursement cases the procedure to be followed is attached herewith as **Annexure**.

शिकायतों के लिए अपनाई जाने वाली प्रक्रिया: यदि बीमाधारक किसी भी तरह से पीड़ित है, तो बीमाधारक सामान्य व्यावसायिक घंटों के दौरान निर्दिष्ट पते पर बीमा कंपनी से संपर्क कर सकता है। यदि एक महीने के भीतर बीमा कंपनी से कोई जवाब नहीं मिलता है या यदि बीमाधारक बीमा कंपनी के जवाब से संतुष्ट नहीं है, तो बीमाधारक अपनी शिकायत के निवारण के लिए अपने अधिकार क्षेत्र के बीमा **लोकपाल के पास जा सकता है। बीमा लोकपाल का विवरण IRDAI की वेबसाइट www.irdai.gov.inपर उपलब्ध है या जनरल इंश्योरेंस परिषद की वेबसाइट www.gicouncil.inया बीमा कंपनी के कार्यालय से प्राप्त करा सकता है।**

Procedure to be followed for Grievances: In case the insured is aggrieved in any way, the insured may contact the Insurance Company at the specified address during normal business hours. If no reply is received from the Insurance Company within one month or if the insured is not satisfied with the reply of the Insurance Company, insured may, subject to vested jurisdiction, approach Insurance Ombudsman for the redressal of his/her **grievance. The details of Insurance Ombudsman is available at IRDAI website www.irdai.gov.in or from the** website of General Insurance Council: **www.gicouncil.in** or from the office of the Insurance Company.

बीमाकंपनीऔरथर्डपार्टीएडमिनिस्ट्रेटर (टीपीए) से संबंधितसूचनानीचे दी जाती हैं।

Details of Insurance Company and Third Party Administrator (TPA) are given below:

1	पॉलिसी सं Policy Number	**76160434220400000003**
2	Policy Period	**06.01.2023 to 05.01.2024**
3	बीमा कंपनी Insurance Company	M/s. THE NEW INDIA ASSURANCE CO.LIMITED, KOTHAMANGALAM BRANCH, PERUMBILLICHIRA BUILDING HIGH RANGE JN, KOTHAMANGALAM, ERNAKULAM, – 686691. PHONE- 0485-2862551 email: **nia.761606@newindia.co.in**
4	थर्डपार्टीएडमिनिस्ट्रेटरTPA FHPL - Head Office	FAMILY HEALTH PLAN INSURANCE TPA LIMITED(FHPL) Regd& Corp Office, Hyderabad, Telangana-500034
	Customer Care No/Intimation: **Email Id: intimation@fhpl.net /** **Cashless preauthorization:kochinpreauth@fhpl.net/cashless@fhpl.net /cashlesshyd@fhpl.net**	**1800-425-4033 (24X7) or 1800-102-4033 (24X7)**
	FOR CLAIM SUBMISSION	
5	Kochi Office	Family Health Plan Insurance TPA Ltd Door Number 62/769,First Floor, Brigade Plaza, Opposite Lotus Club,Warriam Road, Kochi - 682016 Ph: 0484 -**2350115/2374374**
6	Trivandrum Office	Family Health Plan insurance TPA Limited TC83/840, 'ELEEZA' Luke's Cottage, 2nd floor, Seeveli Nagar, Kaithamukku, Trivandrum – 695024 **Ph: 0471 2578940Email: Trivandrumclaims@fhpl.net** **Mob: 9544105554 (Aswathy)**
7	Mumbai Office	Family Health Plan insurance (TPA) Limited Neelkanth Corporate Park, Office No.710 &711, 7th floor Kirol Road, Vidya vihar Railway Station (West) Mumbai- 400 086 **Ph: 022-62401500** Email: bhagyashree.v@fhpl.net/sawant.mansi@fhpl.net Mob: 8652033111(Bhagyasree)/ 9223329004(Manasi)
8	**HOCL KOCHI OFFICE** **(contact details)**	**0484-2727200/2727201/2720911** **Email : hindi@hoclindia.com or kochi@hoclindia.com**

सदस्यों के अस्पताल में भर्ती संबंधी सभी प्रकार के दावे पर कार्रवाई और निपटान केवल थर्ड पार्टी एडमिनिस्ट्रेटर (टीपीए) द्वारा किया जाएगा। स्वास्थ्य दावे की कार्यप्रणाली, दावे की सूचना, कैशलेस दावा आदि विस्तुत जानकारी एफ़एचपीएल की वेबसाइट में दी गयी है। अधिक जानकारी के लिए कृपया `https://www.fhpl.net`देखें।

All hospitalisation claims of members of the policy will be processed and settled by Third Party Administrator(TPA) only. The Health Claim procedure, Claim Intimation, Cashless Claim, etc are well explained in their website also. Please **visit** **https://www.fhpl.net** for more details.

निम्नलिखित दस्तावेज़ आपके उपयोग एवं अभिलेखार्थ इसके साथ संलग्न है

Following documents are sent herewith for your record. **The soft copy of Insurance Card will be sent to you directly by the TPA.**

(1) Instructions to be followed for getting cashless treatment and reimbursement of claim
(2) Claim Form for getting reimbursement of hospitalization expenses.

कृतेहिंदुस्तानऑर्गेनिककेमिकल्सलिमिटेडFor
HINDUSTAN ORGANIC CHEMICALS LTD,

(एन वी रविदेव N V RAVIDEV)
मुख्य महा प्रबन्धक (मा. सं.)
CHIEF GENERAL MANAGER (HR)

Annexure

For getting cashless facility or reimbursement cases the procedure to be followed:

1. For cashless cases

   - **Member can approach the Hospital insurance desk with FHPL Health Card / E-Card and valid Proof of Identity**
   - **Hospital sends the Pre-authorization request** with complete hospitalization details through fax or online mode, for cashless treatment approval

2. Reimbursement Cases:
   Intimation is mandatory within 24 hours of hospitalization in case of treatment being taken in a non-network hospital.
   For intimation, the member can call our Toll Free number and talk to our customer care representative giving details about the treatment being taken and the approximate estimate towards the hospitalization or E-Mail us at intimation@fhpl.net.

   - Duly filled Claim Form of respective insurance company (Kindly find the attachment)
   - Copy of Members FHPL ID Card with the member's details
   - Govt. ID Proof of the patient (prefer Aadhar Card)
   - PAN Card copy of the Main Member (policy holder)
   - Corporate ID proof of Main member
   - Cancelled Cheque / copy of the account pass book front page in which Bank Name, Bank Branch Name, A/C Holder Name, A/C No, IFS Code should be very clear(Account has to be that of the Main Member)
   - Duly filled CKYC form of main member if the claim is above One Lakh(attached)
   - Original detail discharge summary with Doctor seal and signature required. Need date and time of hospital admission and discharge. (If submitting Pre-Post Claim, submit the copy of the Discharge Summary).
   - Original Hospital Bill – consolidated and detailed breakup with the seal and sign of the hospital with cash paid receipt (in case of any advance paid to the hospital, its receipt to be attached-)
   - Original Investigation reports including lab reports, x-ray, ECG , scan reports etc with hospital seal and signature
   - In case of surgical packages – detailed breakup of the package
   - Pharmacy bills and breakup with seal and sign of hospital.
   - Prescriptions mandatory for pre-post and main claims
   - kindly provide no-objection certificate (NOC), Affidavit , Legal heirship certificate / relationship certificate-if the main member expired
   - In case of hospitalization due to accident, copy of MLC / FIR. If there is no MLC/FIR, kindly submit self-declaration letter of patient
   - For Cataract, IOL Sticker and A-scan report to be attached with breakup bill
   - For Maternity Claims GPLA Status
   - In case of cardiac surgery, invoice of stent and sticker to be attached
   - In case of orthopedic surgery, invoice of implant/screw and sticker to be attached
   - In case of dialysis, chemotherapy -chart copy with treating doctor attestation required

List of network hospitals is available on website www. https://www.fhpl.net

CLAIM FORM FOR HEALTH INSURANCE POLICIES OF THE NEW INDIA ASSURANCE CO LTD– 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 FIRST NAME MIDDLE NAME

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: 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

SECTION C

DETAILS OF INSURED PERSON HOSPITALIZED:

a) Name: SURNAME FIRST NAME MIDDLE NAME

b) Gender: Male Female c) Age: years Y Y months M M 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: E-mail ID:

SECTION D

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: D D M M Y Y

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 i. 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, provide details in annexure)

c) Details of Lump sum / 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:

- Claim Form Duly signed
- Copy of the claim intimation, if any
- Hospital Main Bill
- Hospital Break-up Bill
- Hospital Bill Payment Receipt
- Hospital Discharge Summary
- Pharmacy Bill
- Operation Theatre Notes
- ECG
- Doctor's request for investigation
- Investigation Reports (Including CT / MRI / USG / HPE)
- Doctor's Prescriptions
- Others

SECTION F

DETAILS OF BILLS ENCLOSED:

Sl. No	Bill No	Date	Issued by	Towards	Amount (Rs)
1.		D D M M Y Y		Hospital Main Bill	
2.		D D M M Y Y		Pre-hospitalization Bills:___Nos	
3.		D D M M Y Y		Post-hospitalization Bills:___Nos	
4.		D D M M Y Y		Pharmacy Bills	
5.		D D M M Y Y			
6.		D D M M Y Y			
7.		D D M M Y Y			
8.		D D M M Y Y			
9.		D D M M Y Y			
10		D D M M Y Y			

SECTION G

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT:

c) Bank Name and Branch:

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

(IMPORTANT: PLEASE TURN OVER)

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.

SECTION H

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

GUIDANCE FOR FILLING CLAIM FORM – PART A (To be filled in by the insured)		
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
c) Company TPA ID No.	Enter the TPA ID No	License number as allotted by IRDA and printed in TPA documents.
d) Name	Enter the full name of the policyholder	Surname, First name, Middle name
e) Address	Enter the full postal address	Include Street, City and Pin Code
SECTION B - DETAILS OF INSURANCE HISTORY		
a) Currently covered by any other Mediclaim / Health Insurance?	Indicate whether currently covered by another Mediclaim / Health Insurance	Tick Yes or No
b) Date of Commencement of first Insurance without break	Enter the date of commencement of first insurance	Use dd-mm-yy format
c) Company Name	Enter the full name of the insurance company	Name of the organization in full
Policy No.	Enter the policy number	As allotted by the insurance company
Sum Insured	Enter the total sum insured as per the policy	In rupees
d) Have you been Hospitalized in the last four years since inception of the contract?	Indicate whether hospitalized in the last four years	Tick Yes or No
Date	Enter the date of hospitalization	Use mm-yy format
Diagnosis	Enter the diagnosis details	Open Text
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.		

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

(To be filled in block letters)

SECTION A

DETAILS OF HOSPITAL

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: SURNAME FIRST NAME MIDDLE NAME

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

SECTION B

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 Maternity i. Date of Delivery: DD MM YY ii. Gravida Status:

l) Status at time of discharge: Discharge to home ☐ Discharge to another hospital ☐ Deceased ☐

SECTION C

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a)	ICD 10 Codes	Description	b)	ICD 10 PCS	Description
i. Primary Diagnosis:			i. Procedure 1:		
ii. Additional Diagnosis:			ii. Procedure 2:		
iii. Co-morbidities:			iii. Procedure 3:		
iv. Co-morbidities:			iv. Details of Procedure:		

c) Present ailment is a complication of PED? ☐ Yes ☐ No (If Yes, specify details)

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:

SECTION D

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

SECTION E

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.:

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

iii. Others :

SECTION F

DECLARATION BY THE INSURED **(PLEASE READ VERY CAREFULLY)**

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, 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: DD MM YY Place: Signature of the Insured:

SECTION G

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. The signature of the insured is taken on this form after Claim Form B is fully filled up by us.

Date: DD MM YY

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 nospital	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 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)	Type of Admission	Indicate type of admission of patient	Tick the right option
j)	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
k)	Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
	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)	Present Ailment is a Complication of PED	Indicate whether present ailment is a complication of some pre-existing disease	Tick Yes or No
d)	Pre-authorization obtained	Indicate whether pre-authorization obtained	Tick Yes or No
e)	Pre-authorization Number	Enter pre-authorization number	As allotted by TPA
f)	If authorization by network hospital not obtained, give reason	Enter reason for not obtaining pre-authorization number	Open text
g)	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.	Enter the registration number of patient	As allocated by the Hospital
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 specify
	SECTION F - DECLARATION BY THE INSURED		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.			
	SECTION G - DECLARATION BY THE HOSPITAL		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign and stamp			