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)

DETAILS OF PRIMARY INSURED:	
a) Policy No:	t) SI. No/ Certificate No:
c) Company/ TPA ID No:	
d) Name : SURNAME	FIRST NAME MIDDLE NAME
e) Address :	
	FIRST NAME MIDDLE NAME CTO
City:	State:
Pin Code: Phone No: 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:
c) If yes, company name:	Policy No.
Sum Insured (Rs.) d) Have you been hospitalize	Policy No. Policy No. Date: M M Y Y e) Previously covered by any other Mediclaim / Health insurance : Yes No
Diagnosis:	e) Previously covered by any other Mediclaim / Health insurance : Yes No
f) If yes, Company Name	
DETAILS OF INSURED PERSON HOSPITALIZED:	
a) Name:	FIRST NAME MIDDLE NAME
b) Gender: Male \square Female \square c) Age: years $\boxed{\ \ \ \ \ \ \ \ \ \ \ }$	months M M d) Date of Birth: D D M M Y Y
e) Relationship to Primary insured: Self Spouse Child C	Father Mother Other (Please Specify)
f) Occupation: Service Self Employed Homemaker	Student Retired Other (Please Specify)
g) Address (if different from above):	Student Retired Other Please Specify
City:	State:
Pin Code: Phone No: Phone No:	E-mail 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 0
c) Hospitalization due to: Injury Illness Maternity	d) Date of Injury / Date Disease first detected /Date of Delivery: D D M M Y Y H: M M g) Date of Discharge: D D M M Y Y h) Time: H H: M M Substance Abuse / Alcohol Consumption i. If Medico legal: Yes No
e) Date of Admission:	H: MM g) Date of Discharge: DD MM YY h) Time: HH H: MM 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	
ii. Reported to police: Yes No iii. MLC Report & Police FIR attached DETAILS OF CLAIM:	
	l: ☐ Yes ☐ No j) System of Medicine: ☐
DETAILS OF CLAIM:	
DETAILS OF CLAIM: a) Details of the treatment expenses claimed	: Yes No j) System of Medicine: Claim Documents Submitted- Check List:
DETAILS OF CLAIM: a) Details of the treatment expenses claimed i. Pre-hospitalization Expenses: Rs.	ii. Hospitalization Expenses: Rs. Claim Documents Submitted- Check List: iv. Health-Check up Cost: Rs. Copy of the claim intimation, if any vi. Others (code): Rs. Hospital Main Bill
DETAILS OF CLAIM: a) Details of the treatment expenses claimed i. Pre-hospitalization Expenses: Rs	ii. Hospitalization Expenses: Rs. Claim Documents Submitted- Check List: iv. Health-Check up Cost: Rs. Copy of the claim intimation, if any vi. Others (code): Rs. Hospital Main Bill Hospital Reak-up Bill
DETAILS OF CLAIM: a) Details of the treatment expenses claimed i. Pre-hospitalization Expenses: Rs	ii. Hospitalization Expenses: Rs. Claim Documents Submitted- Check List: iv. Health-Check up Cost: Rs. Copy of the claim intimation, if any vi. Others (code): Rs. Hospital Braekun Bill
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DETAILS OF CLAIM: a) Details of the treatment expenses claimed i. Pre-hospitalization Expenses: Rs	ii. Hospitalization Expenses: Rs. Claim Documents Submitted- Check List: iv. Health-Check up Cost: Rs. 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 ii. Surgical Cash: Rs. Doctor's request for investigation
DETAILS OF CLAIM: a) Details of the treatment expenses claimed i. Pre-hospitalization Expenses: Rs	ii. Hospitalization Expenses: Rs. Claim Documents Submitted- Check List: iv. Health-Check up Cost: Rs. Copy of the claim intimation, if any Hospital Main Bill Total Rs. Copy of the claim intimation, if any Hospital Break-up Bill Wiii. Post-hospitalization period: days Copy of the claim intimation, if any Hospital Break-up Bill Hospital Bill Payment Receipt Hospital Discharge Summary Pharmacy Bill Operation Theatre Notes ii. Surgical Cash: Rs. Copy of the claim intimation, if any Hospital Main Bill Hospital Discharge Summary Pharmacy Bill Operation Theatre Notes iii. Surgical Cash: Rs. Copy of the claim intimation, if any Hospital Main Bill Hospital Bill Payment Receipt Hospital Discharge Summary Pharmacy Bill Operation Theatre Notes III. Notes (Including CT)
DETAILS OF CLAIM: a) Details of the treatment expenses claimed i. Pre-hospitalization Expenses: Rs	ii. Hospitalization Expenses: Rs. Claim Documents Submitted- Check List: iv. Health-Check up Cost: Rs. Copy of the claim intimation, if any Hospital Main Bill Total Rs. Hospitalization period: days Hospital Bill Payment Receipt Hospital Bill Payment Receipt Hospital Bill Payment Receipt Hospital Bill Payment Receipt Hospital Discharge Summary Pharmacy Bill Operation Theatre Notes ii. Surgical Cash: Rs. Convalescence: Rs. Con
DETAILS OF CLAIM: a) Details of the treatment expenses claimed i. Pre-hospitalization Expenses: Rs	ii. Hospitalization Expenses: Rs. Claim Documents Submitted- Check List: iv. Health-Check up Cost: Rs. Claim Form Duly signed Copy of the claim intimation, if any Hospital Main Bill Hospital Break-up Bill Viii. Post-hospitalization period: days Hospital Discharge Summary Pharmacy Bill Operation Theatre Notes iv. Convalescence: Rs. Doctor's request for investigation Investigation Reports (Including CT / MRI / USG / HPE) Doctor's Prescriptions
DETAILS OF CLAIM: a) Details of the treatment expenses claimed i. Pre-hospitalization Expenses: Rs	ii. Hospitalization Expenses: Rs. Claim Documents Submitted- Check List: ii. Hospitalization Expenses: Rs. Claim Form Duly signed iv. Health-Check up Cost: Rs. 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 ii. Surgical Cash: Rs. Copy of the claim intimation, if any Hospital Bill Payment Receipt Hospital Discharge Summary Pharmacy Bill Operation Theatre Notes ECC Doctor's request for investigation Investigation Reports (Including CT //MRI //USG / HPE) Doctor's Prescriptions Others Towards Amount (Rs)
DETAILS OF CLAIM: a) Details of the treatment expenses claimed i. Pre-hospitalization Expenses: Rs	ii. Hospitalization Expenses: Rs. Claim Documents Submitted- Check List: ii. Hospitalization Expenses: Rs. Claim Form Duly signed iv. Health-Check up Cost: Rs. 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 ii. Surgical Cash: Rs. Copy of the claim intimation, if any Hospital Main 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 Towards Hospital Main Bill Amount (Rs)
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Details of the treatment expenses claimed	ii. Hospitalization Expenses: Rs. Claim Form Duly signed iv. Health-Check up Cost: Rs. Copy of the claim intimation, if any Hospital Main Bill Hospital Break-up Bill Coperation Theatre Notes ECG Doctor's request for investigation Investigation Reports (Including CT //MRI / USC / HPE) Doctor's Prescriptions Others Towards Hospital Main Bill Amount (Rs) Hospital Main Bill
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Details of the treatment expenses claimed	Claim Documents Submitted- Check List: Claim Form Duly signed Copy of the claim intention, if any Hospital Main Bill Hospital Bill Main Bill Hospital Main Bill Hospital Main Bill Hospital Bills Nos Post-hospitalization Bills: Nos Post-hospitalization Bills: Nos Pharmacy Bills Pre-hospitalization Bills: Nos Pharmacy Bills Pre-hospitalization Bills: Nos Pharmacy Bills Pharm
DETAILS OF CLAIM: a) Details of the treatment expenses claimed i. Pre-hospitalization Expenses: Rs	Claim Documents Submitted- Check List: Claim Form Duly signed Copy of the claim initination, if any Hospital Main Bill Hospital Bill Payment Receipt Hospital Discharge Summary Pharmacy Bill Operation Theatre Notes ECG Doctor's request for investigation Investigation Reports (Including CT //MR1 / USG / HPE) Doctor's Prescriptions Others Towards Amount (Rs) Pharmacy Bills Pre-hospitalization Bills: Nos Nos Pharmacy Bills
DETAILS OF CLAIM: a) Details of the treatment expenses claimed i. Pre-hospitalization Expenses: Rs	Claim Documents Submitted- Check List: Claim Form Duly signed Copy of the claim intention, if any Hospital Main Bill Hospital Bill Main Bill Hospital Main Bill Hospital Main Bill Hospital Bills Nos Post-hospitalization Bills: Nos Post-hospitalization Bills: Nos Pharmacy Bills Pre-hospitalization Bills: Nos Pharmacy Bills Pre-hospitalization Bills: Nos Pharmacy Bills Pharm
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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	Y Place:	Signature of the Insured	

		R FILLING CLAIM FORM – PART A (To be filled in by the insur	1
	DATA ELEMENT	DESCRIPTION SECTION A - DETAILS OF PRIMARY INSURED	FORMAT
a)	Policy No.	Enter the policy number	As allotted by the insurance company
	SI. No/ Certificate No.	Enter the social insurance number or the certificate number of	
b)	SI. NO/ Certificate No.	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 print 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	Indicate whether previously covered by another Mediclaim /	Tick Yes or No
f)	Insurance? Company Name	Health Insurance Enter the full name of the insurance company	Name of the organization in full
.,		ION C - DETAILS OF INSURED PERSON HOSPITALIZED	Traine of the organization in tail
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	T
a)	Details of Treatment Expenses	Enter the amount claimed as treatment expenses	In rupees (Do not enter paise values)
p)	Claim for Domiciliary Hospitalization	Indicate whether claim is for domiciliary hospitalization	Tick Yes or No
d)	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 SECTION F - DETAILS OF BILLS ENCLOSED	Tick the right option
Indi	cate which hills are enclosed with the amounts in rupocs	GEOTION F - DETAILS OF BILLS ENGLOSED	
ıııul	cate which bills are enclosed with the amounts in rupees SECTIO	N G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT	
a)	PAN	Enter the permanent account number	As allotted by the Income Tax department
а) 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
		Enter the name of the beneficiary the cheque/ DD should be	
d)	Cheque/ DD payable details	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

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)

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: $\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \$	Network Non Network (If non network fill section E)
e) Qualification: f) Registration No. with State Code:	g) Phone No.
DETAILS OF THE PATIENT ADMITTED	
a) Name of the Patient:	
b) IP Registration Number: c) Gender: Male Female	d) Age: Years Y Y Months M M e) Date of birth: D D M M Y Y
f) Date of Admission:	h) Date of Discharge: DD MM YY i) Time: HH : MM
j) Type of Admission: Emergency Planned Day Care Maternity k) If Mat	ernity i. Date of Delivery: D D M M Y Y ii. Gravida Status:
I) Status at time of discharge: Discharge to home Discharge to another hos	
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?	
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	
v. FIR no. vi. If not reported to police give reason:	(in res, attach reports) III. If we close regal
CLAIM DOCUMENTS SUBMITTED - CHECK LIST	
Claim Form duly signed Original Pre-authorization request	Investigation reports CT/MR/USG/HPE investigation reports
Copy of the Pre-authorization approval letter	Doctor's reference slip for investigation ECG Pharmacy bills
Copy of photo ID card of patient verified by hospital Hospital Discharge summary	☐ ECG ☐ Pharmacy bills
Operation Theatre notes	MLC report & Police FIR
Hospital main bill	Original death summary from hospital where applicable
Hospital break-up bill	Any other, please specify
DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITA	1)
a) Address of the Hospital:	
City: b)Phone No.	State: C) Registration No.:
d) PAN:	f) Facilities available in the hospital: i. OT: Yes \ No \ ii. ICU: Yes \ No
iii. Others :	
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 to claim reimbursement shall be forfeited. I also consent & authorize TPA / insurance company, to seek necessa against whom this claim is made. I hereby declare that I have included all the bills / receipts for the purpose of this	ry medical information / documents from any hospital / Medical Practitioner who has attended on the person
Date: DD MM M YYY Place:	
	Signature of the Insured:
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 knowledg our right to claim under this claim shall be forfeited. The signature of the insured is taken on this form after Claim F	
Date: DD MM M YYY	

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 Enter the registration number of the doctor along with the state	Abbreviations of educational qualifications	
f)	Registration No. with State Code	code	As allocated by the Medical Council of India	
g)	Phone No.	Enter the phone number of doctor	Include STD code with telephone number	
	s	ECTION 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	
,		ION C – DETAILS OF AILMENT DIAGNOSED (PRIMARY)	T	
a)	ICD 10 Code	Enter the ICD 10 Code and description of the primary		
	Primary Diagnosis	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	
	SECT	ION D – CLAIM DOCUMENTS SUBMITTED-CHECK LIST		
Indio	cate which supporting documents are submitted			
	SECTION	ON 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 specif	
		SECTION F - DECLARATION BY THE INSURED		
Rea	d declaration carefully and mention date (in dd:mm:yy form	nat), place (open text) and sign.		
		SECTION G - DECLARATION BY THE HOSPITAL		
≀ea	d declaration carefully and mention date (in dd:mm:yy forn	nat), place (open text) and sign and stamp		
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