navi GENERAL INSURANCE

CLAIM FORM – PART A
TO BE FILLED BY THE INSURED (in block letters)
(The issue of this Form is not to be taken as an admission of liability)

SECTION A – DETAILS OF PRIMARY INSURED

a) Policy No. :
b) Sl. No./Certificate No. : c) Company/TPA Id No. :
d) Name :
e) Address :
City : State :
Pin Code : 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 (₹) :
d) Have you been hospitalised 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 :
f) If Yes, Company Name :

SECTION C – DETAILS OF INSURED PERSON HOSPITALISED

a) Name : b) Gender : Male ☐ Female ☐
c) Age : Years Y Y Months M M d) Date of Birth: D D M M Y Y Y Y
e) Relation with Primary Insured : Self ☐ Spouse ☐ Child ☐ Father ☐ Mother ☐
Other ☐ (Please Specify)
f) Occupation : Self ☐ Spouse ☐ Child ☐ Father ☐ Mother ☐
Other ☐ (Please Specify)
g) Address :
City : State :
Pin Code : Email ID :

SECTION D – DETAILS OF HOSPITALISATION

a) Name of Hospital where admitted :
b) Room Category Occupied: Day care ☐ Single Occupancy ☐ Twin Sharing ☐ 3 or more beds per room
c) Hospitalisation due to : Injury ☐ Illness ☐ Maternity ☐
d) Date of injury/Date of 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 Treatment expenses claimed (in Rupees)** :

i)	Pre-hospitalisation Expenses	: ₹	ii)	Hospitalisation Expenses	: ₹
iii)	Post-hospitalisation Expenses	: ₹	iv)	Health-Check up cost	: ₹
v)	Ambulance Charges	: ₹	vi)	Others (code):	₹
				Total	: ₹
vii)	Pre-hospitalisation Period: days		viii)	Post-hospitalisation Period: days	

b) Claim for domiciliary hospitalisation : ☐ Yes ☐ No (If yes, provide details in annexure)

c) Details of Lump sum / cash benefit claimed (in Rupees) :

i)	Hospital Daily Cash	: ₹	ii)	Surgical Cash	: ₹
iii)	Critical Illness Benefit	: ₹	iv)	Convalescence	: ₹
v)	Pre/Post hospitalisation Lump sum benefit	: ₹	vi)	Others:	₹
				Total	: ₹

Claims Documents Submitted – Check List

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

SECTION F – DETAILS OF BILLS ENCLOSED

Sl. No.	Bill No.	Date	Issued by	Towards	Amount (₹)
1		D D M M Y Y		Hospital main bill	
2		D D M M Y Y		Pre-hospitalisation bills	
3		D D M M Y Y		Post-hospitalisation bills	
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

a) PAN : b) Account Number :

c) Bank Name and Branch :

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

SECTION H – DECLARATION BY THE INSURED

I hereby declare that the information furnished in the claim form is true and 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 and authorise 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 and I will not be making any supplementary claim except the pre/post-hospitalisation claim, if any.

Date: D D M M Y Y Place: Signature of 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)	SI No./Certificate No.	Enter the Social Insurance number or the certificate number of social health insurance scheme	As allotted by the organisation
c)	Company TPA ID No.	Enter the TPA ID No.	License number as allocated by IRDAI 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 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 Organisation 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 hospitalised in the last four years since inception of the contract?	Indicate whether hospitalised in the last four years	Tick Yes or No
	Date	Enter the date of hospitalisation	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 Organisation in full
SECTION C – DETAILS OF INSURED PERSON HOSPITALISED			
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)	Relation with Primary Insured	Indicate relation 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 the patient	Include STD code with telephone number
i)	E-mail ID	Enter e-mail address of the patient	Complete e-mail address
SECTION D – DETAILS OF HOSPITALISATION			
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)	Hospitalisation due to	Indicate reason of hospitalisation	Tick the right option
d)	Date of injury/Date of 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 Hospitalisation	Indicate whether claim is for domiciliary hospitalisation	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 amount in rupees			
SECTION I – DETAILS OF PRIMARY INSURED'S BANK ACCOUNT			
a)	PAN	Enter the Permanent Account Number	As allocated 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 /organisation in full
e)	IFSC Code	Enter the IFSC Code of the Bank Branch	IFSC code of the bank branch in full
SECTION J – 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 (in block letters)
The issue of this Form is not to be taken as an admission of liability
Please include the original pre-authorisation request form in lieu of PART A

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 :
e) Qualification :
f) Registration No. with state code : g) Phone No. :

SECTION B – 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 : D D M M Y Y g) Time: H H : M M
h) Date of Discharge : D D M M Y Y i) Time: H H : M M
j) Type of Admission : Emergency ☐ Planned ☐ Day Care ☐ Maternity ☐
k) If Maternity : Date of Delivery : D D M M Y Y
Gravida Status :
l) Status at time of Discharge : Discharge to home ☐ Discharge to another hospital ☐ Deceased ☐
m) Total claimed amount

SECTION C – DETAILS OF AILMENT DIAGNOSED (PRIMARY)

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

c) Pre-authorisation obtained ☐ Yes ☐ No d) Pre-authorisation number
e) If authorisation by network hospital not obtained, give reason :
f) Hospitalisation 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	☐	Investigation reports
☐	Original Pre-authorisation request	☐	CT/MRI/USG/HPE investigation reports
☐	Copy of the Pre-authorisation approval letter	☐	Doctor's reference slip for investigation
☐	Hospital Discharge Summary	☐	ECG
☐	Operation Theatre Notes	☐	Pharmacy Bills
☐	Hospital main bill	☐	MLC reports and Police FIR
☐	Copy of the photo ID card of the patient verified by Hospital	☐	Original death summary from hospital where applicable
☐	Hospital break-up bill	☐	Any other, please specify

SECTION E

ADDITIONAL DETAILS IN CASE OF NON NETWORK HOPITAL (ONLY FILL IN CASE OF NON NETWORK HOSPITAL)

a) Address :

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 : i. OT: ☐ Yes ☐ No ii. ICU: ☐ Yes ☐ No

iii. Others :

SECTION F

DECLARATION BY THE HOSPITAL

We hereby declare that the information furnished in the claim form is true and correct to the best of my 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.

Date: D D M M Y Y Place :

Treating Doctor's 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 the hospital	Enter the name of hospital	Name of the hospital in full
b)	Hospital ID	Enter ID number of the 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 qualification 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 the doctor	Include STD code with telephone number
SECTION B – DETAILS OF THE PATIENT ADMITTED			
a)	Name of the Patient	Enter the name of patient	Name of patient 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 ans months
e)	Date of Birth	Enter date of birth	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		
	i. Date of Delivery	Enter date of delivery if maternity	Use dd-mm-yy format
	ii. Gravida	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 INSURED PERSON HOSPITALISED			
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 Code and description of the first procedure	Standard Format and Open text
	Procedure 2	Enter the ICD 10 Code and description of the second procedure	Standard Format and Open text
	Procedure 3	Enter the ICD 10 Code and description of the third procedure	Standard Format and Open text
	Details of Procedure	Enter the details of the procedure	Open text
c)	Pre-authorisation obtained	Indicate whether pre-authorisation obtained	Tick Yes or No
d)	Pre-authorisation Number	Enter pre-authorisation number	As allotted by TPA
e)	If authorisation by network hospital not obtained, give reason	Enter reason for not obtaining pre-authorisation number	Open text
f)	Hospitalisation due to injury	Indicate if hospitalisation 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 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 Hospital obtained from local body like City Corporation/Municipality	As allocated by the City Corporation / Municipality
d)	Hospital PAN	Enter the Permanent Account Number	As allocated 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 J – DECLARATION BY THE HOSPITAL			
Read declaration carefully and mention date (in dd-mm-yy format), place (open text) and sign with stamp.			

Paramount Health
Your link to good health

POLICY DECLARATION FORM

Date:……

Name of the Hospital :……

Address:……

PATIENT NAME (BLOCK LETTERS):…… AGE/SEX :……

Mobile No of Patient:……

Date of Admission:…… Date of Discharge:……

Undertaking by the Patient regarding Heath Insurance Policy
(स्वास्थ्य बीमा पॉलिसी के संबंध में रोगी द्वारा शपथ-पत्र))

☐ I declare that I do not have any health insurance policy.
(मैं घोषणा (खुलासा) करता हूं कि मेरे पास कोई भी स्वास्थ्य बीमा पॉलिसी नहीं है।

Signature: …… (हस्ताक्षर)
Name of the Patient/Patient's attendant (मरीज का नाम)

☐ I declare that I have health insurance policy.
(मैं घोषणा (खुलासा) करता हूं कि मेरे पास एक स्वास्थ्य बीमा पॉलिसी है।

Signature: …… (हस्ताक्षर)
Name of the Patient/Patient's attendant (मरीज का नाम)

Based on patient undertaking hospital declare that patient: (रोगी के उपक्रम के आधार पर हम उस रोगी की घोषणा करते हैं)

- Does not have insurance coverage hence we will bill the patient as per our rack rates. We may or may not consider discount for all such undertakings. (स्वास्थ्य बीमा कवरेज नहीं है इसलिए हम मरीज को अपनी रैक दरों के अनुसार बिल देंगे। हम ऐसे सभी उपक्रमों के लिए छूट पर विचार कर भी सकते हैं और नहीं भी।)

- Patient has health insurance coverage but out of own free will is opting for reimbursement/ cash paying mode. . As insured is already covered under TPA servicing for which we are network provider, hence we agree to bill this patient as per PHS or insurer agreed rate list (whichever is less). The benefit of discount as per MOU will also be given to this patient. (रोगी के पास स्वास्थ्य बीमा कवरेज है लेकिन वह अपनी मर्जी से रीइंबससमेंट/नकद भुगतान मोड का विकल्प चुन रहा है। . चूँकि बीमित व्यक्ति पहले से ही टीपीए सर्विसिंग के अंतर्गत कवर है जिसके लिए हम नेटवर्क प्रदाता हैं, इसलिए हम इस मरीज को पीएचएस या बीमाकर्ता द्वारा सहमत दर सूची (जो भी कम हो) के अनुसार बिल देने के लिए सहमत हैं। एमओयू के अनुसार छूट का लाभ भी इस मरीज को दिया जायेगा.)

Signature: ……

Name of the Hospital Representative & Hospital Seal