RAHEJA QBE

Health Insurance Claim Form

Raheja QBE General Insurance Company Limited
1800-102-7723 / claims@rahejaqbe.com / www.rahejaqbe.com
Claim Form Part - A

To be filled in by the insured
The issue of this Form is not to be taken in as admission of liability

(To be filled in block letters)

DETAILS OF PRIMARY INSURED (SECTION A)

a) Policy No.:
b) Sl. No./Certification No.: c) Company/TPA ID No.:
d) Name: Surname First name Middle name
e) Address
City:
State: PIN:
Phone No.: Email ID:

DETAILS OF INSURANCE HISTORY (SECTION B)

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 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: D D M M Y Y Y Y Diagnosis:
e) Previously covered by any other Mediclaim/Health Insurance Yes ☐ No ☐
f) If yes, Company Name:

DETAILS OF INSURED PERSON HOSPITALIZED (SECTION C)

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 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:
Phone No.: Email ID:

DETAILS OF HOSPITALIZATION (SECTION D)

a) Name of Hospital where Admitted:
b) Room Category occupied: Day Care ☐ Single occupancy ☐ Twin sharing ☐ 3 or more beds per room ☐
c) Hospitalizaton due to: Injury ☐ Illness ☐ Maternity ☐
d) Date of injury/Date Disease first detected/Date of Delivery: D D M M Y Y Y Y
e) Date of Admission: D D M M Y Y Y Y f) Time: H H M M

g) Date of Discharge: D D M M Y Y 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:

DETAILS OF CLAIM (SECTION E)

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

DETAILS OF BILLS ENCLOSED: (SECTION F)

SL No.	Bill No.	Date	Issued By	Towards	Amount
1				Hospital Main Bill	
2				Pre-hospitalization Bills: Nos	
3				Post-hospitalization Bills: Nos	
4				Pharmacy Bills	
5					
6					
7					
8					
9					
10					

DETAILS OF PRIMARY INSURED BANK ACCOUNT (SECTION G)

a) PAN: b) Account Number:

c) Bank Name and Branch:

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

DECLARATION BY THE INSURED (SECTION H)

I hereby declare that the information furnished in this Claim From 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 M Y Y 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 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 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-yyyy 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-yyyy 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-yyyy format

GUIDANCE FOR FILLING CLAIM FORM-PART A (To be filled in by the hospital) (Contd...)			
	DATA ELEMENT	DESCRIPTION	FORMAT
	SECTION C: DETAILS OF PRIMARY INSURED (Contd...)		
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-yyyy format
e)	Date of admission	Enter date of admission	Use dd-mm-yyyy format
f)	Time	Enter time of admission	Use hh-mm format
g)	Date of discharge	Enter date of discharge	Use dd-mm-yyyy 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 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-yyyy format) place (open text) and sign.			

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Health Insurance Claim Form

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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

(To be filled in block letters)

DETAILS OF HOSPITAL (SECTION A)

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.:

DETAILS OF THE PATIENT ADMITTED (SECTION B)

a) Name of the Patient: Surname First name Middle name
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 Y Y
f) Date of Admission: D D M M Y Y Y Y g) Time: ___:___
h) Date of Discharge: D D M M Y Y Y Y i) Time _____ ___

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

DETAILS OF AILMENT DIAGNOSED (PRIMARY) (SECTION C)

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) 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 ☐

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, attachreport)

iii) If Medico legal: Yes ☐ No ☐ iv) Reported to Police: Yes ☐ No ☐

v) FIR No.:

vi) If not reported to police give reason _____

CLAIM DOCUMENTS SUBMITTED-CHECK LIST (SECTION D)

- ☐ 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

DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL) (SECTION E)

a) Name and Address of the Hospital:

City:

State: PINCODE

b) Phone No:

c) Registration No. with State Code:

e) Number of Inpatient beds:

d) Hospital PAN:

f) Facilities available in the hospital: i) OT: Yes ☐ No ☐ ii) ICU: Yes ☐ No ☐

iii) Others _____

DECLARATION BY THE HOSPITAL (PLEASE READ VERY CAREFULLY) (SECTION F)

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.

Date: D D M M Y Y Y Y

Place:_____ Signature and Seal of the Hospital Authority

Communication details of TPA (kindly submit the dully signed filled claim form along with original documents at following address)

Paramount Health Services & Insurance TPA Pvt. Ltd.

Plot No. A-442, Road No.28, M.I.D.C Industrial Area, Wagle Estate, Ram Nagar,

Thane (W), Mumbai, Pin Code – 400 604

INSURANCE ACT 1938 Section 41 Prohibition of Rebates

No person shall allow or offer to allow, either directly or indirectly, as an inducement to any person to take out or renew or continue an insurance in respect of any kind of risk relating to lives or property in India, any rebate of the whole or part of the commission payable or any rebate of the premium shown on the policy, nor shall any person taking out or renewing or continuing a policy accept any rebate, except such rebate as may be allowed in accordance with the published prospectus or tables of the Insurer. ANY PERSON MAKING DEFAULT IN COMPLYING WITH THE PROVISIONS OF THIS SECTION SHALL BE LIABLE FOR PENALTY WHICH MAY EXTEND TO TEN LAKHRUPEES.

Insurance is the subject matter of the solicitation. For more details on risk factors, terms and conditions, please read sales brochure carefully, before concluding a sale.

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Website: www.rahejaqbe.com Email: customercare@rahejaqbe.com
Corporate Identity Number: U66030MH2007PLC173129, IRDAI Reg. No. 141

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 qualification of the treating doctor	Abbreviations of educational qualification
f)	Registration No. withState 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 allocated 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-yyyy format
f)	Date of Admission	Enter date of admission	Use dd-mm-yyyy format
g)	Time	Enter time of admission	Use hh-mm format
h)	Date of Discharge	Enter date of discharge	Use dd-mm-yyyy 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-yyyy 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 thefirst 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 thethird procedure	Standard Format and Open text
	Details of Procedure	Enter the details of the procedure	Open text

GUIDANCE FOR FILLING CLAIM FORM-PART B (To be filled in by the hospital) (Contd...)			
	DATA ELEMENT	DESCRIPTION	FORMAT
	SECTION C: DETAILS OF AILMENT DIAGNOSED (PRIMARY) (Contd...)		
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 with 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)	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 F: DECLARATION BY THE HOSPITAL			
Read declaration carefully and mention date (in dd-mm-yyyy format), place (open text) and sign and stamp			