EDELWEISS GROUP HEALTH INSURANCE - CLAIM FORM A

Need to claim? We're here to make it easy!

Edelweiss | GENERAL INSURANCE

Toll Free 1800 12000

Instructions:

1. This form should be filled in by the member
2. Issuance of this form does not imply acceptance of liability
3. Please fill all the details in BLOCK LETTERS
4. All fields in this form are mandatory
5. If there is any other information to be provided, please write the same in a separate sheet, sign the sheet and attach it to this Claim Form

SECTION A – SOME DETAILS ABOUT YOU

a) Policy No.: b) Certificate No.:

c) TPA ID No.:

d) Name of the Member:

e) ID proof type: PAN Passport Driving License Elector's Photo Identity Card

f) Address: Landmark:

City: State: Pin Code:

Phone No.: Email ID:

g) Name of Insured / Policyholder: Employee No.: Branch Location:

SECTION B – SHARE YOUR PAST/OTHER INSURANCE INFORMATION

a) Are you currently covered by any other Mediclaim / Health Insurance: Yes No

b) Date of beginning of the First Insurance without break: D D M M Y Y Y Y

c) If Yes, Name of Insurer: Policy No.: Sum Insured (INR):

d) Have you been Hospitalized in the last four years since the start of such policy? Yes No Date: D D M M Y Y Y Y

Diagnosis:

e) Have you been previously covered by any other Mediclaim / Health Insurance: Yes No

f) If yes, Name of Insurer:

SECTION C – A BIT ABOUT THE PERSON HOSPITALIZED

a) Name:

b) ID proof type: PAN Passport Driving License Elector's Photo Identity Card

c) Gender: Male Female Third Gender d) Age: Years Months e) Date of Birth: D D M M Y Y Y Y

f) Relationship with Primary Member: Self Spouse Child Father Mother Other (Please specify)

g) Occupation: Service Self-employed Homemaker Student Retired Other (Please specify)

h) Address (if different from above):

City: State: Pin Code:

i) Phone No.: j) Email ID:

SECTION D – TELL US MORE ABOUT THE HOSPITALIZATION

a) Name of Hospital, wherein Admitted:

Address:

Landmark:

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 on which Disease was 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 Time: H H : M M

f) Date of Discharge: D D M M Y Y Y Y Time: H H : M M

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

h) If Medico-legal: (i)Yes No (ii) Reported to Police: Yes No (iii) MLC Report & Police FIR attached: Yes No

i) System of Medicine:

SECTION E – WHAT DO WE NEED FOR YOUR CLAIM?

a) Details of the treatment expenses claimed for

(i) Pre-Hospitalization cost: ₹ _____ (ii) Hospitalization cost: ₹ _____

(iii) Post-Hospitalization cost: ₹ _____ (iv) Health check-up cost: ₹ _____

(v) Ambulance charges: ₹ _____ (vi) OPD: ₹ _____

Total: ₹ _____

(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: ₹ _____ (ii) Surgical cash: ₹ _____

(iii) Critical Illness benefit: ₹ _____ (iv) Convalescence: ₹ _____

(v) Pre / Post Hospitalization lump sum benefit: ₹ _____ (vi) Others: ₹ _____

Total: ₹ _____

The documents we'll need

- ☐ Duly signed Claim Form
- ☐ Copy of the claim intimation, if any
- ☐ Hospital main bill
- ☐ Hospital break-up bill
- ☐ Hospital release in short
- ☐ Pharmacy bill
- ☐ ECG
- ☐ Doctor's request for investigation
- ☐ Investigation reports (Including CT / MRI / USG / HPE)
- ☐ Doctor's prescriptions
- ☐ Hospital bill payment receipt
- ☐ Operation theatre notes

SECTION F – DETAILS OF BILLS ENCLOSED

Sr.No.	Bill No.	Date	Issued by	Towards	Amount (INR)
1		(DD/MM/YYYY)		Hospital Main Bill	
2		(DD/MM/YYYY)		Pre-Hospitalization Bills: ___ nos.	
3		(DD/MM/YYYY)		Post-Hospitalization Bills: ___nos.	
4		(DD/MM/YYYY)		Pharmacy Bills	
5		(DD/MM/YYYY)			
6		(DD/MM/YYYY)			
7		(DD/MM/YYYY)			
8		(DD/MM/YYYY)			
9		(DD/MM/YYYY)			
10		(DD/MM/YYYY)			

SECTION G - IN CASE IT'S AN ACCIDENT (Tick the right option)

a) Death ☐ b) Permanent Partial Disability ☐ c) Permanent Total Disability ☐ d) Temporary Total Disability ☐

SECTION H - TELL US MORE ABOUT THE ACCIDENT

a) Date and time of accident: D D M M Y Y Y Y and H H : M M b) Place of accident: _____

c) Cause of accident: _____ d) Was there any Hospitalization due to an Accident?: _____

SECTION I - THE MEMBER'S OR NOMINEE'S BANK ACCOUNT DETAILS

a) PAN (if amount is or exceeds INR 1lakh): ☐☐☐☐☐☐☐☐☐☐

b) Account No.: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

c) Bank Name and Branch: _____

d) Cheque / DD payable details: ☐☐☐☐☐☐☐ e) IFSC: ☐☐☐☐☐☐☐☐☐☐☐

SECTION J - DETAILS OF OUT - PATIENT COVER

a) Treatment start date: D D M M Y Y Y Y b) Treatment end date: D D M M Y Y Y Y

c) Name and contact details of treating doctor: _____

d) Name and address of clinic / hospital: _____

e) Nature of illness / disease: _____

f) Consultation fees: _____ g) Pharmacy / Investigations etc.: _____

SECTION K – DECLARATION BY THE MEMBER / NONIMEE

(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, suppressed or concealed 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 / Insurer, to seek necessary medical information / documents from any hospital / medical practitioner who has treated the person for 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 other claim except the pre / post Hospitalization claim, if any.

Date: D D M M Y Y Y Y

Place: _____

Signature of the Member

SOME TIPS TO FILL THE CLAIM FORM – PART A

DATA ELEMENT	DESCRIPTION	FORMAT
SECTION A - SOME DETAILS ABOUT YOU		
a) Policy No.	Enter the Policy number	As given by the Insurance Company
b) Certificate No.	Enter the certificate number written on your certificate of insurance	As appears on the certificate
c) TPA ID No.	Enter the TPA ID number	License number as given by IRDAI and printed in TPA documents
d) Name of the member	Enter the full name of the member	Surname, First name, Middle name
e) ID Proof	Select the correct option	Tick on appropriate option
f) Address	Enter the full postal address	Include street, city and pin code
g) Name of Insured / Policyholder	Enter the full name of the Policyholder	Surname, First name, Middle name
Employee No.	Enter Employee No.	
Branch Location	Enter Branch Location	
SECTION B – SHARE YOUR PAST/OTHER INSURANCE INFORMATION		
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 beginning of the First Insurance without break	Enter the date of starting 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 given 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 the start of such policy	Tell us if Hospitalized in the last four years	Tick Yes or No
Date	Enter the date of Hospitalization	Use dd-mm-yyyy format
Diagnosis	Enter the Diagnosis Details	Open Text
e) Have you been previously covered by any other Mediclaim / Health Insurance	Tell is if earlier 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 - A BIT ABOUT THE PERSON HOSPITALIZED		
a) Name	Enter the full name of the Patient	Surname, First name, Middle name
b) ID Proof	Select the correct option	Tick on appropriate option
c) Gender	Indicate gender of the Hospitalized person	Tick on appropriate option
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-yyyy format
f) Relationship with Primary Member	Indicate relationship of Hospitalized person with the Primary Member	Tick the right option. If others, please mention.
g) Occupation	Indicate occupation of Hospitalized person	Tick the right option. If others, please mention.
h) Address	Enter the full Postal Address	Include street, city and pin code
i) Phone No	Enter the phone number of Hospitalized person	Include STD code with telephone number
j) E-mail ID	Enter the e-mail id of Hospitalized person	Complete e-mail address
SECTION D – TELL US MORE ABOUT THE HOSPITALIZATION		
a) Name of Hospital, wherein Admitted	Enter the name of Hospital	Name of Hospital in full
b) Room category occupied	Indicate the room category taken	Tick the right box
c) Hospitalization due to	Indicate reason of Hospitalization	Tick the right box
d) Date of Injury / Date on which disease was 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
Time	Enter time of Admission	Use hh:mm format
f) Date of Discharge	Enter date of Discharge	Use dd-mm-yyyy format
Time	Enter time of Discharge	Use hh:mm format

SOME TIPS TO FILL THECLAIM FORM – PART A

g) If injury, give cause	Indicate cause of injury	Tick the right option
h) If Medico-legal	Indicate whether injury is medico-legal or not	Tick Yes or No
Reported to police	Indicate whether police report was filed or not	Tick Yes or No
MLC report & police FIR attached	Indicate whether MLC report and police FIR was attached or not	Tick Yes or No
i) System of medicine	Enter the system of medicine followed in treating the Hospitalized person	Open text
SECTION E - WHAT DO WE NEED FOR YOUR CLAIM?		
a) Details of treatment expenses	Enter the amount claimed as treatment costs	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 the bills which are enclosed, alongwith the amounts in rupees		
SECTION G - IN CASE IT'S AN ACCIDENT (Tick the right option)		
a) Death	Indicate whether claim is for death	Tick the right option
b) Permanent Partial Disability	Indicate whether claim is for PPD	Tick the right option
c) Permanent Total Disability	Indicate whether claim is for PTD	Tick the right option
d) Temporary Total Disability	Indicate whether claim is for TTD	Tick the right option
SECTION H – TELL US MORE ABOUT THE ACCIDENT		
a) Date and time of Accident	Indicate the date and time of Accident	Use dd-mm-yyyy format & HH:MM
b) Place of Accident	Indicate the place of Accident	Mention the place of Accident
c) Cause of Accident	Indicate the cause of Accident	Mention the cause of Accident
d) Was there any Hospitalization due to an Accident?	Indicate whether Hospitalization was undertaken or not	Mention whether Hospitalization was undertaken or not
SECTION I – THE MEMBER'S OR NOMINEE'S BANK ACCOUNT DETAILS		
a) PAN (if amount is or exceeds INR 1lakh)	Enter the permanent account number (if applicable)	As given by the Income Tax department
b) Account No.	Enter the bank account number	As given 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 to whom the payment should be made out to	Name of the person / organization in full
e) IFSC	Enter the IFSC of the bank branch	IFSC of the bank branch in full
SECTION J - DETAILS OF OUT - PATIENT COVER		
a) Treatment start date	Enter treatment start date	Use dd-mm-yyyy
b) Treatment end date	Enter treatment end date	Use dd-mm-yyyy
c) Name and contact details of treating doctor	Enter name and contact details of treating doctor	Name and contact details of treating doctor
d) Name and address of clinic / hospital	Enter Name and address of clinic / hospital	Name and address of clinic / hospital
e) Nature of illness / disease	Enter name of the disease	Name of disease / ICD code
f) Consultation fees	Enter the amount claimed as treatment costs	In rupees (Do not enter paise values)
g) Pharmacy / Investigation fees	Enter the amount claimed as treatment costs	In rupees (Do not enter paise values)
SECTION K – DECLARATION BY THE MEMBER / NONIMEE		
Read declaration carefully and mention date (in dd:mm:yyyy format), place (open text) and sign.		