This form should be filled in by the hospital Beaume of this modes not imply acceptance of liability Fill all details in EUCX LET FIRS Proze add the outprint HOSPITAL AND DOCTOR a) Name of Hospital: () Inorpital D: () Inorpit	So your patient needs to claim? Relax	we're here to make it easy!		Т	oll	Free	180	00 12	2000
SECTION A - ABOUT THE HOSPITAL AND DOCTOR a) Name of Hospital:	Instructions: 1. This form should be filled in by the hospital 2. Issuance of this form does not imply acceptance of 3. Fill all details in BLOCK LETTERS 4. Please add the original pre-authorization request for	liability rm with Part A							
a) Name of Hospital:									
b) Hospital ID:									
a) Name of the patient: e) Qualification: f) Registration No. with state code: g) Phone No.: g) Name of the patient:			Non-ne	twork	(lf no	n_neti	work f	ill Secti	ion F)
f) Registration No. with state code:									
SECTION B - SOME DETAILS ABOUT THE PATIENT a) Name of the patient: b) Name of the member: c) Employee No.: e) Name of the Insured / Policyholder: g) Date of Admission: f) Branch: g) Date of Admission: f) Branch: g) Date of Discharge: f) Discharge: j) Status at time of Discharge: j) Discharge to home j) Status at time of Discharge: j) Bischarge to home j) Age (Y) (M) (M) (Y) (Y) (Y) (W) (G) Gravida Status:									
a) Name of the patient:		y) FII							
b) Name of the member: c) Department: d) Employee No.: e) Name of the Insured / Policyholder: g) Date of Admission: f) Marght Y Y Y no Time of Admission: g) Date of Admission: Emergency g) Date of Discharge: Discharge: h) Marght Y Y Y no Time of Discharge: h) Total claimed amount (in ₹):	SECTION B - SOME DETAILS ABOUT THE	PATIENT							
a) Employee No: a) Name of the Insured / Policyholder: b) Date of Admission: b) Date of Admission: b) M M Y Y Y h) Time of Admission: b) H M M Y Y Y h) Time of Admission: b) Date of Discharge: b) M M Y Y Y h) Time of Discharge: b) M M M Y Y Y h) Time of Discharge: b) The Admission: b) M M Y Y Y h) Time of Discharge: b) M M Y Y Y h) Time of Discharge: b) The Admission: b) The Matemity b) If Maternity, (i) Date of Delivery: b) M M Y Y Y (i) Gravida Status: c) Name of Discharge: b) M M Y Y Y (ii) Time of Discharge to another hospital b) Age Y Y M M p) Gender: Male c) Nage Y Y M M p) Gender: Male c) Nage Y Y M M p) Gender: Male c) Procedure amount (in ₹): c) Discharge to home c) Procedure 1: c) Discharge: (ii) Additional Diagnosis: c) CD 10 Codes (iii) Additional Diagnosis: c) CD 10 PCS c) Procedure 1: c) CD 10 PCS (ii) Procedure 3: c) Procedure 3: (iii) Procedure 3: c) Pre-authorization No.: c) Pre-authorization obtained: yes	a) Name of the patient:								
g) Date of Admission: D M M Y Y M<									
i) Date of Discharge: iii M Y Y Y iii Time of Discharge: iii M M (k) Type of Admission: Emergency Planned Day Care Maternity (k) M M Y Y Y Iii Time of Discharge: Discharge to home Discharge to another hospital Deceased (k) Type of Admission: Emergency Discharge to home Discharge to another hospital Deceased (k) Type of Admission: Emergency Discharge to another hospital Deceased (k) Type of Admission: M Y Y Y Y M M Y Y Y (k) Type of Admission: Emergency Discharge to another hospital Deceased (k) Additional Diagnosis: (k) Or M Y Y Y Y M M Y Y Y (k) Or morbidities: (k) Or morbidities: (k) Or morbidities: (k) Oc-morbidities: (k) Or morbidities: (k) Or morbidities: (k) Procedure 1: (k) Procedure 2: (k) Procedure 2: (k) Procedure 2: (k) Procedure 3: (k) Or morbidities: (k) Procedure 3: (k) Procedure 3: (k) Procedure 3: (k) Procedure 3: (k) Procedure 3: (k) Procedure 3: (k) Procedure 1: (k) Procedure 3: (k) Procedure 3: (k) Procedure 1: (k) Procedure 3: (k) Procedure 3: (k) Procedure 2: (k) Procedure 3: (k) Procedure 3: (k) Procedure 3: (k) Procedure 3: (k) Procedure 3: (k) Procedure 1: (k) Procedure 3: (k) Procedure 3: (k) Procedure 3: (k) Procedure 4: (k) Procedure 4: (k) Proted, It has not agreed,		e Insured / Policyholder:f) Branch:							
k) Type of Admission: Emergency Planned Day Care Maternity, h) Maternity, (h) Date of Delivery: Discharge to home Discharge to another hospital Deceased n) Status at time of Discharge: Discharge to home Discharge to another hospital Deceased n) Status at time of Discharge: Discharge to home Discharge to another hospital Deceased n) Total claimed amount (in ?):	g) Date of Admission: D D M M Y Y Y Y	h) Time of Admission: H H M M							
i) If Maternity, (i) Date of Delivery: D_D_M_YYYYY (i) Gravida Status:	i) Date of Discharge: D D M M Y Y Y Y	j) Time of Discharge: H H M M							
n) Status at time of Discharge: Discharge to home Discharge to another hospital Deceased n) Total claimed amount (in ₹):	k) Type of Admission: Emergency Planned	Day Care Maternity							
n) Status at time of Discharge: Discharge to home Discharge to another hospital Deceased n) Total claimed amount (in ₹): D) Age Y Y M M p) Gender: Male Female Third gender Q) Date of Birth: D D M Y Y Y SECTION C - WHAT WAS THE PRIMARY ALLMENT BEING TREATED? a) ICD 10 Codes Description (i) Primary Diagnosis: (ii) Additional Diagnosis: (iii) Additional Diagnosis: (iii) Co-morbidities: (iv) Co-amotholities: (iv) Co-amotholities: (iv) Co-amotholities: (iv) Co-amotholities: (iv) Decedure 1: (iv) Procedure 2: (iv) Procedure 3: (iv) Details of procedure 4: (iv) Prosecure 3: (iv) Details of procedure 9: (iv) Details of procedure 9: (iv) Details of procedure 9: (iv) Pre-authorization No.: (v) Details of procedure 9: (v) If the network hospital has not agreed, please state the reason: (v) If the network hospital has not agreed, please state the reason: (v) If the network hospital has not agreed, please state the reason: (v) If the network hospital has not agreed, please state the reason: (v) If the network hospital has not agreed, please state the reason: (v) If the network hospital has not agreed, please state the reason: (v) If reported, FIR No.: (v) If reported, FIR No.: (v) If reported, FIR No.: (v) If noreported, please state the reason: (v) If noreported, please state the reason: (v) If noreported, please state the reason: (v) If reported, please state the reason: (v) If noreported, please state the rea	I) If Maternity, (i) Date of Delivery: $\begin{bmatrix} D \\ D \end{bmatrix} \begin{bmatrix} M \end{bmatrix} \begin{bmatrix} M \end{bmatrix}$	Y Y Y K (ii) Gravida Status:							
n) Total claimed amount (in ₹):						cease	d		
a) Age Y M p) Gender: Male Female Third gender q) Date of Birth: M Y Y Y SECTION C - WHAT WAS THE PRIMARY AILMENT BEING TREATED? a) ICD 10 Codes Description (i) Primary Diagnosis: (ii) Additional Diagnosis: ICD 10 Codes Description (ii) Co-morbidities: ICD 10 PCS Description (i) Procedure 1: (iii) Procedure 3: ICD 10 PCS Description (ii) Procedure 3: ICD 10 PCS Description (ii) Procedure 3: ICD 10 PCS Description (iii) Procedure 3: ICD 10 PCS Description (ii) Procedure 3: ICD 10 PCS Description (i) Procedure 3: (ii) Pre-authorization No.: (iii) Procedure 3: ICD 10 PCS (i) Pre-authorization obtained: (iv) Details of procedure: ICD 10 PCS (i) Pre-authorization No.: (ii) Pre-authorization No.: (iii) Pre-authorization No.: (iv) Frequence (iv) Additional Pre-authorization No.: (iv) Pre-authorization No.: (iv) Frequence (iv) Pre-authorization No.: (iv) Pre-authorization No.: (iv) Pre-authorization No.: (iv) Frequence (iv) P						00000			
a) ICD 10 Codes Description (i) Primary Diagnosis:		e 🔄 Female 🔄 Third gender 🛛 🛛	q) Date of Bi	rth: D	DI	M	ΥΥ	ΥΥ	,
a) ICD 10 Codes Description (i) Primary Diagnosis:	SECTION C - WHAT WAS THE PRIMARY A	ILMENT BEING TREATED?							
(ii) Additional Diagnosis:	a)				Des	criptio	n		
(ii) Co-morbidities: (iv) Co-morbidities: (iv) Co-morbidities: (iv) Co-morbidities: (ii) Procedure 1: (ii) Procedure 2: (iii) Procedure 2: (iii) Procedure 3: (iv) Details of procedure: (iv) If yes, give cause: (iv) If Yes No (iv) Reported to Police: (iv) Substance Abuse / Alcohol Consumption (iv) If reported, FIR No.: (vi) If not reported, please state the reason: (vi) If not reported, please state the reason: (vi) Signed Claim Form (iv) Nettigation reports (iv) Reported Claim Form (iv) Reported Claim Form (iv) Reported Police: (iv) Re									
(iv) Co-morbidities: ICD 10 PCS Description (i) Procedure 1:									
b) ICD 10 PCS Description (i) Procedure 1:									
(i) Procedure 1:									
(ii) Procedure 2:	b)	ICD 10 PCS			Des	criptio	n		
(ii) Procedure 3:									
(iv) Details of procedure:									
c) Pre-authorization obtained: Yes No d) Pre-authorization No.: c) Pre-authorization obtained: Yes No c) If the network hospital has not agreed, please state the 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 prove this: Yes No (If Yes, attach reports) (iii) If medico-legal: Yes No (v) If reported, FIR No.: (v) If reported, please state the reason: SECTION D - HAVE ALL THE DOCUMENTS YOU NEED? Signed Claim Form									
e) If the network hospital has not agreed, please state the reason:		d) Pre-author	ization No ·						
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 prove this: Yes No (If Yes, attach reports) (iii) If medico-legal: Yes No (iv) Reported to Police: Yes No (v) If reported, FIR No.:		,	12411011110						
(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 prove this: Yes No (If Yes, attach reports) (iii) If medico-legal: Yes No (iv) Reported to Police: Yes No (v) If reported, FIR No.:									
<pre>(ii) If injury due to Substance Abuse / Alcohol Consumption, test conducted to prove this:YesNo (If Yes, attach reports) (iii) If medico-legal:YesNo (iv) Reported to Police:YesNo (v) If reported, FIR No.:(vi) If not reported, please state the reason:</pre>	f) Hospitalization due to injury: Yes	D							
(iii) If medico-legal: Yes No (iv) Reported to Police: Yes No (v) If reported, FIR No.:	(i) If Yes, give cause: Self-Inflicted	Road Traffic Accident Substance Abu	ise / Alcoho	Cons	umpti	on			
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(v) If reported, FIR No.:	(iii) If medico-legal: 🔄 Yes 🔛 No								
(vi) If not reported, please state the reason: SECTION D - HAVE ALL THE DOCUMENTS YOU NEED? Signed Claim Form Investigation reports	(iv) Reported to Police: Yes No								
SECTION D - HAVE ALL THE DOCUMENTS YOU NEED?	(v) If reported, FIR No.:								
Signed Claim Form	(vi) If not reported, please state the reason:								
Signed Claim Form	L								
	SECTION D - HAVE ALL THE DOCUMENTS	SYOU NEED?							
Original pre-authorization request	Signed Claim Form	Investigation reports	5						
	Original pre-authorization request	CT / MR / USG / HP	E investigati	on rep	orts				

EDELWEISS GROUP HEALTH INSURANCE - CLAIM FORM B

Edelweiss | GENERAL INSURANCE

Copy of the pre-authorization approval lette					
Copy of photo ID card of patient, verified by	•				
Discharge summary		Pharmacy bills			
Operation theatre notes	MLC report & po				
Main hospital bill		ummary from hospital, where needed			
Hospital bill break-up	Any other, please	Any other, please specify			
SECTION E - NON-NETWORK HOSPITAL?	PLEASE HELP US WITH SOME DETA	ILS.			
a) Address of Hospital:					
Landmark:	_ City: State:	Pin Code:			
b) Phone No.:	c) Registration no. with state co	de:			
d) PAN of hospital:					
f) Facilities given in the hospital:(i) OT:	No (ii) ICU: Yes	No			
(iii) Medical Store: Yes No (iv) Pat	nology: Yes No (v) Radiology:	Yes No (vi) Other:			
SECTION F - DECLARATION BY THE HOSI	ΡΙΤΔΙ	(PLEASE READ VERY CAREFULLY)			
		· · · · · · · · · · · · · · · · · · ·			
We hereby declare that the information given in any false or untrue statement and / or suppress		est of our knowledge and belief. If we have made oclaim shall stand forfeited.			
Date: D D M M Y Y Y Y					
Place:		Signature and stamp of authorized signatory			
SOME TIPS ON HOW TO FILL CLAIM FORM- PAR	r R				
DATA ELEMENT	DESCRIPTION	FORMAT			
SECTION A - ABOUT THE HOSPITAL AND DOCTOR 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 d) Name of attending doctor	Write if in network or non-network hospital Enter the name of the treating doctor				
e) Qualification	Enter the qualifications of the treating doctor				
f) Registration No. with state code	Enter the registration number of the doctor along with the As given by the Medical Council of India state code				
g) Phone No.	Enter the phone number of doctor	Include STD code with telephone number			
SECTION B - SOME DETAILS ABOUT THE PATIENT a) Name of Patient	Enter the name of hospital	Name of hospital in full			
b) Name of the member	Enter the name of member	nber Name of member in full			
c) Department d) Employee no.	Enter name of department Enter Employee No.	nent Name of department in full			
e) Name of the Insured/ Policyholder	Enter the full name of the Policyholder	Policyholder Surname, First name, Middle name			
f) Branch g) Date of Admission	Enter Branch Location Enter date of admission				
h) Time of Admission	Enter time of admission	ion Use hh:mm format			
i) Date of Discharge j) Time of Discharge	Enter date of release Enter time of release				
k) Type of Admission	Indicate type of admission of patient	Tick the right option			
I) If Maternity					
Date of Delivery Gravida Status	Enter date of delivery, in case of maternity Enter gravida status if maternity	Use dd-mm-yyyy format Use standard format			
m) Status at time of discharge	Indicate status of patient at time of release	t time of release Tick the right option			
n) Total claimed amount (in ₹) o) Age	Indicate the total claimed amount Enter age of the Patient	In rupees (Do not enter paise values) Number of years and months			
p) Gender: Male, Female, Third gender	Indicate gender of the Hospitalized person	Tick on appropriate option			
q) Date of Birth	Enter date of birth of Patient	Use dd-mm-yyyy format			
SECTION C - WHAT WAS THE PRIMARY AILMENT BEING TRE	ATED?				
a) ICD 10 Code		orange and the second second			
Primary Diagnosis	Enter the ICD 10 Code and description of the primary di	e and description of the primary diagnosis Standard format and open text e and description of the additional diagnosis Standard format and open text			
Additional Diagnosis Co-morbidities	Enter the ICD 10 Code and description of the co-morbid				
b) ICD 10 PCS					
Procedure 1	Enter the ICD 10 PCS and description of the first proced				
Procedure 2	Enter the ICD 10 PCS and description of the second pro				
Procedure 3 Details of procedure	Enter the ICD 10 PCS and description of the third proce Enter the details of the procedure	dure Standard format and open text Open text			
Details of procedule	Liner the details of the procedure				

c) Pre-authorization obtained	Indicate whether pre-authorization obtained	Tick Yes or No		
d) Pre-authorization No.	Enter pre-authorization number	As allotted by TPA		
e) If the network hospital has not agreed, please state the reason	Enter reason for not obtaining pre-authorization number	Open text		
f) Hospitalization due to injury	Indicate if hospitalization is due to injury or not	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 if test is done or not	Tick Yes or No		
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		
If reported, FIR No.	Enter first information report number	As issued by police authorities		
If not reported, please state the reason	Enter reason for not reporting to police	Open Text		
SECTION D - HAVE ALL THE DOCUMENTS YOU NEED?				
Indicate which supporting documents are submitted.				
SECTION E - NON-NETWORK HOSPITAL? PLEASE HELP US W	/ITH SOME DETAILS			
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 given by the Medical Council of India		
d) PAN of hospital	Enter the permanent account number	As given by the Income Tax Department		
e) Number of inpatient beds	Enter the number of inpatient beds	Digits		
f) Facilities given in the hospital	Facilities in the hospital	Tick the right option. If others, please mention		
SECTION F - DECLARATION BY THE HOSPITAL				
Read declaration carefully and mention date (in dd:mm:yyyy form	at), place (open text) and sign and stamp.			

Edelweiss Group Health Insurance | UIN: EDLHLGP19112V01819

Edelweiss General Insurance Company Limited, Corporate Office: 5th Floor, Tower 3, Kohinoor City Mall, Kohinoor City, Kirol Road, Kurla (West), Mumbai-400070, Registered Office: Edelweiss House, Off CST Road, Kalina, Mumbai-400 098, IRDAI Regn. No.: 159, CIN: U66000MH2016PLC273758, Reach us on: 1800 12000, Email: support@edelweissinsurance.com, Website: www.edelweissinsurance.com, Issuing/Corporate Office: +91 22 2286 4400, Grievance Redressal Officer: +91 22 4931 4422, Dedicated Toll-Free Number for Grievance: 1800 120 216216. Trade logo displayed above belongs to Edelweiss Financial Services Limited and is used by Edelweiss General Insurance Company Limited under license.