TATA AIG INSURANCE
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MediCare | **MediCare** Premier | **MediCare** Protect | **MediCare** Plus

Where to submit the claim

Health Claims Hub
Tata AIG General Insurance Co. Ltd.
Door No. 615, 616, 5th and 6th Floor
Imperial Towers, Ameerpet
Next to Ameerpet Metro Station
Hyderabad - 500016
Telangana.

How to track the claim

STEP 1
Open www.tataaig.com and click on Self Service

STEP 2
Login & choose search claims

STEP 3
Track claim status with the help of Policy Number/ Member ID/ Claim Number

Please submit complete documents as per the check list for speedy claim settlement.

CHECK-LIST

S.No.	Document	Yes	No	Type of document
1.	Copy of cancelled cheque for the proposer - Account holder's name, account number and IFSC code should be printed on the submitted copy			Original/Photo Copy
2.	If the claimed amount is more than 1 Lakh; CKYC Form along with Photograph + PAN Card Copy of the Proposer + Address Proof			Original/Photo Copy
3.	Claim form - Please fill all the mandatory fields with appropriate information			Original/Photo Copy
4.	Tata AIG Health Card or Policy Copy			Original/Photo Copy
5.	ID, Address & Age Proof of the Patient			Original/Photo Copy
6.	Discharge/ Daycare Summary from the hospital indicating the presenting complaints, diagnosis, treatment given and past medical history			Original/Photo Copy
7.	Consolidated Final Bill along with breakup of the individual items			Original Mandatory
8.	Proof of payment paid at hospital - cash receipt			Original Mandatory
9.	In case of Implants being used - Please share relevant Invoice & Sticker			Original Mandatory
10.	Pharmacy & Lab Bills			Original Mandatory
11.	Diagnostic/ Lab Reports for submitted bills			Original/Photo Copy
12.	Doctor Prescriptions for submitted pharmacy bills			Original/Photo Copy
13.	Medical records and consultation papers prior to hospitalization			Original/Photo Copy
14.	Any previously approved settlement letter from other insurance (if any)			Original/Photo Copy
15.	In case of accidental injuries, please submit Medico-Legal Certificate (MLC) /First Information Report (FIR)			Original/Photo Copy
16.	In case of death of the proposer, details of nominee (as per policy schedule), along with address & ID proof of nominee			Original/Photo Copy
17.	Hospital Registration Certificate			Original/Photo Copy

Note: All financial documents (bills & receipts) should be submitted in original.

TYPE OF CLAIM (Please submit a different form for each type of claim)

- ☐ In-Patient Treatment
- ☐ Day Care Procedures
- ☐ Health Checkup
- ☐ High End Diagnostics
- ☐ OPD Treatment – Dental
- ☐ Maternity Cover
- ☐ Restore benefits
- ☐ OPD Treatment
- ☐ Daily Cash for choosing Shared Accommodation
- ☐ Pre & Post-Hospitalization expenses
- ☐ Others

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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. Please fill-up this form in CAPITAL LETTERS.

DETAILS OF PRIMARY INSURED (*Mandatory fields) (SECTION A)

Policy No.*: ☐☐☐☐☐☐☐☐☐☐ UHID: _____ Intimation Number: _____

Sl. No. / Certificate No*.: ☐☐☐☐☐☐☐☐☐☐ Company Name*: **Tata AIG General Insurance Company Ltd.**

Name*: _____
Prefix First Name Middle Name Last Name

Address*: _____

_____

Registered E-mail ID*: _____

Registered Phone Number*: ☐☐☐☐☐☐☐☐☐☐ Alternative Phone Number: ☐☐☐☐☐☐☐☐☐☐

DETAILS OF INSURANCE HISTORY (SECTION B)

i. Currently covered by any other Mediclaim/Health Insurance: Yes ☐ No ☐

ii. Have you been hospitalized in the last four years since inception of the contract? Yes ☐ No ☐

Date: _____ Diagnosis: _____

iii. Date of commencement of first insurance without break: _____

If yes, Company Name: _____

Policy No.: _____ Sum Insured (₹): _____

iv. Previously covered by any other Mediclaim/Health Insurance: Yes ☐ No ☐

If yes, Company Name: _____

Policy No.: _____ Sum Insured (₹): _____

DETAILS OF INSURED PERSON HOSPITALIZED (SECTION C)

Name: _____
Prefix First Name Middle Name Last Name

Gender: ☐ Male ☐ Female ☐ Other Date of birth: ☐☐☐☐☐☐☐☐ Age ☐☐ Years ☐☐ Months ☐☐

Relationship to Primary Insured: ☐ Self ☐ Spouse ☐ Child ☐ Father ☐ Mother ☐ Other (Please Specify) _____

Occupation: ☐ Service ☐ Self Employed ☐ Homemaker ☐ Student ☐ Retired ☐ Other (Please Specify) _____

DETAILS OF HOSPITALIZATION (SECTION D)

Name of Hospital: where admitted _____

_____

Room Category occupied: ☐ Day Care ☐ Single Occupancy ☐ Twin Sharing ☐ 3 or more beds per room

Hospitalizaton due to: ☐ Injury ☐ Illness ☐ Maternity

Date of injury/Date Disease first detected/Date of Delivery: _____

Date of Admission: _____ Time: _____

Date of Discharge: _____ Time: _____

If Injury, give cause: ☐ Self Inflicted ☐ Road Traffic Accident ☐ Substance Abuse/Alcohol Consumption

If Medico legal: Yes ☐ No ☐

Reported to police: Yes ☐ No ☐

MLC Report & Police FIR attached: Yes ☐ No ☐ (If yes, attach report)

System of Medicine ☐ Allopathy ☐ Other (Please Specify) _____

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DETAILS OF CLAIM (SECTION E)

Details of the treatment expenses claimed:		Details of Lump sum/cash benefit claimed:	
Type of claims	**Total expenses**	**Type of claims**	**Total expenses**
In-Patient Treatment		Critical Illness	
Pre & Post-Hospitalization Expenses		Accidental death benefits	
Day Care Procedures			
Health Checkup			
Daily Cash for choosing Shared Accommodation			
OPD Treatment			
OPD Treatment – Dental			
Maternity Cover			
High End Diagnostics			

Note: Please submit a different form for each type of claim

DETAILS OF BILLS ENCLOSED: (SECTION F)

S. No.	Bill No.	Date	Issued by	Towards	Amount	Total
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
				Grand Total		

Note: In case of multiple bills, you can attach a separate sheet.

Incase of delay in submitting the documents (Post 30days from Date of Discharge), please provide a separate covering letter with the reason for the delay.

DETAILS OF PRIMARY INSURED BANK ACCOUNT: (SECTION G)

PAN: ☐☐☐☐☐☐☐☐☐☐

Account No.: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Bank Name and Branch: _____

Cheque/DD Payable details: _____ IFSC Code: ☐☐☐☐☐☐☐☐☐☐☐

Please provide a Cancelled cheque of Proposer (with printed Payee Name)

DECLARATION BY THE INSURED (SECTION H)

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: _____ Signature of the Insured _____

Place: _____

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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 pre-authorization request form in lieu of PART A.

Please fill-up this form in CAPITAL LETTERS.

DETAILS OF HOSPITAL (SECTION A)

Name of the Hospital: _____

Type of Hospital: ☐ Network ☐ Non-network (If non-network fill Section D) ROHINI ID: _____

Facilities available in the hospital: OT: ☐☐ ICU: ☐☐

Name of the treating Doctor: _____
Prefix First Name Middle Name Last Name

Qualification: _____ Phone No.: ☐☐☐☐☐☐☐☐☐☐

Registration No.: (with State Code) _____

DETAILS OF THE PATIENT ADMITTED (SECTION B)

Name of the Patient: _____
Prefix First Name Middle Name Last Name

IP Registration Number: _____ Gender: ☐ M ☐ F Age: ☐☐ Years ☐☐ Months ☐☐

Date of Birth: ☐☐☐☐☐☐☐☐ Date of Admission: ☐☐☐☐☐☐☐☐ Time: _____

Date of Discharge: ☐☐☐☐☐☐☐☐ Time: _____

Type of Admission: ☐ Emergency ☐ Planned ☐ Day Care ☐ Maternity

If Maternity: i) Date of Delivery: _____ i) Gravida Status: ☐ G ☐ P ☐ L ☐ A

Status at time of discharge: ☐ Discharge to home ☐ Discharge to another hospital ☐ Deceased

Total claimed amount ₹: ☐☐☐☐☐☐☐☐

DETAILS OF AILMENT DIAGNOSED (PRIMARY) (SECTION C)

ICD 10 Codes:		Description	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	_____

Pre-authorization obtained: ☐ Yes ☐ No Pre-authorization Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

If authorization by network hospital not obtained, give reason: _____

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, attach report)

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

vi) If not reported to police, give reason: _____

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

Name of the Hospital: _____

Address: _____

City/Town _____ District _____

Pin Code ☐☐☐☐☐☐ State _____

E-Mail _____ Phone ☐☐☐☐☐☐☐☐☐☐

Registration No.: with State Code _____ Hospital PAN: ☐☐☐☐☐☐☐☐☐☐ Number of In-patient beds: _____

Facilities available in the hospital: i) OT: ☐ Yes ☐ No ii) ICU: ☐ Yes ☐ No iii) Others _____

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

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: _____

Place: _____ Signature and Seal of the Hospital Authority: _____

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

Health Claims Hub, Tata AIG General Insurance Co. Ltd. Door No. 615, 616, 5th and 6th Floor, Imperial Towers, Ameerpet, Next to Ameerpet Metro Station, Hyderabad - 500016, Telangana, Phone-040-66864900. Toll-Free: 1800 266 7780 or 1800 229 966 (For Senior Citizens). Website: www.tataaig.com. Email: healthclaimsupport@tataaig.com

Prohibition of Rebates - Section 41 of Insurance Act, 1938 as amended by Insurance Laws (Amendment) Act, 2015

1. 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 insurancein 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.
2. Any person making default in complying with the provisions of this section shall be liable for a penalty which may extend to ten lakh rupees.

Part C - Know Your Customer (KYC)

With reference to IRDAI Circular No. IRDAI/SDD/MISC/CIR/135/07/2016,
KYC details are required for Individual/ Retail policy holders, if the total claimed amount exceeds ₹100,000

CENTRAL KYC REGISTRY | Know Your Customer (KYC) Application Form | Individual

Important Instructions:

A) Fields marked with '*' are mandatory fields.
B) Tick '✓' wherever applicable.
C) Please fill the form in English and in BLOCK letters.
D) Please fill the date in DD-MM-YYYY format.
E) Please read section-wise detailed guidelines / instructions at the end.
F) For a particular section update, please tick (✓) in the box section number and strike off the sections not required to be updated.
G) List of State / U.T code as per Indian Motor Vehicle Act, 1988 is available at the end.
H) List of two character ISO 3166 country codes is available at the end.
I) KYC number of applicant is mandatory for update application.
J) The 'OTP based E-KYC' check box is to be checked for accounts opened using OTP based E-KYC in non-face to face mode

For office use only
(To be filled by financial institution)

Application Type* ☐ New ☐ Update

KYC Number (Mandatory for KYC update request)

Account Type* ☐ Normal ☐ Minor ☐ Aadhaar OTP based E-KYC (in non-face to face mode)

☐ 1. PERSONAL DETAILS* (Please refer instruction A at the end)

	Prefix	First Name	Middle Name	Last Name
☐ Name* (Same as ID proof)				
Maiden Name				
Father / Spouse Name				
Mother Name				

Date of Birth* Gender* ☐ M- Male ☐ F- Female ☐ T-Transgender

Pan* ☐ Form 60 furnished

☐ 2. PROOF OF IDENTITY AND ADDRESS* (Please refer instruction B at the end)

I. Certified copy of OVD or equivalent e-document of OVD or OVD obtained through digital KYC process needs to be submitted (anyone of the following OVDs)

☐ PHOTO*

☐ A- Passport Number
☐ B- Voter ID Card
☐ C- Driving Licence
☐ D- NREGA Job Card
☐ E- National Population Register Letter
☐ F- Proof of Possession of Aadhaar

II. ☐ E-KYC Authentication

III. ☐ Offline verification of Aadhaar

Address

Line 1*

Line 2

Line 3 City / Town / Village*

District* Pin / Post Code*

State / U.T Code* ISO 3166 Country Code*

☐ 3. CURRENT ADDRESS DETAILS (Please refer instruction B at the end)

☐ Same as above mentioned address (In such cases, address details as below, need not be provided)

I. Certified copy of OVD or equivalent e-document of OVD or OVD obtained through digital KYC process needs to be submitted (anyone of the following OVDs)

☐ A- Passport Number ☐ B- Voter ID Card
☐ C- Driving Licence
☐ D- NREGA Job Card

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- ☐ E- National Population Register Letter
- ☐ F- Proof of Possession of Aadhaar
- II. ☐ E-KYC Authentication
- III. ☐ Offline verification of Aadhaar
- IV. ☐ Deemed Proof of Address - Document Type Code

Address

Line 1*

Line 2

Line 3 City / Town / Village*

District* Pin / Post Code*

State / U.T Code* ISO 3166 Country Code*

☐ 4. CONTACT DETAILS (All communication will be sent to Mobile number/ Email-ID provided) (Please refer instruction C at the end)

Tel. (Off) - Tel. (Res) -

Email ID Mobile

☐ 5. REMARKS (If any)

☐ 6. APPLICANT DECLARATION

- I hereby declare that the details furnished above are true and correct to the best of my knowledge and belief and I undertake to inform you of any changes therein, immediately. In case any of the above information is found to be false or untrue or misleading or misrepresenting, I am aware that I may be held liable for it.
- I hereby consent to receiving information from Central KYC Registry through SMS/Email on the above registered number/email address.

[Signature / Thumb Impression]

Signature / Thumb Impression of Applicant

Date: Place:

☐ 7. ATTESTATION / FOR OFFICE USE ONLY

Documents Received

- ☐ Certified Copies
- ☐ E-KYC data received from UIDAI
- ☐ Data received from offline verification
- ☐ Digital KYC Process
- ☐ Equivalent e-document
- ☐ Video Based KYC

KYC VERIFICATION CARRIED OUT BY		INSTITUTION DETAILS	
Date		Name	
Emp. Name		Code	
Emp. Code			
Emp. Designation			
Emp. Branch			

[Employee Signature]

[Institution Stamp]

To know more about Instructions / Checklist / Guidelines for filling Individual KYC Application Form, please visit E-KYC website.

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