

हैत्थ इन्स्योरेंस टीपीए ऑफ इन्डिया लिमिटेड HEALTH INSURANCE TPA OF INDIA LTD. TO BE FILLED BY THE INSURED The issue of this Form is not to be taken as an admission of liability

(To be Filled in block letters)

Policy No.:
Company/TPA ID No.:
Name: SURNAME FIRST NAME NAME
Address:
City:
Pin Code: Phone No.: Phone No.: Email ID:
ETAILS OF INSURANCE HISTORY:
Currently covered by any other Mediclaim / Health Insurance: Yes No b) Date of commencement of first Insurance without break: DD MM MYYYYYY
) If yes, company name:
sum Insured (Rs.)
oliagnosis: e) Previously covered by any other Mediclaim/Health insurance: Yes No
) If yes, company name:
DETAILS OF INSURED PERSON HOSPITALIZED::
Name: SURNAME NAME NAME
Gender Male Female c) Age years Y Y Months M M Date of Birth D D M M Y Y Y Y
Relationship to primary Insured: Self Spouse Child Father Mother Other (Please Specify)
Occupation Service Self Employed Home Maker Student Retired Other (Please Specify)
Address (if diffrent from above):
City: State: Sta
Pin Code Phone No.: Email ID:
ETAILS OF HOSPITALIZATION::
) Name of Hospital where Admited:
) Hospitalization due to: Injury Illness Maternity d) Date of injury / Date Disease first detected /Date of Delivery:
) Date of admission: DD MM YY f) Time: HH M H g) Date of Discharge: DD M M YY h) Time: HH M H
If injury give cause: Self inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption I) If medical legal Yes No
) Reported to Police Yes No iii) MLC Report & Police FIR attached Yes No j) System of Medicine:
) Reported to Police Yes No iii) MLC Report & Police FIR attached Yes No j) System of Medicine: DETAILS OF CLAIM:
DETAILS OF CLAIM: (1) Details of the Treatment expenses claimed (2) Pre-hospitalization expenses (3) Rs. (1) Rospitalization expenses (4) Claim Documents Submitted - Check List: (5) Claim form duly signed
DETAILS OF CLAIM: Claim Documents Submitted - Check List: Pre-hospitalization expenses Rs.
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Details of the Treatment expenses claimed Pre-hospitalization expenses Rs.
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DETAILS OF CLAIM: Details of the Treatment expenses claimed
Details of the Treatment expenses claimed Claim Documents Submitted - Check List: Pre-hospitalization expenses Rs.
DETAILS OF CLAIM: Details of the Treatment expenses claimed



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			
a) Name of the hospital:	10000000000000000000000000000000000000		
b) Hospital ID:	c) Type of Hospital: Network: Non Network: (if non Network fill section E)	SEC.	
c) Name of the treating doctor:	RNAMEFIRST NAMEMIDDLE NAME]	
e) Qualification:	f) Registration No. with State Code:] -	
DETAILS OF THE PATIENT ADMIT	TED	.	
a) Name of the Patient:	RNAME 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]	
f) Date of Admission:	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 i)Date of Delivery: DD MM MYY ii) Gravida Status:			
I) Status at time of discharge: Discharge	home Discharge to another hospital Deceased mn) Total claimed amount		
DETAILS OF AILMENT DIAGNOSI	D (PRIMARY)	.	
a) ICD 10 (odes Description b) ICD 10 Codes Description		
I. Primary Diagnosis	I. Procedure 1:		
ii. Additional Diagnosis:	ii. Procedure 2:		
iii. Co-morbidities	iii. Procedure 3:		
III. 00 III0Istatites		, E	
iv. Co-morbidities	iv. Details of procedure:	I C	
		_ c	
c) Pre-authorization obtained:	Yes No d) Pre-authorization Number:		
e) If authorization by network hospital not of	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 of	onsumption, Test conducted to establish this: Yes No (If Yes, attach reports) iii, If Medico legal: Yes No iv, Reported to police Yes No		
	onsumption, Test conducted to establish this: Yes No (If Yes, attach reports) iii. If Medico legal: Yes No iv. Reported to police Yes No	1	
ii) If injury due to substance abuse / alcohol o	onsumption, Test conducted to establish this: Yes No (If Yes, attach reports) iii. If Medico legal: Yes No iv. Reported to police Yes No vi. If not reported to police give reason:)	
	vi. If not reported to police give reason:	-	
v. FIR No CLAIM DOCUMENTS SUBMITTED Claim Form duty signed	vi. If not reported to police give reason: - CHECK LIST Investigation reports	-	
v. FIR No	- CHECK LIST Investigation reports CT/MR/USG/HPE investigation reports		
v. FIR No CLAIM DOCUMENTS SUBMITTED Claim Form duty signed	- CHECK LIST Investigation reports CT/MR/USG/HPE investigation reports Doctor's reference slip for investigation		
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v. FIR No. CLAIM DOCUMENTS SUBMITTED Claim Form duty signed Original Pre-authorization request Copy of the Pre-authorization appre Copy of Photo ID Card of patient Ve Hospital Discharge summary Operation Theatre Notes	- CHECK LIST Investigation reports CT/MR/USG/IPPE investigation reports Doctor's reference slip for investigation eports ECG Pharmacy bills MLC reports & Police FIR	SECTION	
v. FIR No. CLAIM DOCUMENTS SUBMITTED Claim Form duty signed Original Pre-authorization request Copy of the Pre-authorization appre Copy of Photo ID Card of patient Ve Hospital Discharge summary Operation Theatre Notes Hospital main bill	CHECK LIST Investigation reports CT/MR/USG/HPE investigation reports Octor's reference slip for investigation ECG Pharmacy bills MLC reports & Police FIR Original death summary from hospital where applicable] -	
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Registered and corporate office :Health Insurance TPA of India Ltd.,2nd Floor, Majestic Omnia Building, A-110, Sector 4 Noida, Uttar Pradesh - 201301.

CONSENT FORM

From:
Patient's Name and address:
Policy no:
Hospital IPD no:
То:
Hospital Name:
Madam/Sir,
I hereby authorize TPA representatives/Investigator free and unlimited access to seek medical information (Indoor case papers, reports, documents, including photocopies thereof pertaining my admission / treatment) from any hospital / medical practitioner from which or whom I have at any time sought or shall seek medical attention concerning any disease/ sickness, ailment or injury, which affects my physical or mental health.
Yours faithfully
Signature of the Patient/Insured