

# HDFC ERGO General Insurance Company Limited

## CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT



### CLAIM FORM – PART A

To be filled in by the Insured

The issue of this form is not to be taken as an admission of liability

(To be filled in block letters)

#### SECTION A – DETAILS OF PRIMARY INSURED

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

c) Company/ TPA ID No.:

d) Name:  SURNAME  FIRST NAME  MIDDLE NAME

e) Address:

City:  State:

Pin Code:  Phone No.:  Email ID:

#### SECTION B- DETAILS OF INSURANCE HISTORY

a) Currently covered by any other mediclaim health insurance:  Yes  No b) Date of commencement of first insurance without break:  DD  MM  YYYY

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:  MM  YY

Diagnosis:  e) Previously covered by any other Mediclaim/Health insurance:  Yes  No

f) If Yes, Company Name:

#### SECTION C- DETAILS OF INSURED PERSON HOSPITALISED

a) Name:  SURNAME  FIRST NAME  MIDDLE NAME

b) Relationship to primary Insured: Self  Spouse  Child  Father  Mother  Other  Please Specify:

c) Date of Birth:  DD  MM  YYYY d) Age:  YY  MM

e) Address (if different from above)

f) Gender: Male  Female

g) Occupation: Service  Self employed  Homemaker  Student  Retired  Other  Please Specify:

City:  State:  Pin Code:

h) Phone No.:  i) Mobile No.:  j) Email ID:

#### SECTION D- DETAILS OF HOSPITALIZATION

a) Name of the Hospital where admitted:

b) Room Category occupied: Daycare  Single Occupancy  Twin Sharing  3 or more beds per room

c) Hospitalisation due to: Illness  Injury  Maternity  d) Date of Injury/ Date of disease first detected/ Date of delivery:  DD  MM  YYYY

e) Date of admission:  DD  MM  YYYY f) Time:  HH  :  MM g) Date of discharge:  DD  MM  YYYY h) Time:  HH  :  MM

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:  Allopathic/ Other systems of medicine

#### SECTION E- DETAILS OF CLAIM

a) Details of the treatment expenses claimed		<b>Claim Documents Submitted- Check List:</b> <input type="checkbox"/> Duly filled and signed Claim Form <input type="checkbox"/> Copy of intimation letter, if any <input type="checkbox"/> Hospital Main Bill <input type="checkbox"/> Hospital Break Up bill <input type="checkbox"/> Hospital Bill Payment Receipt <input type="checkbox"/> Hospital Discharge Summary <input type="checkbox"/> Pharmacy Bill <input type="checkbox"/> Operation Theater Notes <input type="checkbox"/> ECG <input type="checkbox"/> Doctor's Request for Investigation <input type="checkbox"/> Doctor's Prescription <input type="checkbox"/> Investigation Reports ( Including CT, MRI/USG/HPE) <input type="checkbox"/> Others		
i) Pre-Hospitalization Expenses	Rs. <input type="text"/>		ii) Hospitalization Expenses	Rs. <input type="text"/>
iii) Post-Hospitalization Expenses	Rs. <input type="text"/>		iv) Health-Check up Cost	Rs. <input type="text"/>
v) Ambulance Charges	Rs. <input type="text"/>		vi) Others (code)	Rs. <input type="text"/>
			<b>Total</b>	Rs. <input type="text"/>
vii) Pre-Hospitalization Period	Days <input type="text"/>		viii) Post -Hospitalization Period	Days <input type="text"/>
b) Claim for Domiciliary Hospitalization: <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, please provide details in annexure)				
c) Details of Lumpsum/ cash benefit claimed:				
i) Hospital Daily Cash	Rs. <input type="text"/>		ii) Surgical Cash	Rs. <input type="text"/>
iii) Critical Illness Benefit	Rs. <input type="text"/>		iv) Convalescence	Rs. <input type="text"/>
v) Pre/Post hospitalization Lump sum benefit	Rs. <input type="text"/>	vi) Others	Rs. <input type="text"/>	
		<b>Total</b>	Rs. <input type="text"/>	

#### SECTION – F DETAILS OF BILLS ENCLOSED

Sr. No.	Bill No.	Date	Issued By	Towards	Amount (Rs)
1.		<input type="text"/> DD <input type="text"/> MM <input type="text"/> YY			
2.		<input type="text"/> DD <input type="text"/> MM <input type="text"/> YY			
3.		<input type="text"/> DD <input type="text"/> MM <input type="text"/> YY			
4.		<input type="text"/> DD <input type="text"/> MM <input type="text"/> YY			



**GUIDANCE FOR FILLING CLAIM FORM – PART A (To be filled in by the insured)****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:yy format), place (open text) and sign.

# HDFC ERGO General Insurance Company Limited



## CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT

### 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)

#### SECTION A – DETAILS OF HOSPITAL

a) Name of the Hospital where treated:

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:

#### SECTION B – DETAILS OF PATIENT ADMITTED

a) Name of the patient:  SURNAME  FIRST NAME  MIDDLE NAME

b) IP Registration Number:  c) Gender: Male  Female  d) Age: YY MM e) Date of Birth: DD MM YYYY

f) Date of admission: DD MM YYYY g) Time: HH:MM h) Date of discharge: DD MM YYYY i) Time: HH:MM

j) Type of Admission: Emergency  Planned  Daycare  Maternity  k) If Maternity: i) Date of Delivery DD MM YYYY ii) Gravida Status

l) Status at time of discharge: Discharged to Home  Discharged to another Hospital  Deceased  Total Claimed Amount

#### SECTION C – DETAILS OF AILMENTS DIAGNISED (PRIMARY)

a) ICD 10 Codes	Description	b) ICD 10 PCS	Description
Primary Diagnosis <input type="text"/>	<input type="text"/>	Procedure 1 <input type="text"/>	<input type="text"/>
Additional Diagnosis <input type="text"/>	<input type="text"/>	Procedure 2 <input type="text"/>	<input type="text"/>
Co-morbidities <input type="text"/>	<input type="text"/>	Procedure 3 <input type="text"/>	<input type="text"/>
Co-morbidities <input type="text"/>	<input type="text"/>	Details of Procedure: <input type="text"/>	

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: 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  No (If yes, attach reports)

iii) Medico Legal: Yes  No  iv) Reported to Police : Yes  No  v) FIR No:

vi) If not reported to Police give reasons :

#### SECTION D – CLAIM DOCUMENTS SUBMITTED – CHECKLIST

<input type="checkbox"/> Claim form duly filled and signed	<input type="checkbox"/> Investigation reports
<input type="checkbox"/> Original Pre authorization Request	<input type="checkbox"/> CT/MRI/USG/HPE investigation Report
<input type="checkbox"/> Copy of Pre-authorization approval Letter	<input type="checkbox"/> Doctor's reference slip for Investigation
<input type="checkbox"/> Copy of photo ID card of patient verified by Hospital	<input type="checkbox"/> ECG
<input type="checkbox"/> Hospital Discharge Summary	<input type="checkbox"/> Pharmacy Bills
<input type="checkbox"/> Operation Theatre Notes	<input type="checkbox"/> MLC Report & Police FIR
<input type="checkbox"/> Hospital Main Bill	<input type="checkbox"/> Original death summary from hospital where applicable
<input type="checkbox"/> Hospital break up Bill	<input type="checkbox"/> Any other, PI specify

#### SECTION E – DETAILS IN CASE OF NON NETWORK HOSPITAL

a) Address of the Hospital:

City:  State:

Pin Code:  b) Phone No.:  c) Registration no with State Code:

d) Hospital PAN:  e) No. of In-patient Beds:  f) Facilities available in Hospital: i) OT: Yes  No  ii) ICU: Yes  No

iii) Others:

#### SECTION F – DECLARATION BY HOSPITAL

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: DD MM YYYY Place:  Signature and seal of the Hospital Authority

**GUIDANCE FOR FILLING CLAIM FORM – PART B (To be filled in by the hospital)**

DATA ELEMENT	DESCRIPTION	FORMAT
<b>SECTION A - DETAILS OF HOSPITAL</b>		
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 qualifications of the treating doctor	Abbreviations of educational qualifications
f) 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
g) Phone No.	Enter the phone number of doctor	Include STD code with telephone number
<b>SECTION B - DETAILS OF THE PATIENT ADMITTED</b>		
a) Name of Patient	Enter the name of hospital	Name of hospital in full
b) IP Registration Number	Enter insurance provider registration number	As allotted 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 Admission	Enter date of admission	Use dd-mm-yy format
f) Time	Enter time of admission	Use hh:mm format
g) Date of Discharge	Enter date of discharge	Use dd-mm-yy format
h) Time	Enter time of discharge	Use hh:mm format
i) Type of Admission	Indicate type of admission of patient	Tick the right option
j) If Maternity		
Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format
Gravida Status	Enter Gravida status if maternity	Use standard format
k) Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
<b>SECTION C – DETAILS OF AILMENT DIAGNOSED (PRIMARY)</b>		
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 the first 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 the third procedure	Standard Format and Open text
Details of Procedure	Enter the details of the procedure	Open text
c) Present Ailment is a Complication of PED	Indicate whether present ailment is a complication of some pre- existing disease	Tick Yes or No
d) Pre-authorization obtained	Indicate whether pre-authorization obtained	Tick Yes or No
e) Pre-authorization Number	Enter pre-authorization number	As allotted by TPA
f) If authorization by network hospital not obtained, give reason	Enter reason for not obtaining pre-authorization number	Open text
g) 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
<b>SECTION D – CLAIM DOCUMENTS SUBMITTED-CHECK LIST</b>		
Indicate which supporting documents are submitted		
<b>SECTION E – ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL</b>		
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.	Enter the registration number of patient	As allocated by the Hospital
d) PAN	Enter the permanent account number	As allotted 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
<b>SECTION F - DECLARATION BY THE INSURED</b>		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.		
<b>SECTION G - DECLARATION BY THE HOSPITAL</b>		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign and stamp.		

**CHECK LIST OF ENCLOSURES FOR SUBMISSION OF CLAIM****Note:**

1. When original bills, receipts, prescriptions, reports and other documents are submitted to the other insurer or to the reimbursement provider, verified photocopies attested by such other organisation/ provider have to be submitted.
2. If original bills, receipts, prescriptions, reports and other documents are submitted to Us and Insured Person requires same for claiming from other organisation/ provider, then on request from the Insured Person We will provide attested copies of the bills and other documents submitted by the Insured Person.

**In-patient Treatment /Day Care Procedures**

- Duly filled and signed Claim Form.
- Photocopy of ID card / Photocopy of current year policy.
- Original Detailed Discharge Summary with date of admission & discharge, clinical history, past history / procedure details/ Day care summary from the hospital.
- Original consolidated hospital bill with break up of each Item, duly signed by the insured.
- Original payment Receipt of the hospital bill.
- First Consultation letter and subsequent Prescriptions.
- Original bills, original payment receipts and Reports for investigation.
- Original medicine bills and receipts with corresponding Prescriptions.
- Original invoice/Sticker of implants/bills for Implants (viz. Stent /PHS Mesh/ IOL etc.) with original payment receipts

**Road Traffic Accident**

In addition to the In-patient Treatment documents:

- Copy of the First Information Report from Police Department / Copy of the Medico-Legal Certificate.

In Non Medico legal cases

- Treating Doctor's Certificate giving details of injuries (How, when and where injury sustained)

In Accidental Death cases

- Copy of Post Mortem Report & Death Certificate (If conducted)

**For Death Cases**

In addition to the In-patient Treatment documents:

- Original Death Summary from the hospital.
- Copy of the Death certificate from treating doctor or the hospital authority.
- Copy of the Legal heir certificate, if the claim is for the death of the principle insured.

**Pre and Post-Hospitalization expenses**

- Duly filled and signed Claim Form.
- Photocopy of ID card / Photocopy of current year policy.
- Original Medicine bills, original payment receipt with prescriptions.
- Original Investigations bills, original payment receipt with prescriptions and report.
- Original Consultation bills, original payment receipt with prescription.
- Copy of the Discharge Summary of the main claim.

**Organ Donation/Transplantation**

In addition to the documents of general hospitalization

- Organ Function test / blood test proving organ failure.
- Treatment Certificate issued by the Transplant Surgeon of the hospital concerned.

**Ambulance Benefit**

- Duly filled and signed Claim Form.
- Photocopy of ID card / Photocopy of current year policy.
- Original Bill with Original Payment Receipt.
- Treating Doctor's consultation prescription indicating Emergency Hospitalization.

**CUSTOMER IDENTIFICATION PROCEDURE (AS PER KYC NORMS OF IRDA)**

Please submit the following documents in case of claim amount exceeds Rs. 100,000

Legal name and any other names used (Any one of the mentioned documents)	Passport/ PAN Card/ Voter's Identity Card/ Driving License/ Letter from a recognized public authority or public servant verifying the identity and residence of the customer
Proof of Residence (Any one of the mentioned documents)	Telephone bill/ Bank account statement/ Letter from any recognized public authority/ Electricity bill/ Ration card