# Easy Health
## Claim Form

ApolloMunich HEALTH INSURANCE

10th Floor, Building No. 10, Tower B, DLF City Phase II, DLF Cyber City, Gurgaon-122002

## 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 preauthorisation request form in lieu of PART A

1. Name of the Hospital where treated : ____________________
2. Hospital ID : ____________________ 3. Type of Hospital : Network ☐ / Non-Network ☐
4. In case of non network , please provide below details :
   a) Address of the Hospital with Pin Code : ____________________
   ____________________
   b) Telephone No : ____________________ c) Registration No : ____________________
   d) Number of Inpatient beds : ____________________ e) PAN : ____________________
   f) Other Facilities available in the hospital :
   i) OT : Yes ☐ / No ☐ ii) ICU : Yes ☐ / No ☐ iii) Others : ____________________
5. Details of the patient admitted :
   a) Name of the patient : ____________________
   b) IP Registration Number : ____________________ c) Gender: Male ☐ / Female ☐ d) Age : ____________________
   e) Date of Admission (DD/MM/YYYY) : ____________________ f) Time of Admission : ____________________
   g) Date of Discharge (DD/MM/YYYY) : ____________________ h) Time of Discharge : ____________________
6. Ailment Diagnosed (Primary) : ____________________
   a) ICD 10 Code :
   Primary Diagnosis : ____________________
   Additional Diagnosis : ____________________
   Co-morbidities : ____________________
   b) Details of Procedure/s done : ____________________
   ____________________
   c) ICD 10 PCS :
   Procedure 1 : ____________________
   Procedure 2 : ____________________
   Procedure 3 : ____________________
7. a) Type of Admission : Emergency ☐ / Planned ☐ / Day-care ☐ / Maternity ☐
   b) Date of delivery, if maternity (DD/MM/YYYY) : ____________________ c) Gravida Status : ____________________
8. Is the treatment for an injury? If Yes, give details ____________________
   a) Was it self inflicted? : Yes ☐ / No ☐ b) Whether RTA : Yes ☐ / No ☐
   c) If MLC, whether notified to police : Yes ☐ / No ☐ d) MLC / FIR No : ____________________
   e) If MLC not notified, give reasons : ____________________
9. Was the Injury/ disease caused due to Substance abuse / Alcohol consumption : Yes ☐ / No ☐
   a) If Yes, whether any test was conducted to establish this? : Yes ☐ / No ☐ If Yes, please attach Report.
10. Whether the present ailment is a complication of any illness suffered in the past : Yes ☐ / No ☐
    If Yes, specify details : ____________________
11. Whether Pre-authorisation obtained : Yes ☐ / No ☐
    a) If Yes, Pre Auth Number : ____________________
    b) If authorisation by network hospital not obtained, give reason : ____________________
    ____________________
12. Details of the Treating Doctor :
    a) Name of the Treating Doctor: ____________________
    b) Registration No with state code : ____________________
    c) Mobile No. : ____________________ d) Qualification : ____________________
13. For details of Claim Documents to be submitted, please refer CHECK LIST.

**DECLARATION BY THE INSURED**

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, my right to claim reimbursement shall be forfeited.
I also consent & authorise TPA / Insurance Company., to seek necessary medical information / documents from any hospital / Medical Practitioner/ Insurer 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 – hospitalisation claim, if any.

**DECLARATION BY THE 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.

Signature of the Insured : ____________________ Seal & Signature of the Hospital Authority : ____________________

Date : ____________________ Date : ____________________