

# National Insurance Company Limited Regd. Office 3, Middleton Street, Post Box 9229, Kolkata 700 071

National Mediclaim Policy
PLEASE FAX / SCAN PAGE 1 ONLY
REQUEST FOR CASHLESS HOSPITALISATION FOR MEDICLAIM INSURANCE POLICY

(To be filled in block letters)

DETAILS OF THE THIRD PARTY	ADMINISTRATOR			
a) Name of TPA / Insurance Compa	any:			
b) Toll free phone number: c) Toll free Fax:				
		TO BE FILLED BY THE INSU	RED / PATIENT	
a) Name of the patient:	1 2 3 4 5 6 7 8	9 10 11 12 13 14 15 16 17 18	19 20 21 22 23 24 25	26 27 28 29 30 31 32 33 34 35 36 37
b) Gender :	1 2 3 4 5 6 7 8 Male Female	c) Age: years months	d) Date of Birth:	26 27 28 29 30 31 32 33 34 35 36 37
e) Contact number:		f) le	nsured card ID number:	
g) Policy number / Name of corpora	ate:			h) Employee ID:
i) Currently do you have any other	Mediclaim / Helath Insurance:	Yes No Company Na	me:	
Give details:				
j) Do you have a family physician?	Yes No	k) Name of the family physician:		
I) Contact number, if any:				ASE COMPLETE DECLARATION ON THE REVERSE SIDE OF THIS FOR
		TO BE FILLED BY THE TREATING		
a) Name of the treating doctor:			b) Co	ontact number:
<ul> <li>c) Nature of illness/ disease</li> <li>with presenting complaints</li> </ul>			d) Relevant clinical findins:	
e) Duration of the present ailment:	Days i. Date of firs	st consultation:	ii. Past history of present ailment, if any	
f) Provisional diagnosis:			i. ICD 10 Code	
g) Proposed line of treatment:	Medical Management Su	rgical Management Intensive Care	Investigation	Non allopathis Treatment
h) If investigation & / or Medical Management, provide details		i.	Route of drug administration:	
i) If Surgical, name of surgery:			i. ICD 10 PCS Code	
,g,g,.				
j) If other treatments, provide details			k) How did the injury occur?	
I) In case of accident:	i. Is it RTA?	ii. Date of injury:	iii. Reported to Po	olice: Yes No iv. FIR No.:
v. Injury / Disease caused due to s	ubstance abuse / alcohol consumption:	Yes No vi. Test conducted to	o extablish this?	No (If yes attach reports)
m) In case of maternity:	GPL	A Date of Delivery:		
Details of the patient admitted			Mandatory : Past history of any of	chronic illness If Yes, since (month / year)
a) Date of admission:		b) Time: :	Diabetes	
c) Is this an emergency / a planned	I hospitalization event? Emergent	cy Planned	Heart Disease	
d) Expected no. of days in hospital	: Days	e) Room Type:	Hypertension	
f) Per Day Room Rent + Nursing &	Service Charges + Patient's Diet:	₹	Hyperlipidemia	
g) Expected cost of investigation +	diagnostics:	₹	Osteoarthritis	
h) ICU Charges:		₹	Asthma / COPD /	Bronchitis
i) OT Charges:		₹	Cancer	
j) Professional fees Surgeon + Ane	sthetist Fees + consultation charges:	₹	Alcohol or drug at	buse
k) Medicines + Consumables + Cos specify), other hospital expens		₹	Any HIV or STD /	
I) All inclusive package charges, if	any applicable:	₹	Any other Ailme	nt, give details:
m) Sum Total, expected cost of h	ospitalization:	₹		
		DECLARATION		(PLEASE READ VERY CAREFULL
We confirm having read, understoo	d and agreed to the Declaration on the reverse of this form			
a) Name of the treating doctor:				
b) Qualification:	c	) Registration No. with state code:		
			Γ	
Hospital Seal (must contain hospital	al ID)		Patient / Insured Name & Signature	(IMPORTANT: PLEASE TURN OVE



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PAGE 2: NOT TO BE FAXED/SCANNED

### DECLARATION BY THE PATIENT / REPRESENTATIVE

- 1. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Insurer/T.P.A after the discharge. I agree to sign on the Final Bill & the Discharge Summary, before my discharge.
- 2. Payment to hospital is governed by the terms and conditions of the policy. In case the Insurer / TPA is not liable to settle the hospital bill, I undertake to settle the bill as per the terms and conditions of the policy.
- 3. All non-medical expenses and expenses and expenses not relevant to current hospitalization and the amounts over & above the limit authorized by the InsurerT.P.A not governed by the terms and conditions of the policy will be paid by me. In case any clarification is needed on admissibility of a particular item I shall contact T.P.A at the Tol Free Number on the reverse of this form.
- 4. I hereby declare to abide by the terms and conditions of the policy and if at any time the facts disclosed by me are found to be false or incorrect I forleit my claim and agree to indemnify the Insurer / T.P.A.
- 5.1 agree and understand that T.P.A is in no way warranting the service of the hospital & that the Insurer / TPA is in no way guaranteeing that the services provided by the hospital will be of a particular quality or standard.
- 6.1 hereby warrant the truth of the forgoing particulars in every respect and I agree that If I have made or shall make any false or untrue statement, suppression or concealment, my right to daim reimbursement of the said expenses shall be absolutely forfeited. I further declare that, in respect of the above treatment, no herefits are admissible under any other Medical Scheme or Insurance
- 7. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer / TPA.

a) Patient's / Insured's Name:		
b) Contact number:	d) Patient's / Insured's Signature:	
HOSPITAL DECLARATION		
1. We have no objection to any author	uthorized TPA / Insurance Company official verifying documents pertaining to hospitalization.	
2. All valid original documents duly co	y countersigned by the insured / patient as per the checklist below will be sent to TPA / Insurance Company within 7 days of the patient's discharge.	
3. All non medical expenses , OR exp	expenses not relevant to hospitalization or illness, OR expenses disallowed in the Authorization Letter of the TPA / Insurance Co, OR arising out of incorrect information in the pre-authorisation form will be collected from the	patient.
4. WE AGREE THAT TPA / INSURA	RANCE COMPANY WILL NOT BE LIABLE TO MAKE THE PAYMENT IN THE EVENT OF ANY DISCREPANCY BETWEEN THE FACTS IN THIS FORM AND DISCHARGE SUMMARY or other documents.	
5. The patient declaration has been s	en signed by the patient or by his representative in our presence.	
6. We agree to provide clarifications to	ns for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications.	
7. We will abide by the terms and cor	conditions agreed in the MOU.	
Hospital Seal	Doctor's Signature	

## DOCUMENTS TO BE PROVIDED BY THE HOSPITAL IN SUPPORT OF THE CLAIM

- Detailed Discharge Summary and all Bills from the hospital
- 2. Cash Memos from the Hospitals / Chemists supported by proper prescription.
- 3. Receipts and Pathological Test Reports from Pathologists, supported by note from the attending Medical Practitioner / Surgeon recommending such pathological Tests.
- 4. Surgeon's Certificate stating nature of operation performed and Surgeon's Bill and Receipt.
- 5. Certificates from attending Medical Practitioner / Surgeon that the patient is fully cured.



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National Mediclaim Policy
CLAIM FORM - PART A
TO BE FILLED IN BY THE INSURED
The issue of theis form is not to be taken as admission of liability

DETAILS OF PRIMARY INSURED																					
a) Policy no:							П	b) S	I. No/ Certific	cate No:				1							_
c) Company/ TPA ID No:							1 1	i ''										1			
d) Name:						<u> </u>		1 1		1 1	П			1	П		Т	1	П		
e) Address:							1 1	1 1	<del>   </del>	1 1	<del>† †</del>	+	<del>   </del>	+		+	+			+	$\vdash$
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DETAILS OF INSURANCE HISTORY			Priorie No.				1_1_	1		EIIIali ID											
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a) Currently covered by any other Mediclaim/ Hea	alth Insurance:		Yes	No				ement of firs	t insurance v	without break	-	_	$\vdash$	4	$\sqcup$	4				_	
c) If yes, company name:						_	licy No:				<u> </u>	_				<u></u>					į
Sum Insured (₹):			d) H	lave you bee	en hospitaliz	ed in the la	st four years	since incept	on of the co		Yes	No		Date:	Ш					_	I <sub>No</sub>
Diagnosis:							_			e) Previou:	sly covere	d by any	other Med	iclaim/ He	ealth Insu	rance :			Ye	es	No c
f) If yes, Company Name :																					
DETAILS OF INSURED PERSON HOSPITALIZE	ED																				
a) Name :																					
b) Gender : Male Fe	emale d	) Date of Birth:					e) S	um insured:	₹					i) (	CB (if any	)					
f) Relatuionship to Primary Insured:	Self	Spouse		Child	Father		Mothe		Other	(Pleas	e specify)										
g) Occupation: Service	Self Employ	ed H	lomemaker		Student	Ħ	Retired	i i i	Other	(Pleas	e specify)	F									-
h) Address (if different from above):		$\pm$				$\exists$	T	一	一		T T	÷	П			T					
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a) Name of Hospital where Admitted:	ــــــــــــــــــــــــــــــــــــــ	$\dashv$	لللل		_			$\dashv$		<u> </u>			井			L_					ш
b) Room category occupied:	Day Ca	=		occupancy	Ш		Twin sharing				ore beds		屵	_		_	_				
c) Hospitalization due to: Injury	Illne	ss	Maternity				d) Da			first detected	# Date of	Delivery:	ᄔ	4_			$\vdash$		l _		]
e) Date of Admission:	ш		f) Time	9:	:		J	g) Date of	-	$\sqsubseteq$	J L		J L	<u> </u>	h)	Time:			: L		ةِ ا
i) If injury, give cause: Self inflicted			fic Accident			Su	bstance abu	se / Alcohol (	Consumption	· 🔲		i. If Me	dico Legal		Yes	No					
ii. Reported to police:	No	iii. MLC	Report & Poli	ce FIR attac	ched:	Yes	No	j) S	ystem of me	dicine:											
DETAILS OF CLAIM																					
a) Details of treatment expenses claimed														Clain	n Docum	ents S	ubmitted	I- Chec	ck List:		
i. Pre Hospitalization Expenses	₹				ii. Pr	e hospitaliz	ation period:		days		П				Claim F	omDul	y signed				
i.Room, boarding, nursing expenses	d	ays @ ₹		per da	By	Limit of 1%	of SI per da	y, max ₹5,0		eximum limit	of 25% of	SI for an	v one	F	Copy of	the cla	im intima	ition, if	any		
ii. ICU, boarding, nursing expenses	==	ays @ ₹		per da				y, max ₹10,		on many	illness	01 101 011	, 0.10		Hospita				•		
i. Medical practitioner's fees		-,- @ -						f SI for any o						Ħ	Hospita						
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	GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled in by the insured)							
DATA ELEMENT	DESCRIPTION	FORMAT						
	SECTION A - DETAILS OF PRIMARY INSURED	•						
a) Policy No.	Enter the policy number	As allotted by the insurance company						
b) SI. No/ Certificate No.	Enter the social insurance number or the certificate number of social health insurance scheme	As allotted by the organization						
c) Company TPA ID No.	Enter the TPA ID No	License number as allotted by IRDA and printed in TPA documents.						
d) Name	Enter the full name of the policyholder	Surname, First name, Middle name						
e) Address	Enter the full postal address	Include Street, City and Pin Code						
	SECTION B - DETAILS OF INSURANCE HISTORY	•						
a) Currently covered by any other Mediclaim / Health Insurance?	Indicate whether currently covered by another Mediclaim / Health Insurance	Tick Yes or No						
b) Date of Commencement of first Insurance without break	Enter the date of commencement of first insurance	Use dd-mm-yy format						
c) Company Name	Enter the full name of the insurance company	Name of the organization in full						
Policy No.	Enter the policy number	As allotted by the insurance company						
Sum Insured	Enter the total sum insured as per the policy	In rupees						
d) Have you been Hospitalized in the last 4 years since inception of the contract?	Indicate whether hospitalized in the last 4 years	Tick Yes or No						
Date	Enter the date of hospitalization	Use mm-yy format						
Diagnosis	Enter the diagnosis details	Open Text						
e) Previously Covered by any other Mediclaim/ Health Insurance?	Indicate whether previously covered by another Mediclaim / Health Insurance	Tick Yes or No						
f) Company Name	Enter the full name of the insurance company	Name of the organization in full						
	SECTION C - DETAILS OF INSURED PERSON HOSPITALIZED							
a) Name	Enter the full name of the patient	Surname, First name, Middle name						
b) Gender	Indicate Gender of the patient	Tick Male or Female						
c) Age	Enter age of the patient	Number of years and months						
d) Date of Birth	Enter Date of Birth of patient	Use dd-mm-yy format						
e) Relationship to primary Insured	Indicate relationship of patient with policyholder	Tick the right option. If others, please specify.						
f) Occupation	Indicate occupation of patient	Tick the right option. If others, please specify.						
g) Address	Enter the full postal address	Include Street, City and Pin Code						
h) Phone No	Enter the phone number of patient	Include STD code with telephone number						
i) E-mail ID	Enter e-mail address of patient	Complete e-mail address						
, =	SECTION D - DETAILS OF HOSPITALIZATION	Complete e-mail address						
a) Name of Hospital where admitted	Enter the name of hospital	Name of hospital in full						
b) Room category occupied	Indicate the room category occupied	Tick the right option						
c) Hospitalization due to	Indicate reason of hospitalization	Tick the right option						
d) Date of Injury/Date Disease first detected/ Date of Delivery	Enter the relevant date	Use dd-mm-yy format						
e) Date of admission	Enter the relevant date  Enter date of admission	Use dd-mm-yy format						
f) Time	Enter date of admission  Enter time of admission	Use hh:mm format						
g) Date of discharge	Enter time of admission  Enter date of discharge	Use dd-mm-yy format						
h) Time								
i) If Injury give cause	Enter time of discharge	Use hh:mm format						
If Medico legal	Indicate cause of injury	Tick the right option						
Reported to Police	Indicate whether injury is medico legal	Tick Yes or No Tick Yes or No						
MLC Report & Police FIR attached	Indicate whether police report was filed							
i) System of Medicine	Indicate whether MLC report and Police FIR attached	Tick Yes or No						
) System of Medicine	Enter the system of medicine followed in treating the patient	Open Text						
a) Details of Treatment Expenses	SECTION E - DETAILS OF CLAIM	In any control of the						
	Enter the amount claimed as treatment expenses	In rupees (Do not enter paise values)						
b) Claim for Domiciliary Hospitalization	Indicate whether claim is for domiciliary hospitalization	Tick Yes or No						
c) Details of Lump sum/ cash benefit claimed d) Claim Documents Submitted-Check List	Enter the amount claimed as lump sum/ cash benefit	In rupees (Do not enter paise values)						
d) Claim Documents Submitted-Check List	Indicate which supporting documents are submitted	Tick the right option						
	SECTION F - DETAILS OF BILLS ENCLOSED							
Indicate which hills are analoged with the age:								
Indicate which bills are enclosed with the amounts in rupees								
·	SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT							
a) PAN	Enter the permanent account number	As allotted by the Income Tax department						
a) PAN b) Account Number	Enter the permanent account number Enter the bank account number	As allotted by the bank						
Indicate which bills are enclosed with the amounts in rupees a) PAN b) Account Number c) Bank Name and Branch	Enter the permanent account number  Enter the bank account number  Enter the bank name along with the branch	As allotted by the bank Name of the Bank in full						
a) PAN b) Account Number c) Bank Name and Branch d) Cheque/ DD payable details	Enter the permanent account number Enter the bank account number Enter the bank name along with the branch Enter the name of the beneficiary the cheque/ DD should be made out to	As allotted by the bank Name of the Bank in full Name of the individual/ organization in full						
a) PAN b) Account Number c) Bank Name and Branch	Enter the permanent account number  Enter the bank account number  Enter the bank name along with the branch	As allotted by the bank Name of the Bank in full						



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## National Mediclaim Policy CLAIM FORM - PART B

TO BE FILLED IN BY THE HOSPITAL

The issue of theis form is not to be taken as 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:																																$\perp$				
c) Hospital ID:										c) '	Туре о	f Hosp	ital:			Ne	etwork		Non N	etwork							(if no	on net	work, f	fill Sect	tion E	)				
d) Name of the treating doctor	or:																															$\mathbb{L}$				
e) Qualification:							Ī		f) F	Registra	ation N	o. with	state	code:									g)	Phon	e No.					T	Τ	T	Т	T		
DETAILS OF PATIENT ADM	IITTED																																			
a) Name of Patient:	TT			T																										T	T	T		T		
b) IP Registration No.:		TT		T				c) Ge	ender :		Male		F	emale			d) A	ge: ye	ears		mo	onths			e) Da	te of B	irth:			T	Ī		Ī	ī		
f) Date of Admission:		T	Ħ	一			i	g) Tir	ne:			:	Ė		Ī		h) Date	of Dis	scharge:			l İ			i			1		i) Tin	ne:	F	Ť	i :		
j) Type of Admission: Eme	ergency	ĪTĪ	Planne	d	ī	Day	y Care		Mat	temity		ĺ		k) l	f Mat	ernity:	i.	Date o	f Delivery:			ĺ			ĺ			Ī		ii. Gr	avida	Status	s:			
I) Status at time of discharge:		Discharge	ed to hor	me	Ī		Disch	arged t	to ano	ther ho	spital		1	Dec	ease	d _	1									n) Tota	al clair	ned ar	nount		Τ	Τ	T	Ī	F	
DETAILS OF AILMENT DIAG								-					•				<b>_</b>													-						
a)		ICD '	10 Code	es						Desc	ription					b)						ICE	10 P	cs							-	Descrip	otion			
i. Primary Diagnosis :		ТТ	<del>- 1</del>	$\neg$	1	1									1		. Proced	ure 1 :									1									
, ,																																				
ii. Additional Diagnosis :																i	i. Proced	ure 2	:								Ī									
iii. Co-morbidities :																i	ii. Proce	dure 3	:																$\equiv$	
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iv. Co-morbidities :	Ш	Ш		L_											4	i	v. Detail:	of Pro	ocedure :																	
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c) Pre authorization obtained								Yes		No			a) I	Pre-aut	noriz	ation nu	mber:			<u> </u>								<u> </u>	<u> </u>	<u></u>						
e) If authorization by network	· ·					. ,,	<u> </u>					0 1/:	0. 1	_	1		1.T. (f)		—	1											=	_			—	
f) Hospitalization due to injury	_	Yes	No.					cause	•			Self in		'⊢	<u> </u>		ad Traffic		-	1			. 1	Sui		e abus		conoi c			<u></u>		_	٦.,	_	l.
ii. If injurydue to Substance al	buse / alcono	consum	iption, 1	est Con	auctea	to esta	adiish t	nis:				<u> </u>	Yes	Ŀ	No	_	(if yes, a	tacn re	eports)	III.	If Medi	co Leg	aı:		Yes		No		IV. I	Report	ea to	Police	_	Yes	<u> </u>	No
v. FIR No.  CLAIM DOCUMENTS SUBM	UTTED OUE	CKLICT					1		VI.	. If not	reporte	ea to p	olice,	give re	eason																				—	
		CKLIST															1 .														_				—	_
Claim Form																	=	-	tion report																	
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	Pre-authoriza															<u> </u>	=		referance s	siip																
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	charge summa	ary															=	armac																		
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Hospital mai																	2	-	death sumi	-	om hos	pital, w	here a	ipplica	able											
Hospital brea	ak-up bill																An	y othe	r, please s	pecify																
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d) Hospital PAN		Ш		<u>Ш</u>					]	e) l	Numbe	r of inp	oatier	nt beds	<u>L</u>				f) Facilities	availa	ble in t	he hos	pital:		i. OT:		Yes	<u></u>	No			ii. ICU	<u>:                                    </u>	Yes	<u> </u>	No
iii. Others:																																				
DECLARATION BY THE HO	SPITAL																															(Pleas	e read	very c	arefull	y)
We hereby declare that to forfeited.	he information	ı fumishe	ed in this	s Claim F	Form is	s true &	correc	ct to the	e best	of our	knowle	edge a	nd be	elief. If v	we ha	ive mad	e any fa	se or u	untrue stat	ement,	suppre	ess or (	concea	ilmen	t of an	u mate	rial fa	ct, our	right t	o claim	ı unde	er this	claim sł	nall be		
Date:		] [																																		
Place:		_					]												Signa	ture of	the ins	ured:														i



# National Insurance Company Limited Regd. Office 3, Middleton Street, Post Box 9229, Kolkata 700 071

DATA ELEMENT	DESCRIPTION	FORMAT							
	SECTION A - DETAILS OF HOSPITAL	•							
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 nospital	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							
	SECTION B – DETAILS OF THE PATIENT ADMITTED	·							
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	M STATE OF THE STA	₩ ********							
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							
<u> </u>	SECTION C - DETAILS OF AILMENT DIAGNOSED (PRIMARY)	1							
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	Enter the 105 TO Gode and description of the co-morbidities	Standard Format and Open text							
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) Pre-authorization obtained		Tick Yes or No							
d) Pre-authorization Number	Indicate whether pre-authorization obtained	As allotted by TPA							
e) If authorization by network hospital not obtained, give reason	Enter pre-authorization number	Open text							
f) Hospitalization due to injury	Enter reason for not obtaining pre-authorization number								
Cause	Indicate if hospitalization is due to injury	Tick Yes or No Tick the right option							
If injury due to substance abuse/alcohol consumption, test conducted to establish this	Indicate cause of injury	Tick Yes or No							
Medico Legal	Indicate whether test conducted	Tick Yes or No							
Reported To Police	Indicate whether injury is medico legal								
FIR No.	Indicate whether police report was filed	Tick Yes or 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  SECTION D – CLAIM DOCUMENTS SUBMITTED-CHECK LIST	Open Text							
Indicate which connecting decompants are submitted	SECTION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST								
Indicate which supporting documents are submitted	CECTION E DETAILS IN CASE OF NON NETWORK HOSDIT!								
a) Address	SECTION E - DETAILS IN CASE OF NON NETWORK HOSPITAL	1, 1, 1, 0, 1, 0, 1, 10, 0, 1							
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 allocated by the Medical Council of India							
d) Hospital PAN	Enter the permanent account number	As allotted by the Income Tax department							
e) Number of Inpatient Beds f) Facilities available in the hospital	Enter the number of inpatient beds	Digits							
	Indicate facilities available in the hospital	Tick the right option. If others, please specify							