Group MediPrime

Claim Form

TATA AIG INSURANCE
WITH YOU ALWAYS

PART A
TO BE FILLED IN BY THE INSURED
The issue of this Form is not to be taken as an admission of liability

SECTION A – DETAILS OF PRIMARY INSURED

a) Policy No | b) Sl. No/ Certificate No:
c) Company / TPA ID No
d) Name
e) Address
Phone no | Code | Mobile
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 D D M M Y Y Y Y
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 D D M M Y Y Y Y
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
b) Relationship (Self/spouse/Child/Father/Mother/Other)
c) Date of Birth D D M M Y Y Y Y | d) Age ☐☐☐ mths/yrs
e) Address (If different than above
Phone no | Code | Mobile
Email ID
f) Gender ☐ Male ☐ Female | g) Occupation Service/Self employed/Homemaker/Student/Retired/Others
h)Telephone | i) Mobile No
j) E-mail ID, if

SECTION D - DETAILS OF HOSPITALISATION

a) Name of the Hospital where admitted
b) Room Category occupied — Daycare/Single Occupancy/Twin Sharing/ 3 or more beds per room
c) Hospitallisation due to — Illness / Injury / Maternity
d) Date of Injury/ Date of disease first detected/ Date of delivery — D D M M Y Y Y Y
e) Date of admission — D D M M Y Y Y Y
f) Time — H H M M
g) Date of discharge — D D M M Y Y Y Y
h) Time — H H M M
i) If injury, give cause — Self Inflicted/Road Traffic Accident/Substance Abuse/Alcohol Consumption
ii) 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

i) Pre-hospitalisation Expenses Rs. _____ ii) Hospitalisation Expenses Rs. _____

iii) Post-hospitalisation Expenses Rs. _____ iv) Health-Check up Cost Rs. _____

v) Ambulance Charges Rs. _____ vi) Others (code) Rs _____

_____ Total Rs. _____

vii) Pre-hospitalisation Period Days _____ viii) Post -hospitalisation Period _____

a) Claim for Domiciliary Hospitalization _____ ☐ YES ☐ NO (if yes, please provide details i9n annexure)

b) Details of Lumpsum / cash benefit claimed: _____

i) Hospital Daily Cash Rs. _____ ii) Surgical Cash Rs. _____

iii) Critical Illness Benefit Rs. _____ iv) Convalescence Rs. _____

v) Pre/Post hospitalisation lumpsum benefit: Rs. _____ vi) Others _____ Rs. _____

Claim Documents Submitted - Check List:

- Duly filled and signed Claim Form
- Copy of intimation letter, if any
- Hospital Main Bill
- Hospital Break Up bill
- Hospital Bill Payment Receipt
- Hospital Discharge Summary
- Pharmacy Bill
- Operation Threater Notes
- ECG
- Doctor's Request for Investigation
- Investigation Reports (Including CT, MRI/USG/HPE)
- Doctor's Prescription.
- Others _____

SECTION – F DETAILS OF BILLS ENCLOSED

Sno	Bill No	Date	Issued By	Towards	Amount (Rs)
		D D M M Y Y Y Y			
		D D M M Y Y Y Y			
		D D M M Y Y Y Y			
		D D M M Y Y Y Y			
		D D M M Y Y Y Y			
		D D M M Y Y Y Y			
		D D M M Y Y Y Y			
		D D M M Y Y Y Y			
		D D M M Y Y Y Y			
		D D M M Y Y Y Y			
		D D M M Y Y Y Y			

SECTION – G DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

a) PAN _____ b) Account Number _____

c) Bank Name/ Branch _____ d) Payable details: Cheque/ DD _____

e) IFSC Code _____ e) *please attach a cancelled cheque pertaining to the same

f) MICR No _____ *please attach a cancelled cheque pertaining to the same

Note:

It is agreed that the Policyholder/Claimant will intimate in writing to Tata-AIG General Insurance Co. Ltd. about any change in bank account details. In an event Insured person bears expenses for treatment please provide account details of Insured Persons in the above format along with proof of incurring such expenses.

SECTION H – 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 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 D D M M Y Y Y Y Place _____

_____
Signature of Insured

GUIDANCE FOR FILLING CLAIM FORM – PART A (To be filled in by the insured)		
DATA ELEMENT	**DESCRIPTION**	**FORMAT**
SECTION A - DETAILS OF PRMARY 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	As allotted by the organizationcertificate number of social health insurance scheme
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	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		
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 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) If Injury give cause	Indicate cause of injury	Tick the right option
If 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
MLC Report & Police FIR attached	Indicate whether MLC report and Police FIR attached	Tick Yes or No
j) System of Medicine	Enter the system of medicine followed in treating the patient	Open Text
SECTION E - DETAILS OF CLIAM		
a) Details of Treatment Expenses	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	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 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
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.		

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

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 form section E)

d) Name of the treating Doctor

e) Qualification | f) Registration No with state Code

g) Phone No:

SECTION B – DETAILS OF PATIENT ADMITTED

a) Name of the patient

b) IP Registration Number

c) Gender ☐ Male ☐ Female | d) Age (Y Y M M) | e)Date of Birth (D D M M Y Y Y Y)

f) Date of Admission (D D M M Y Y Y Y) | g) Time of Admission (H H M M)

h) Date of Discharge (D D M M Y Y Y Y) | i) Time of Discharge (H H M M)

j) Type of Admission Emergency/Planned/Daycare/Maternity | k) If Maternity

i) Date of Delivery (D D M M Y Y Y Y) | ii) Gravida Status

l) Status at time of discharge Discharged to Home, Discharged to another Hospital, Deceased | Total Claimed Amount Rs (H H M M)

SECTION C – DETAILS OF AILMENTS DIAGNISED (PRIMARY)

a) ICD 10 Code | Primary Diagnosis | Additional Diagnosis | Co-morbidities

Details of Procedure/s done

b) ICD 10 PCS | Procedure 1 | Procedure 2 | Procedure 3

d) Pre-authorization obtained ☐ Y ☐ N | e) Pre-authorization No

f) If authorization by network hospital not obtained, give reason

g) Hospitalisation due to Injury ☐ Y ☐ N | i) If yes, give cause

Self inflicted? ☐ Y ☐ N | Road Traffic Accident ☐ Y ☐ N

Substance Abuse / Alcohol Consumption ☐ Y ☐ N

ii) If Injury due to Substance abuse / alcohol consumption, Test Conducted to establish this: ☐ Y ☐ N

(If yes, attach reports ☐ Y ☐ N | v) FIR No

iii) Medico Legal ☐ Y ☐ N | vi) If not reported to Policy give reasons

iv) Reported to Policy ☐ Y ☐ N

SECTION D – CLAIM DOCUMENTS SUBMITTED - CHECKLIST

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

SECTION E –ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL

a) Address of the Hospital

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 ☐ Y ☐ N | ii) ICU ☐ Y ☐ N

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 D D M M Y Y Y Y

Place_____

_____

Signature and seal of the Hospital Authority

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

DATA	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 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
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		
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
SECTION C - DETAILS OF AILMENT DIAGNOSED (PRIMARY)		
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	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
SECTION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST		
Indicate which supporting documents are submitted		
SECTION E - DETAILS IN CASE OF NON NETWORK HOSPITAL		
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 specify
SECTION F - DECLARATION BY THE INSURED		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.		
SECTION G - DECLARATION BY THE HOSPITAL		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign and stamp		

PART C

(To be filled ONLY for re-imbursement under wellness benefit of Product Name policy)

SECTION A – DETAILS OF PRIMARY INSURED

Policy No

Member ID Company/ TPA ID No

Name

Address

Telephone No Mobile

Email ID

Policyholder's Bank Account particulars

Policyholders PAN Account Number

Payable details: Cheque/ DD/NEFT* Payable to

Bank Name/ Branch

IFSC Code MICR No

*please attach a cancelled cheque pertaining to the same

Note:

It is agreed that the Policyholder/Claimant will intimate in writing to Tata-AIG General Insurance Co. Ltd. about any change in bank account details.

Sl. No.	Bill No.	Date	Issued by	Towards	Amount
Total					

DECLARATION BY THE INSURED

- I confirm that the expenses for which claim is being lodged have been incurred in respect of the insured.
- 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 for this policy year.

Date: _____

_____

Signature of the Policyholder

CHECK LIST OF ENCLOSURES FOR SUBMISSION OF CLAIM

- Duly filled and signed Re-imbursement Form.
- Original payment Receipt of the hospital bill.

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-hospitalisation 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

For more information; Email us at customersupport@tata-aig.com or visit www.tataaiginsurance.in
Contact us on our 24 hour Toll Free Helpline at 1800 266 7780 or 1800 22 9966
(only for senior citizen policy holders) Insurance is the subject matter of the solicitation

Tata AIG General Insurance Company Limited

Registered Office: Peninsula Business Park, Tower A, 15th Floor, G.K. Marg, Lower Parel, Mumbai – 400013
24X7 Toll Free No: 1800 266 7780 or 1800 22 9966 (For Senior Citizens) Fax: 022 6693 8170 Email: customersupport@tata-aig.com
Website: www.tataaiginsurance.in IRDA of India Registration No: 108 CIN:U85110MH2000PLC128425