HEALTH INSURANCE TPA OF INDIA LTD

CLAIM FORM - PART A TO 'CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL & PERSONAL ACCIDENT

TO BE FILLED BY THE INSURED

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

DETAILS OF PRIMARY INSURED:

A) PolicyNo. **0210002820P100798818** b) Sl.No./Certificate No. **MD-15-0014222008**

c) Company TPA/ID No.

d) Name

e) Address:

City	**MUMBAI**		**State**		
Pin Code		**Phone N o**			**Email id**

DETAILS OF INSURANCE HISTORY:

a) Currently covered by any other Mediclaim/Health Insurance yes **No**

c) If yes,company name Policy no.

Sum insured d) Have you been hospitalised in the last four years since inception of the contract? YES NO DATE 12/19

Diagnosis: e) Previously covered by ay other Mediclaim/Health Insurance

f) If yes,company name

DETAILS OF INSURED PERSON HOSPITALISED

a) Name

b) Gender Male **FEMALE** **c) Age Yrs** **month** d) date of birth

e) Relationship to primary insured: self spouse father Mother other Please specify:

f) Occupation **Service** SelfEmployed Home maker student Retired other Please specify:

g) Address(if different from above) :

SAME S AS ABOVE					
City			State		
Pin Code		Phone N o			Email id

DETAILS OF HOSPITALIZATION:

a) Name of Hospital where admitted

b) Room Category occupied Day care Single Occupancy **Twin sharing** 3 or more beds per room

c) Hospitalization due to : injury illness d) date of injury/date disease first detected/date of delivery 08.04.2020

e) Date of admission f)time g) date of discharge

i) If injury give cause: self inflicted road traffic accident substance/alcohol consumption i) If Medico legal YES/NO

j) system of medicine

ii) Reported to Police iii) MLC Report & Police FIR attached yes no ALLOPATHY

DETAILS OF CLAIM:

a) Details of the treatment expenses claimed

i) Pre-hospitalisation ii) Hospitalisation expenes

iii) Post-hospitalisation iv) Health Checkup cost 0

v) Ambulance charges **0** vi) others(code) 0

total **0**

vii) Pre-Hospitalisation period **days** viii) Post hospitalisation period days

b) Claim for Domiciliary Hospitalisation yes no (if yes provide details in annexure)

c) Details of Lump sum/cash benefit claimed

i) Hospital daily cash Rs. ii) Surgical cash Rs.

iii) Critical illness benefit Rs. iv) Convalasence : Rs.

v) Pre/Post hospitalisation lump sum beneit Rs. vi) others(code) Rs.

Claim documents submitted - Check list

claim form duly signed

copy of the claim intimation if any

Hospital Main Bill

Hospital breakup Bill

Hospital Bill payment receipt

Hospital discharge summary

Pharmacy bill

Operation Theatre Notes

ECG

Doctors request for investigation

Investigation Reports (inluding CT/MRI/USG/HPE)

Doctors prescription

Others

HEALTH INSURANCE TPA OF INDIA LTD

DETAILS OF BILLS ENCLOSED

Sl.No	Bill No	Date	Issued By	Towards		Amount	RS.
1				Hospital Main bill			
2				Pre-hospitalisation bills Nos			
3				Post-hospitalisation bills Nos			
4				Pharmacy Bills		3 nos	
5							
6							
7							
8							
9							
10							0

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT:

a)	PAN		b) Account Number			
c)	Bank Name and Branch					
d)	Cheque/DD Payable details		IFSC Code			

DECLARATION BY THE INSURED

I hereby declare that the information furnished in the 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 in questions asked in relation to the claim. my right to claim reimbursement shall be forfeited. I also consent and authorise 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 fo the purpose of this claim and that I will not be making any supplementary claim except the pre/post hospitalisation claim if any.

Date Place: **Mumbai** Signature of the Insured