DHS
An ISO 9001 : 2008 Certified TPA

EMP No. :

CLAIM FORM FOR HEALTH INSURANCE POLICIES – PART A

Name of Insurance Company: United India Insurance Co. Ltd Client Name: BANK OF INDIA

Type of Claim : ☐ Mediclaim / ☐ Domiciliary
Zone :

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)

DETAILS OF PRIMARY INSURED

a) Policy No.		b) Sl. No./Certificate	
c) Company/TPA ID No.			
d) Name			
e) Address			
City			
State		Pin Code	
Ph. No.		Email ID	

DETAILS OF INSURANCE HISTORY

a) Currently covered by any other Mediclaim/Health Insurance				Yes ☐	No ☐
b) If yes, Company Name					
Policy No.		Sum Insured (`)			
c) Date of commencement of first Insurance without break	DD / MM / YYYY	(Copies of Policies to be attached)			
d) Have you been hospitalized in the last 4 years? (since inception of the contract)	Yes ☐	No ☐	Date DD / MM / YYYY		
	Diagnosis				
e) Have you been covered by any other Mediclaim/Health Insurance in last 4 years				Yes ☐	No ☐
f) If yes, Company Name					

DETAILS OF INSURED PERSON HOSPITALIZED / DOMICILIARY

a) Name									
b) Gender	Male ☐	Female ☐	c) Age	years	months	d) Date of Birth	DD / MM / YYYY		
e) Relationship to Primary insured	Self ☐	Spouse ☐	Child ☐	Father ☐	Mother ☐	Other ☐	(Please Specify)		
f) Occupation	Service ☐	Self Employee ☐	Homemaker ☐	Student ☐	Retired ☐	Other ☐	(Please Specify)		
Address (if different from above)									
City									
State		Pin Code							
Ph. No.		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 ☐	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									
k) Date of Surgery	DD / MM / YYYY	l) Claim Intimated	Yes ☐	No ☐					
i. Intimated to whom	SBU ☐	Intermediaries ☐	Call Centre ☐	Health Claims Team ☐					
ii. Intimation No. & date		DD / MM / YYYY							
iii. If not Intimated, reason?									

DETAILS OF CLAIM

a) Details of the treatment expenses claimed

i. Pre-hospitalization Expenses	`	ii. Hospitalization Expenses	`
iii. Post-hospitalization expenses	`	iv. Health-Check up Cost	`
v. Ambulance Charges	`	vi. Others (code)	`
vii. Pre-hospitalization period	days	**Total**	`
		viii. Post hospitalization period	days
b) Claim for Domiciliary Hospitalization	Yes / No	(If yes, provide details in annexure)	

c) Details of Lump sum/cash benefit claimed

i. Hospital Daily Cash	`	ii. Surgical Cash	`
iii. Critical Illness Benefit	`	iv. Convalescence	`
v. Pre/Post hospitalization Lump sum benefit	`	vi. Others	`
		Total	`

Claim Documents Submitted - Check List		Operation Theatre Notes	
Claim Form Duly signed		ECG	
Copy of the claim intimation		Doctor's request for investigation	
Hospital Main Bill		Investigation Reports (CT/MRI/USG/HPE)	
Hospital Break - up Bill		Doctor's Prescriptions	
Hospital Bill Payment Receipt		Pre-Hosp. Bills	
Hospital Discharge Summary		Post-Hosp. Bills	
Pharmacy Bill		Others	

DETAILS OF BILLS ENCLOSED

Sl. No.	Bill No.	Date	Issued by	Towards (Hospitalization / Pre-hospitalization/ Post-hospitalization / Domiciliary Ailment	Amount (`)
1		DD / MM / YYYY			
2		DD / MM / YYYY			
3		DD / MM / YYYY			
4		DD / MM / YYYY			
5		DD / MM / YYYY			
6		DD / MM / YYYY			
7		DD / MM / YYYY			
8		DD / MM / YYYY			
9		DD / MM / YYYY			
10		DD / MM / YYYY			

Do you want to opt for Automatic Reinstatement of Sum Insured in the event of a claim? If, Yes, applicable premium at short period rates would be deducted from the claim amount due to you. This reinstated sum will not be available for the same hospitalization. It will be available for treatment (other than certain chronic diseases) including the same illness or disease but separate independent case of hospitalization which are not case of relapse within 45 days of first hospitalization. Please contact the agent/our office for further details: Yes / No

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT (Please submit a cancelled cheque copy for NEFT)

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

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.

Place:_____ Date: DD/MM/YYYY Signature of the Insured

Important:

1. Please submit copy of valid Photo ID.
2. For claimed amount above 1 lac, it is mandatory to submit the KYC (Know your customer) form.

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
(To be filled in block letters)

Please include the original preauthorization request form in lieu of PART A

DETAILS OF HOSPITAL

a)	Name of the Hospital						
b)	Hospital ID		c) Type of Hospital	Network		Non Network	(If non network fill section E)
d)	Name of the treating doctor						
e)	Qualification		f) Registration No. with State Code		g) Ph No.		

DETAILS OF THE PATIENT ADMITTED

a)	Name of the Patient								
b)	IP Registration Number		c) Gender	Male		Female		d) Age	Years / Months
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		Day Care		Maternity	
k)	If Maternity	i. Date of Delivery	DD / MM / YYYY	ii. Gravida Status					
l)	Status at time of discharge	Discharge to home		Discharge to another hospital		Deceased			
m)	Total Claimed Amount	`							

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a)		ICD 10 Codes	Description
	i. Primary Diagnosis		
	ii. Additional Diagnosis		
	iii. Co-morbidities		
	iv. Co-morbidities		
b)		ICD 10 Codes	Description
	i. Procedure 1		
	ii. Procedure 2		
	iii. Procedure 3		
	iv. Details of Procedure		

c)	Present ailment is a complication of PED?	Yes		No		(If Yes, specify details)						
d)	Pre-authorization obtained	Yes		No								
e)	Pre-authorization Number											
f)	If authorization by network hospital not obtained, give reason											
g)	Hospitalization due to Injury	Yes		No		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		(If Yes, attach reports)				
	iii. If Medico legal	Yes		No		iv. Reported to Police	Yes		No		v. FIR No.	
	vi. If not reported to police give reason											

CLAIM DOCUMENTS SUBMITTED - CHECK LIST					
Claim Form duly signed		Operation Theatre notes		Doctor's reference slip for investigation	
Original Pre-authorization request		Hospital main bill		ECG	
Copy of the Pre-authorization approval letter		Hospital break-up bill		Pharmacy bills	
Copy of photo ID card of patient verified by hospital		Investigation reports		MLC report & Police FIR	
Hospital Discharge summary		CT/MR/USG/HPE investigation reports		Original death summary from hospital where applicable	
Any other, please specify					

ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL (Only fill in case of non-network hospital)						
a)	Address of the Hospital					
	City					
	State		Pin Code			
b)	Phone No.	c) Registration No.				
	Date of Registration DD / MM / YYYY	Expiry date of Registration	DD / MM / YYYY			
	Name of the Registering Authority					
d)	PAN	e) Number of Inpatient beds				
f)	Facilities available in the hospital	i. OT	Yes	No	ii. ICU	Yes / No
	iii. Others					

DECLARATION BY THE HOSPITAL (PLEASE READ VERY CAREFULLY)

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. The signature of the insured is taken on this form after Claim Form B is fully filled up by us.

Hospital have required infrastructure to fulfill the hospital definition as per IRDA guideline, which is reproduced below:

- Has at least 10 inpatient beds, in those towns having a population of less than 10,00,000 and 15 inpatient beds in all other places
- Has fully qualified nursing staff under its employment round the clock
- Has fully qualified doctor(s) in charge round the clock
- Has a fully equipped operation theatre of its own where surgical procedures are carried out.
- Maintains daily Medical records of patients and will make these accessible to the Company's authorized personnel.

Place: _____ **Date:** DD/MM/YYYY **Signature of Insured/Claimant** **Signature and Seal of the Hospital Authority**