## Sample Claim form-Reimbursement

Caringly years  DEALAL Allianz (1)  Health Card Number: 00-4  Customer ID: XXXXXXXX  Policy No: 00-0000-000  Inception Date: 00/00/00  Valid Up to: 00/00/0000  Member Name: ABC	0000000-00   ited.
HEALTH & WELLNES	Enter your Policy Number ACCIDENT - PAR LA
	The issue of this for admission of liability  DETAILS OF PRIMARY INSURED
Enter Health ID card Number of Policy Holder	a) Policy No:
	e) Company Name: g) Name: h) Address: As On Policy Documents  Your employee code no Applicable only For Corporate Customers
٨	City: Pin Code: Pin Code: DETAILS OF INSURANCE HISTORY
In case you have another health insurance	a) Currently covered by any other Mediclaim / Health Insurance Yes No b) date of commencement of first insurance without break Policy No:  C) If yes, company name: Policy No:  Sum Insured (Rs.):  Diagnosis  A Date: DDM MYYYYY  B  B  B  COMMENT  B
<b>V</b>	e) Previously covered by any other Mediclaim / Health Insurance: Yes Mentioned Name of the Member Hospitalized  DETAILS OF INSURED PERSON HOSPITALIZED
Mentioned Health ID card number of Hospitalized Member	a) Name of the Patient:
	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
Type of hospitalization Details	c) Hospitalisation due to: Injury Illness Maternity d) Date of Injury/Date Disease first detected/Date of Delivery: DDDMMYYYYY e) Date of admission DDDMMYYYYYY f) Time HH: MM g) Date of Discharge DDMMYYYYYY l) Name of treating doctor Diagnosis
If it was a medico legal case.	i) If injury give cause: Self inflicted Road Traffic Accident Substance Abuse /Alcohol Consumption   ii) Reported to police: Yes No No No Note Pix attached: Yes No No Note Pix attached: Yes No No Note Pix attached: Yes Note Pix attached:

## Sample Claim form-Reimbursement

a) Details of the treatment expenses claims  L. Pre-Hospitalisation Expenses: ii. Pres-Hospitalisation Expenses: iii. Pres-Hospitalisation Expenses: v. Ambulance Charges: v. Convolets: v. Ambulance Charges: v. Convolets: v. Ambulance Charges:		DETAILS OF CLAIM		Expenses incurred be after Hospitaliza		Total hospitalizatio n bill
in case medical treatment taken at home  In case medical treatment taken at home  In case you have benefit based plan  In case you have benefit will consider the previous days and the previous days are provided details in annexure)  In case you have benefit based plan  In case you have benefit will consider the previous days are provided details in annexure)  In case you have benefit will consider the previous days are provided details in annexure)  In case you have benefit will consider the previous days are provided details in annexure)  In case you have benefit will consider the previous days are provided details in annexure)  In case you have benefit will consider the previous days are provided details in annexure)  In case you have benefit will consider the previous days are provided details in annexure)  In case you have benefit will consider the previous days are provided details in annexure)  In case you have benefit will consider the previous days are provided details in annexure)  In case you have benefit will consider the previous days are provided details in annexure)  In case you have benefit will previous days are provided details in annexure)  In case you have benefit will previous details in annexure will be previous days are provided details in annexure will be previous days are previous days.  In case you have benefit will previous days are previous days are previous days are previous days.  In case you have benefit annexure will be previous days are previous days.  In case you have benefit annexure will be previous days are previous days.  In case you have benefit annexure will be previous days are previous days.  In case you have benefit annexure will be previous days.  In case you have benefit annexure will be previous days.  In case you ha			rlaimed			
iii. Post-Hospitalisation Expenses:  N. Ambulance Charges:  N. Ambul		and the second s		I I I I ii. Hospitz	alication Expenses Rs.	/, , , , , , , , ,
In case medical treatment taken at home  b) Claim for Domiciliary Hospitalisation: Yes No (If yes, provide details in annexure)  c) Details of Lump sum / cash benefit claimed:  i. Hospitalisation period: days   viii. Post Hospitalisation period: viii. Post Hospitalisation period: viii. Post Hospitalisation period: viii. Po						
In case would have benefit based plan  In case you have benefit based plan  Claim Documents Submitted - Check List  Claim Form Duly Signed  Copy of claim intrimation if any  Original Hospital Breakup Bill  Operation Theater Notes  Coperation Theater Notes  Coperation Theater Notes  Coperation Theater Notes  Conciled blank cheque leaf with payee name printed. If name of the payee is not printed on the cheque leaf p pase attach copy of the first page of the bank passbook.  DETAILS OF BILLS ENCLOSED  Service Bill No  Date  Date  Towards  Amount (Rs)  Pry important  Total  Rs.  List of documents to be attached with this claim form  Cancelled blank cheque leaf with payee name printed. If name of the payee is not printed on the cheque leaf p pase attach copy of the first page of the bank passbook.  DETAILS OF BILLS ENCLOSED  Service Bill No  Date  The Pre-Hospitalisation Bills  Amount (Rs)  Pry important  Total  Rs.  List of documents to be attached with this claim form  Cancelled blank cheque leaf with payee name printed. If name of the payee is not printed on the cheque leaf p passe attach copy of the first page of the bank passbook.  DETAILS OF BILLS ENCLOSED  Service Bill No  Date  The Pre-Hospitalisation Bills  Nos  Bill No  Date  The Pre-Hospitalisation Bills  Nos  Bill No  Date  The Pre-Hospitalisation Bills  Nos  Bill No  Date  Date  The Pre-Hospitalisation Bills  Nos  Bill No  Date  The Pre-Hospitalisation Bills  Nos  Bill No  Date  D			1 1 1 1	<del>† † † †</del>		
in case you have benefit based plan  Claim for Domicliany Hospitalisation: Yes No (If yes, provide details in annexure)  O petails of Lump sum / cash benefit claimed:  Li Hospital Dally Cash  iii. Critical il iness Benefit  v. Pre/Post hospitalisation Rs. Iii. Surgical Cash  Rs. Iii. Surgical Cash  Rs. Iii. Surgical Cash  Rs. Iii. Critical il iness Benefit  v. Pre/Post hospitalisation  Rs. Iii. Critical il iness Benefit  v. Pre/Post hospitalisation  Rs. Iii. Critical il iness Benefit  v. Pre/Post hospitalisation  Claim Form Duly Signed  Original Hospital Birk Augustian  Original Hospital Birk Augustian  Original Hospital Birk Payment Receipt  Original Doctor's Presor for  Original Doctor's Presor for  Cancelled blank cheque leaf with payee name printed. If name of the payee is not printed on the cheque leaf pase of the bank passbook.  DETAILS OF BILLS ENCLOSED  Scho Bill No Date  Scho Bill No Date  Scho Bill No Date  Date Issued by Towards  Date Issued by Towards  Date Issued by Towards  Date Issued Birk Account Holder (As per Bank Account)  DETAILS OF PRIMARY INSURED'S BANK ACCOUNT  And All Y Y  DETAILS OF PRIMARY INSURED'S BANK ACCOUNT  Details Insured by Date Issued by Towards  Date Insurance In		v. Ambulance charges.	N3.		` '	
In case you have benefit based plan    Comparison   Compa		vii Pro Hospitalisation periods	dave			SEC.
In case you have benefit based plan    Comparison   Compa						TION
i. Hospital Daily Cash	de nome			(II yes, provide details in a	nnexure)	m
iii. Critical illness Benefit				ii Surgice	al Cash De	<b>.</b>
Amount (Rs)    Claim Documents Submitted - Check List   Claim Form Duly Signed   Copy of claim intimation if any   Original Hospital Main I   Claim Form Duly Signed   Copy of claim intimation if any   Original Hospital Main I   Claim Form Duly Signed   Original Hospital Breakup Bill   Original Hospital Dischor to the attached with this claim form   Cancelled blank cheque leaf with payee name printed. If name of the payee is not printed on the cheque leaf p asse attach copy of the first page of the bank passbook.    DETAILS OF BILLS ENCLOSED   Sr.No   Bill No   Date   I   Date   Date	In case you		1 1 1 1	1 1 1		
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## Sample Claim form-Reimbursement

BAJAJ Allianz (ii) Bajaj Allianz General Insurance Company Limited. Regd. & Head Office: GE Plaza, Airport Road, Yerawada, Pune 411 006 Email id: customercare@bajajallianz.co.in, Toll free no. 1800-209-5858, 020-30305858 **CLAIM FORM- PART B** TO BE FILLED IN BY THE HOSPITAL The issue of this 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:\_ \_\_\_c) Type of hospital : Network 🔲 Non-Network 🔲 (If non-network fill section E) b) Hospital ID:\_ d) Name of treating doctor:\_ f) Registration No with State Code\_\_ \_\_ g) Phone No: e) Qualification: **DETAILS OF THE PATIENT ADMITTED** a) Name of the patient: \_c) Gender: Male 🗌 Female 🗌 d) Age : Years | | Months: | | e) Date of birth: | D | D | M | M | Y | Y | b) IP registration Number:\_ f) Date of admission: DDDMMMYY g) Time: HHHMM h) Date of discharge: | D | D | M | M | Y | Y | i) Time: j) Type of Admission : Emergency 🔲 Planned 问 Day Care 🦳 Maternity 🦳 k) If Maternity 📑 i) Date of delivery 🔼 🕞 🗎 M M M Y Y 🗡 ii) Cravida Status: 📗 1) Status at time of discharge: Discharge to home Discharge to another hospital Deceased: m) Total claimed Amount: **DETAILS OF AILMENT DIAGNOSED (PRIMARY)** ICD 10 PCS Description a) i) Primary Diagnosis: i) Procedure 1: ii) Additional Diagnosis: ii) Procedure 2: iii) Co-morbidities: iv) Details of Procedure: iv) Co-morbidities: d) Pre-Authorization Obtained: Yes No e) Pre-Authorization Number: f) If authorization by network hospital no 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) Medico Legal: Yes 🔲 No 🔀 iv)Reported to Police: Yes No v) FIR no: \_\_\_\_\_vi) if not reported to police give reason: \_ **CLAIM DOCUMENTS - CHECK LIST**  Claim form duly signed Ingestion reports Original Pre-Authorization request CT/MR/USG/HPE investigation report Copy of Pre-Authorization letter Doctor's reference slip for investigation ECG Copy of photo ID card of patient verified by hospital Hospital discharge summary Pharmacy bills MLC report & Police FIR Operation theatre notes Hospital main bill Original death summary from hospital where applicable Hospital break up bill ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON NETWORK HOSPITAL) a) Address of hospital\_ Pin Code: \_ Phone No: City: c) Registration no with State Code: State: d) Hospital PAN: \_e) Number of Inpatient beds: | | Facilities available in hospital: i) OT: Yes No iii) Others: \_ DECLARATION BY THE HOSPITAL: (PLEASE READ VERY CAREFULLY) We hereby declare that the information furnished in the Claim Form is true and correct to the best of our knowledge and belief. If we have made any false and untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited. SECTION F Date: DDMMYY Signature and Seal of the Hospital Authority

To be filled by the hospital in Concern