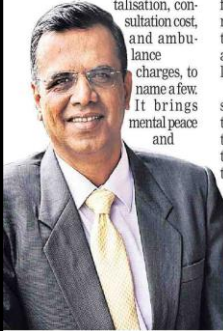


Measures to avoid rejection of health insurance claims

Health insurance provides financial support to the policyholders by covering the medical expenses, cost of hospitalisation, consultation cost, and ambulance charges, to name a few. It brings mental peace and



safety to the insured. However, there are times a health claim gets rejected and it often leads to confusion and bitterness. There are a few basic reasons why the claim might be rejected, and it is essential to know them so that one can avoid the mistakes which might lead to the rejection of the claim.

Policy tenure: Most health insurance plans are time-bound contracts that require annual renewal to keep the policy operational. At times, policyholders do not realise that their contract has expired and discover this only when their claims get rejected, and this comes as a big shock to many. Please note, that if the policy

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has expired then the insurance company is not liable to pay the claim. To avoid such unpleasant experiences, it is crucial that one keeps a close track of the policy renewals to ensure that one is covered through and through. In case you have missed the policy renewal, you need not panic, most insurers offer a 15 days grace period, during which you can renew the policy without losing the benefits acquired during the policy term. However, any claim which falls during the break-in period will not be entertained by the insurer.

Non-disclosure of a pre-existing disease or other material information: It is important to disclose the pre-existing ailments or conditions that the insured has like blood pressure, cardiovascular conditions, hypertension, etc. If one has undergone any major sur-

gery previously, one must disclose that as well. It is also important to disclose any new medical condition or ailment that one might have acquired during the year, at the time of insurance renewal. In a health insurance policy, it is of utmost importance to share the details related to the health with the insurer to avoid hassles during the time of claim. Certain pre-existing diseases have permanent exclusions or may materially impact the decision of accepting the proposal, and thus it is important to disclose these details.

Waiting period: The waiting period in health insurance refers to the pre-defined time period in the policy during which the claim cannot be raised for the mentioned ailment or condition. The waiting period commences with the start of the policy and varies from in-

surer to insurer and ailment to ailment. The policyholder has to serve the waiting period before the insurer becomes liable to pay for the mentioned ailment. If a claim is made during the waiting period, then the same will get rejected.

If the ailment is not covered by the policy: All the insurance policies explicitly mention the list of coverages and exclusions, and if the policyholder raises the claim against an ailment that is specifically part of the exclusion lists, then the claim will get rejected.

Exceeding the time limit for raising the claim: The insurance policies mention a stipulated timeline within which the policyholder should raise the claim, usually the policy allows a 60-90 days period from the date of the discharge to file the claim. The failure to adhere to the mentioned timeline might lead

to claim rejection; it is smart to file the claim soon after the discharge. Insurer may admit the claim for genuine reason of delay in submission of claim.

Lack of documentation or incorrect document: At times the claims, specially reimbursement claims get rejected due to missing or incorrect documents; the policyholder must submit all the original documents, test reports, doctor consultation letters, and other documents along with the duly filled claim form to avoid any issue.

To ensure a smooth claim settlement, it is also highly recommended that you pick a preferred network hospital for treatment, as you can avail cashless facilities, can get better rates, waiver on certain charges and benefits of other non-insurance items in these hospitals.