

## REIMBURSEMENT CLAIM FORM

TO BE FILLED BY THE INSURED
The issue of this Form is not to be taken as an admission of liablity

(To be Filled in block letters)

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) Claim for Domiciliary Hos					Ye	S	No	(If ye	es, p	rovid	e de	etails	in an	nexur	e)												L		Pharr Opera		•		00			
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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
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:											
b) Hospital ID: c) Type of Hosp	ital: Network Non Network (If non network fill section E)										
d) Name of the treating doctor: $\begin{tabular}{ l l l l l l l l l l l l l l l l l l l$	T NAME MIDDLE NAME										
e) Qualification: f) Registration No. with State Code:	g) Phone No.										
DETAILS OF THE PATIENT ADMITTED											
a) Name of the Patient:	T NAME MIDDLE NAME										
b) IP Registration Number: C) Gender: Male Female	d) Age: Years Y Y Months M M e) Date of birth: D D M M Y Y Y										
f) Date of Admission:	h) Date of Discharge: DD MM YY i ) Time: HH: MM										
j) Type of Admission: Emergency Planned Day Care Maternity k)	h) Date of Discharge: DD MM YY i) Time: HHH: MM  If Maternity i. Date of Delivery: DD MM YY ii. Gravida Status:										
I) Status at time of discharge: Discharge to home Discharge to another hospital Dece	ased m) Total claimed amount										
DETAILS OF AILMENT DIAGNOSED (PRIMARY)											
a) ICD 10 Codes   Description	b) ICD 10 PCS Description										
i. Primary Diagnosis:	i. Procedure 1:										
ii. Additional Diagnosis:	ii. Procedure 2:										
iii. Co-morbidities:	iii. Procedure 3:										
iv. Co-morbidities:	iv. Details of Procedure										
_											
d) Pre-authorization obtained: Yes No e) Pre-authoriz	zation Number:										
f) If authorization by network hospital not obtained, give reason:											
	David Truffin Assistant Current opening Alashel accommentary										
g) Hospitalization due to Injury: Yes No i. If Yes, give cause Self-inflicted											
ii. If Injury due to Substance abuse / alcohol consumption, Test Conducted to establish this: Yes											
v. FIR no vi. If not reported to police give rea	son:										
CLAIM DOCUMENTS SUBMITTED - CHECK LIST											
Claim Form duly signed	☐ Investigation reports										
Original Pre-authorization request	CT/MR/USG/HPE investigation reports										
Copy of the Pre-authorization approval letter  Copy of photo ID card of patient verified by hospital	☐ Doctor's reference slip for investigation ☐ ECG										
Hospital Discharge summary	Pharmacy bills										
Operation Theatre notes	□ Doctor's reference slip for investigation □ ECG □ Pharmacy bills □ MLC report & Police FIR										
Hospital main bill	Original death summary from hospital where applicable										
Hospital break-up bill	Any other, please specify										
ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-N	FTWORK HOSPITAL)										
a) Address of the Hospital:											
City:	State:										
Pin Code: b)Phone No. b)Phone No.	State: C) Registration No. with State Code: No ii. ICU: Yes No										
d) Hospital PAN: e) Number of Inpatient bed	s f) Facilities available in the hospital: i. OT : Yes No ii. ICU : Yes No										
iii. Others :											
DECLARATION BY THE HOSPITAL	(PLEASE READ VERY CAREFULLY)										
	whether and helief. 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.											
	WHC I CO										
Date: D D M M Y Y	Ž										
Place: Signature and Seal	of the Hospital Authority:										