



**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 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) Phone 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:

f) Date of Admission:  g) Time:  h) Date of Discharge:  i) Time:

j) Type of Admission: Emergency  Planned  Day Care  Maternity  k) If Maternity i. Date of Delivery:  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	b)	ICD 10 PCS	Description
i. Primary Diagnosis:	<input type="text"/>	<input type="text"/>	i. Procedure 1:	<input type="text"/>	<input type="text"/>
ii. Additional Diagnosis:	<input type="text"/>	<input type="text"/>	ii. Procedure 2:	<input type="text"/>	<input type="text"/>
iii. Co-morbidities:	<input type="text"/>	<input type="text"/>	iii. Procedure 3:	<input type="text"/>	<input type="text"/>
iv. Co-morbidities:	<input type="text"/>	<input type="text"/>	iv. Details of Procedure:	<input type="text"/>	<input type="text"/>

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**

- |  |  |
|--|--|
| <input type="checkbox"/> Claim Form duly signed                                | <input type="checkbox"/> Investigation reports                                 |
| <input type="checkbox"/> Original Pre-authorization request                    | <input type="checkbox"/> CT/MR/USG/HPE investigation reports                   |
| <input type="checkbox"/> Copy of the Pre-authorization approval letter         | <input type="checkbox"/> Doctor's reference slip for investigation             |
| <input type="checkbox"/> Copy of photo ID card of patient verified by hospital | <input type="checkbox"/> ECG   |
| <input type="checkbox"/> Hospital Discharge summary                            | <input type="checkbox"/> Pharmacy bills  |
| <input type="checkbox"/> Operation Theatre notes                               | <input type="checkbox"/> MLC report & Police FIR                               |
| <input type="checkbox"/> Hospital main bill                                    | <input type="checkbox"/> Original death summary from hospital where applicable |
| <input type="checkbox"/> Hospital break-up bill                                | <input type="checkbox"/> 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. with State Code:

d) Hospital 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.

Date:

Place:

Signature and Seal of the Hospital Authority:

SECTION A  
SECTION B  
SECTION C  
SECTION D  
SECTION E  
SECTION F