

HDFC ERGO General Insurance Company Limited



Claim Form

HDFC ERGO Group Health Insurance

CLAIM FORM – PART A TO BE FILLED IN BY THE INSURED

Issuance of this form is not a proof of admissibility of liability

SECTION A - DETAILS OF OF PRIMARY INSURED

Policy Number	<input type="text"/>	SI No/Certificate No.:	<input type="text"/>
Company/ TPA ID No.:	<input type="text"/>		
Name	<input type="text"/>		
Address	<input type="text"/>		
City	<input type="text"/>	State	<input type="text"/>
Pin Code	<input type="text"/>	Phone	<input type="text"/>
Email ID	<input type="text"/>	Mobile	<input type="text"/>

SECTION B - DETAILS OF INSURANCE HISTORY

a) Currently covered by any other mediclaim health insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Date of commencement of first insurance without break	<input type="text"/>
c) If Yes, Company Name	
Policy No.	
Sum Insured	
d) Have you been hospitalized in the last four years since inception of the contract	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/>
Diagnosis	
e) Previously covered by any other Mediclaim/Health insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No
f) If yes, Company Name	

SECTION C - DETAILS OF INSURED PERSON HOSPITALISED

a) Name	<input type="text"/>		
a) Relationship(Self/spouse/Child/Father/Mother/Other)	c) Date of Birth	d) Age	Mths/yrs
e) Address (If different than above)	<input type="text"/>		
f) Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	g) Occupation	Service/Self-employed/Homemaker/student/Retired/ Others
h) Telephone No	i) Mobile No	<input type="text"/>	
j) E-mail ID, if any	<input type="text"/>		

SECTION D - DETAILS OF HOSPITALISATION

a) Name of the Hospital where admitted	<input type="text"/>		
b) Room Category occupied	Daycare/Single Occupancy/Twin Sharing/ 3 or more beds per room		
c) Hospitalization due to	Illness / Injury/ 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	ii) Reported to police?	<input type="checkbox"/> Yes <input type="checkbox"/> No
iii) MLC Report, & Police FIR attached?	<input type="checkbox"/> Yes <input type="checkbox"/> No	j) System of medicine	Allopathic/Other systems of medicine

SECTION E - DETAILS OF CLAIM

A.Claim under Hospitalization Cover	
i) In-Patient Hospitalization <input type="checkbox"/> Yes <input type="checkbox"/> No	ii) Pre-hospitalization Expenses <input type="checkbox"/> Yes <input type="checkbox"/> No
iii) Post-hospitalization Expenses <input type="checkbox"/> Yes <input type="checkbox"/> No	iv) Day Care Procedures <input type="checkbox"/> Yes <input type="checkbox"/> No
v) Domiciliary Hospitalization <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, please provide details in annexure)	vi) Road Ambulance Cover <input type="checkbox"/> Yes <input type="checkbox"/> No
vii) Organ Donor <input type="checkbox"/> Yes <input type="checkbox"/> No	
Please tick the applicable Optional Cover claimed under Hospitalization Cover:	
i) Hospital Cash <input type="checkbox"/> Yes <input type="checkbox"/> No	<<Please provide details>>

ii) Preventive Health Check Up	<input type="checkbox"/> Yes <input type="checkbox"/> No	<<Please provide details>>
iii) Restore Benefit	<input type="checkbox"/> Yes <input type="checkbox"/> No	<<Please provide details>>
iv) Alternative Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	<<Please provide details>>
v) Second Medical Opinion	<input type="checkbox"/> Yes <input type="checkbox"/> No	<<Please provide details>>
vi) Double Restore Benefit	<input type="checkbox"/> Yes <input type="checkbox"/> No	<<Please provide details>>
vii) Maternity Expenses	<input type="checkbox"/> Yes <input type="checkbox"/> No	<<Please provide details>>
viii) Pre and Post Natal Expenses	<input type="checkbox"/> Yes <input type="checkbox"/> No	<<Please provide details>>
ix) Infertility Cover	<input type="checkbox"/> Yes <input type="checkbox"/> No	<<Please provide details>>
x) Accidental Death	<input type="checkbox"/> Yes <input type="checkbox"/> No	<<Please provide details>>
xi) Permanent Disablement	<input type="checkbox"/> Yes <input type="checkbox"/> No	<<Please provide details>>
xii) OPD Cover	<input type="checkbox"/> Yes <input type="checkbox"/> No	<<Please provide details>>
xiii) Double Sum Insured for Critical Illness	<input type="checkbox"/> Yes <input type="checkbox"/> No	<<Please provide details>>
xiii) Critical Illness (Benefit Based)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<<Please provide details>>

Claim Documents Submitted Check List: Hospitalization Claim		Check list of additional documents for Hospital Cash claims
<input type="checkbox"/> Duly filled and signed Claim Form	<input type="checkbox"/> Copy of intimation letter, if any	<input type="checkbox"/> Copy of Discharge Summary / Discharge Certificate along with time of admission and discharge for Hospital cash benefit
<input type="checkbox"/> Hospital Main Bill	<input type="checkbox"/> Hospital bill break up	<input type="checkbox"/> First consultation letter from treating Medical Practitioner
<input type="checkbox"/> Hospital Bill Payment Receipt	<input type="checkbox"/> Hospital Discharge summary	<input type="checkbox"/> Certificate from treating Medical Practitioner, specifying the duration and aetiology
<input type="checkbox"/> Pharmacy Bill	<input type="checkbox"/> Operation theatre notes	<input type="checkbox"/> MLC/FIR copy/ certificate regarding abuse of Alcohol/intoxicating agent if applicable
<input type="checkbox"/> Investigation / diagnostic Reports with bills and payment receipt	<input type="checkbox"/> Doctors request for investigations	
<input type="checkbox"/> ECG	<input type="checkbox"/> Prescriptions	
<input type="checkbox"/> Copy of the Network Provider's Registration Certificate	<input type="checkbox"/> MLC/FIR copy of applicable	
<input type="checkbox"/> KYC Documents	<input type="checkbox"/> implant stickers for all implants used during surgeries	

SECTION F - DETAILS OF BILLS ENCLOSED

Sr.no.	Bill No.	Date	Issued By	Towards	Amount (Rs)
		DDMMYYYY			

SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

a) PAN	b) Account Number
c) Bank Name/ Branch	d) Payable details: Cheque/ DD
e) IFSC Code	e) *please attach a cancelled cheque pertaining to the same
f) MICR No	*please attach a cancelled cheque pertaining to the same

Note:
It is agreed that the Policyholder/Claimant will intimate in writing to HDFC ERGO General Insurance Co. Ltd. about any change in bank account details.
In an event Insured person bears expenses for treatment please provide account details of Insured Persons in the above format along with proof of incurring such expenses..

SECTION H - 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.

Date: DDMMYYYY

Place: _____

Signature of Insured

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 pre-authorization request form in lieu of PART A

SECTION A - DETAILS OF HOSPITAL

Name of the Hospital where treated Hospital ID

Type of Hospital Network Non Network (If non network fill section E)

Name of the treating Doctor

Qualification Registration No with state Code

Phone

SECTION B - DETAILS OF PATIENT ADMITTED

a) Name of the patient	b) IP Registration Number
c) Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	d) Age YY/MM
e) Date of Birth DDMMYYYY	
f) Date of Admission DDMMYYYY	g) Time of Admission HH/MM
h) Date of Discharge DDMMYYYY	i) Time of Discharge HH/MM
j) Type of Admission Emergency/Planned/Daycare/Maternity	k) If Maternity
l) Date of Delivery DDMMYYYY	ii) Gravida Status
m) Status at time of discharge Discharged to Home Discharged to another Hospital Deceased	Total Claimed Amount

SECTION C - DETAILS OF AILMENTS DIAGNOSED (PRIMARY)

a) ICD 10 Codes	Primary Diagnosis	Additional Diagnosis	Co-morbidities
Details of Procedure/s done			
b) ICD 10 PCS	Procedure 1	Procedure 2	Procedure 3
i) Pre-authorization obtained	<input type="checkbox"/> Yes <input type="checkbox"/> No	ii) Pre-authorization No	
c) If authorization by network hospital not obtained, give reason			
f) Hospitalisation due to Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No	i) If yes, give cause	
Self inflicted?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Road Traffic Accident	<input type="checkbox"/> Yes <input type="checkbox"/> No
ii) If Injury due to Substance abuse / alcohol consumption, Test Conducted to establish this:		<input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, attach reports)	iii) Medico Legal <input type="checkbox"/> Yes <input type="checkbox"/> No
iv) Reported to Police	<input type="checkbox"/> Yes <input type="checkbox"/> No	v) FIR No	
vi) If not reported to Police give reasons			

SECTION D - CLAIM DOCUMENTS SUBMITTED - CHECKLIST

<input type="checkbox"/> Claim form duly filled and signed	<input type="checkbox"/> Investigation reports
<input type="checkbox"/> Pre authorization Request	<input type="checkbox"/> CT/MRI/USG/HPE investigation Report
<input type="checkbox"/> Copy of 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"/> Death summary from hospital where applicable
<input type="checkbox"/> Hospital break up Bill	<input type="checkbox"/> Any other, PI specify

SECTION E - DETAILS IN CASE OF NON NETWORK HOSPITAL

a) Address of the Hospital	b) Phone No:
c) Registration no with State Code	d) Hospital PAN
e) No of In-patient Beds	f) Facilities available in Hospital
i) OT <input type="checkbox"/> Yes <input type="checkbox"/> No	ii) ICU <input type="checkbox"/> Yes <input type="checkbox"/> No
iii) Others	

SECTION F - DECLARATION BY HOSPITAL

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: DDMMYYYY

Place: _____

Signature of Insured

LIST OF ENCLOSURES FOR SUBMISSION OF CLAIM

Note:

1. When original bills, receipts, prescriptions, reports and other documents are submitted to the other insurer or to the reimbursement provider, verified photocopies attested by such other organization/provider have to be submitted.
2. If original bills, receipts, prescriptions, reports and other documents are submitted to Us and Insured Person requires same for claiming from other organization/provider, then on request from the Insured Person We will provide attested copies of the bills and other documents submitted by the Insured Person.
3. If below mentioned documents are not provided in full or are insufficient for Us to consider the claim, then We may request additional information or documentation.

List of Documents for Reimbursement Claims:

- | | |
|--------------------------|--|
| <input type="checkbox"/> | Completely filled claim form, duly signed (by claimant/proposer) and stamped (by hospital). |
| <input type="checkbox"/> | Government approved Photo ID & Age Proof |
| <input type="checkbox"/> | Copy of claim intimation letter / reference of Claim Intimation Number in the absence of main claim documents |
| <input type="checkbox"/> | Copy of the Hospital's Registration Certificate/Hospital Registration number in case of hospitalization in any non network hospital of HDFC ERGO Health Insurance Limited or certificate from hospital authorities providing facilities available including number of beds. |
| <input type="checkbox"/> | Discharge Card / Day Care Summary / Transfer Summary |
| <input type="checkbox"/> | Final hospital bill with all deposit and final payment receipt and refund receipt(s), if advance amount refunded |
| <input type="checkbox"/> | Invoice with payment receipt and implant stickers for all implants used during surgeries e.g. lens sticker and invoice in cataract Surgery, stent invoice and sticker in Angioplasty Surgery. |
| <input type="checkbox"/> | All previous consultation papers indicating history and treatment details for current illness and advice for current hospitalization. |
| <input type="checkbox"/> | All diagnostic reports (including imaging and laboratory) along with prescription by Medical Practitioner and invoice / bill with receipt from diagnostic centre |
| <input type="checkbox"/> | All medicine / pharmacy bills along with prescription by Medical Practitioner |
| <input type="checkbox"/> | MLC / FIR Copy – in Accidental cases only |
| <input type="checkbox"/> | History of alcohol consumption or any intoxication certified by first treating doctor in case of accidental cases. |
| <input type="checkbox"/> | Copy of Death Summary and copy of Death Certificate (in death claims only) |
| <input type="checkbox"/> | Pre and Post-Operative Imaging reports |
| <input type="checkbox"/> | Copy of indoor case papers with nursing sheet detailing medical history of the patient, treatment details, and patient's progress (to be submitted wherever required by the insurer). |
| <input type="checkbox"/> | Invoice for Vaccination and payment receipt |
| <input type="checkbox"/> | KYC documents (in all claims above Rs 1 lakh) - (Ration Card/ Driving License/ Aadhar Card/ Passport /any other Government authorized identity proof of the Proposer carrying name, photograph & address) and duly filled KYC form with 1 signed across passport size coloured photograph of the Proposer. *** |
| <input type="checkbox"/> | Duly filled NEFT form with cancelled blank cheque (with IFSC code, A/C number, and name mentioned on cheque leaf) |
| <input type="checkbox"/> | Settlement letter(s), copy(-ies) of payment receipts, and entire certified copy of paid claims in case of partial claim settlement from other insurer. |

*** In case of death of proposer, the same document requirement would be for nominee/legal heir of proposer (NOC in favour of 1 or more than 1 undisputedly selected legal heir(s) by remaining legal heir(s)).

In-patient Treatment /Day Care Procedures

- | | |
|--------------------------|--|
| <input type="checkbox"/> | Duly filled and signed Claim Form. |
| <input type="checkbox"/> | Photocopy of ID card / Photocopy of current year policy. |
| <input type="checkbox"/> | Detailed Discharge Summary with date of admission & discharge, clinical history, past history / procedure details/ Day care summary from the hospital. |
| <input type="checkbox"/> | Consolidated hospital bill with break up of each item, duly signed by the insured. |
| <input type="checkbox"/> | Payment Receipt of the hospital bill. |
| <input type="checkbox"/> | First Consultation letter and subsequent Prescriptions. |
| <input type="checkbox"/> | Bills, payment receipts and Reports for investigation. |
| <input type="checkbox"/> | Medicine bills and receipts with corresponding Prescriptions. |
| <input type="checkbox"/> | Invoice/Sticker of implants/bills for Implants (viz. Stent /PHS Mesh/ IOL etc.) with payment receipts |

In-patient Treatment /Day Care Procedures

- | | |
|--------------------------|--|
| <input type="checkbox"/> | In addition to the In-patient Treatment documents: |
| <input type="checkbox"/> | Copy of the First Information Report from Police Department / Copy of the Medico-Legal Certificate.
In Non Medico legal cases |
| <input type="checkbox"/> | Treating Doctor's Certificate giving details of injuries (How, when and where injury sustained)
In Accidental Death cases |
| <input type="checkbox"/> | Copy of Post Mortem Report & Death Certificate (If conducted) |

Pre and Post-hospitalization

- | | |
|--------------------------|---|
| <input type="checkbox"/> | Duly filled and signed Claim Form. |
| <input type="checkbox"/> | Photocopy of ID card / Photocopy of current year policy. |
| <input type="checkbox"/> | Medicine bills, payment receipt with prescriptions. |
| <input type="checkbox"/> | Investigations bills, payment receipt with prescriptions and report. |
| <input type="checkbox"/> | Consultation documents and bills, payment receipt with prescription. |
| <input type="checkbox"/> | Copy of the Discharge Summary of the main claim.(except for out patient dental claim) |

Organ Donation/Transplantation

- In addition to the documents of general hospitalization.
- Organ Function test / blood test proving organ failure.
 - Treatment Certificate issued by the Transplant Surgeon of the hospital concerned.

Ambulance Benefit

- Duly filled and signed Claim Form.
- Photocopy of ID card / Photocopy of current year policy.
- Bills with Payment Receipt.
- Treating Doctor's consultation prescription indicating Emergency Hospitalization

Hospital Cash Benefit

- Duly filled and signed Claim Form.
- Discharge card / day care summary / transfer summary
- Final Hospital Bill
- Previous consultation papers indicating history and treatment details for current ailment.
- Diagnostic test reports (including imaging and laboratory) along with the Medical prescription & copy of invoice / bill and receipt from the diagnostic centre.
- MLC / FIR copy – in Accidental cases only
- Death summary & death certificate (in death claims only)

Preventive Health Check up

- Duly filled and signed Claim Form.
- Health check up test reports
- Bill and receipt from the diagnostic centre.

For Death Cases

- In addition to the In-patient Treatment documents:
- Death Summary from the hospital.
 - Copy of the Death certificate from treating doctor or the hospital authority.
 - Copy of the Legal heir certificate, if the claim is for the death of the principle insured.
 - Bank Account Details of nominee/legal heir with a copy of cancelled cheque

Customer Identification Procedure (as per KYC norms of IRDAI)

Please submit the following documents in case of claim amount exceeds Rs. 100,000

Legal name and any other names used (Any one of the mentioned documents)

Passport/ PAN Card/ Voter's Identity Card/ Driving License/ Letter from a recognized public authority or public servant verifying the identity and residence of the customer

Proof of Residence (Any one of the mentioned documents)

Telephone bill/ Bank account statement/ Letter from any recognized public authority/ Electricity bill/ Ration card