HDFC ERGO General Insurance Company Limited

Claim Form- Health Insurance except Personal Accident and Travel

CLAIM FORM – PART A
TO BE FILLED IN BY THE INSURED
The issue of this Form is not to be taken as an admission of liability

SECTION A – DETAILS OF PRIMARY INSURED

a) Policy No. b) Sl. No/ Certificate No: c) Company/ TPA ID No.

d) Name

e) Address

Phone No. Email ID

SECTION B – DETAILS OF INSURANCE HISTORY

a) Currently covered by any other Medi Claim Health Insurance. Yes ☐ No ☐ b) Date of commencement of first insurance without break D D M M Y Y Y Y

c) If Yes, Company Name

Policy No. Sum Insured

d) Have you been hospitalized in the last four years since inception of the contract Yes ☐ No ☐ Date D D M M Y Y Y Y

Diagnosis

e) Previously covered by any other Medi Claim / Health Insurance Yes ☐ No ☐

f) If yes, Company Name

SECTION C- DETAILS OF INSURED PERSON HOSPITALISED

a) Name

b) Relationship ☐ Self ☐ Spouse ☐ Child ☐ Father ☐ Mother Other _____

c) Date of Birth D D M M Y Y Y Y d) Age Y Y M M

e) Address (If different than above)

f) Gender ☐ Male ☐ Female ☐ T/G g) Occupation: ☐ Service ☐ Self Employed ☐ Homemaker ☐ Student ☐ Retired Others _____

h) Telephone No I) Mobile No.

j) E-mail ID, if any

SECTION D- DETAILS OF HOSPITALISATION

a) Name of the Hospital where admitted

b) Room Category occupied ☐ Daycare ☐ Single Occupancy ☐ Twin Sharing ☐ 3 or more beds per room

c) Hospitalisation due to ☐ Illness ☐ Injury ☐ Maternity

d) Date of Injury/ Date of disease first detected/ Date of delivery D D M M Y Y Y Y e) Date of admission D D M M Y Y Y Y f) Time H H M M

g) Date of discharge D D M M Y Y Y Y h) Time H H M M

I) If injury, give cause ☐ Self-Inflicted ☐ Road Traffic Accident ☐ Substance Abuse ☐ Alcohol Consumption

i) If Medico legal Yes ☐ No ☐ ii) Reported to police? Yes ☐ No ☐ iii) MLC Report, & Police FIR attached? Yes ☐ No ☐

j) System of medicine ☐ Allopathic ☐ Other systems of medicine

SECTION E- DETAILS OF CLAIM

a) Details of the treatment expenses claimed

i) Pre-hospitalisation Expenses		ii) Hospitalisation Expenses	
iii) Post-hospitalisation Expenses		iv) Health-Check up Cost	
v) Ambulance Charges		vi) Others (code)	
		Total	
vii) Pre-hospitalisation Period	Days	viii) Post -hospitalisation Period	

b) **Claim for Domiciliary Hospitalization** YES / NO (if yes, please provide details in annexure)

c) **Please tick the applicable Add on cover claimed:**

i) Hospital Daily Cash		Please mention the number of days claimed for:	
iii) Critical Illness Benefit		Please mention the Critical Illness claimed for:	

Claim Documents Submitted Check List: Hospitalization Claim		**Check list of additional documents for Critical Illness claims**
☐ Duly filled and signed Claim Form	☐ Copy of intimation letter, if any	☐ Medical certificate confirming the diagnosis of Critical Illness
☐ Hospital Main Bill	☐ Hospital bill break up	☐ Certificate from attending Medical Practitioner confirming the duration of illness
☐ Hospital Bill Payment Receipt	☐ Hospital Discharge summary	☐ First consultation letter and subsequent prescriptions
☐ Pharmacy Bill	☐ Operation theatre notes	☐ Indoor case papers if applicable
☐ ECG	☐ Doctors request for investigations	☐ FIR copy or medico legal certificate (wherever applicable)
☐ Investigation Reports confirming the diagnosis (Including CT, MRI/USG/HPE)	☐ Prescriptions	
☐ Others		

SECTION – F DETAILS OF BILLS ENCLOSED

S. No	Bill No.	Date						Issued By	Towards	Amount (Rs)						
		D	D	M	M	Y	Y									

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: D D M M Y Y Y Y

Place:

Signature of Insured

HDFC ERGO General Insurance Company Limited

Claim Form - my:health Suraksha

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 preauthorisation request form in lieu of PART A

SECTION A – DETAILS OF HOSPITAL

a) Name of the Hospital where treated
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:

SECTION B – DETAILS OF PATIENT ADMITTED

a) Name of the patient
b) IP Registration Number
c) Gender ☐ Male ☐ Female ☐ T/G
d) Date of Birth D D M M Y Y Y Y
e) Age Y Y M M
f) Date of Admission D D M M Y Y Y Y
g) Time of Admission H H M M
h) Date of Discharge D D M M Y Y Y Y
I) Time of Discharge H H M M
j) Type of Admission ☐ Emergency ☐ Planned ☐ Daycare ☐ Maternity
k) If Maternity
i) Date of Delivery D D M M Y Y Y Y
ii) Gravida Status D D M M Y Y Y Y
k) Status at time of discharge ☐ Discharged to Home ☐ Discharged to another Hospital ☐ Deceased
l) 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	
c) Pre-authorization obtained	☐ Yes ☐ No		d) Pre-authorization No.			
e) If authorization by network hospital not obtained, give reason						
f) Hospitalisation due to Injury	☐ Yes ☐ No		g) If yes, give cause			
Self inflicted?	☐ Yes ☐ No	Road Traffic Accident	☐ Yes ☐ No	Substance Abuse / Alcohol Consumption	☐ Yes ☐ No	
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 reasons						

SECTION D – CLAIM DOCUMENTS SUBMITTED – CHECKLIST

☐ Claim form duly filled and signed	☐ Investigation reports
☐ Original Pre authorization Request	☐ CT/MRI/USG/HPE investigation Report
☐ Copy of Pre-authorization approval Letter	☐ Doctor's reference slip for Investigation
☐ Copy of photo ID card of patient verified by Hospital	☐ ECG
☐ Hospital Discharge Summary	☐ Pharmacy Bills
☐ Operation Theatre Notes	☐ MLC Report & Police FIR
☐ Hospital Main Bill	☐ Original death summary from hospital where applicable
☐ Hospital break up Bill	☐ Any other, PI specify

SECTION E – DETAILS IN CASE OF NON NETWORK HOSPITAL

Address of the Hospital

Phone No. Registration No. with State Code

Hospital PAN No of In-patient Beds Facilities available in Hospital: OT ICU 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: D D M M Y Y Y Y

Place:

Signature and seal of the Hospital Authority

GUIDANCE FOR FILLING CLAIM FORM – PART B (TO BE FILLED IN BY THE HOSPITAL)

DATA ELEMENT	DESCRIPTION	FORMAT
SECTION A – DETAILS OF HOSPITAL		
a) Name of Hospital	Enter the name of hospital	Name of hospital in full
b) Hospital ID	Enter ID number of hospital	As allocated by the TPA
c) Type of Hospital	Indicate whether In network or non network Hospital	Tick the right option
d) Name of treating doctor	Enter the name of the treating doctor	Name of doctor in full
e) Qualification	Enter the qualifications of the treating doctor	Abbreviations of educational qualifications
f) Registration No. with State Code	Enter the registration number of the doctor alongwith the state code	As allocated by the Medical Council of India or the equivalent Authority in the country of hospitalization
g) Phone No.	Enter the phone number of doctor	Include STD code with telephone number
SECTION B – DETAILS OF THE PATIENT ADMITTED		
a) Name of Patient	Enter the name of hospital	Name of hospital in full
b) IP Registration Number	Enter insurance provider registration number	As allotted by the insurance provider
c) Gender	Indicate Gender of the patient	Tick Male or Female
d) Age	Enter age of the patient	Number of years and months
e) Date of Admission	Enter date of admission	Use dd-mm-yy format
f) Time	Enter time of admission	Use hh: mm format
g) Date of Discharge	Enter date of discharge	Use dd-mm-yy format
h) Time	Enter time of discharge	Use hh: mm format
i) Type of Admission	Indicate type of admission of patient	Tick the right option
j) If Maternity		
Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format
Gravida Status	Enter Gravida status if maternity	Use standard format
k) Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option

SECTION C – DETAILS OF AILMENT DIAGNOSED (PRIMARY)		
a) ICD 10 Code		
Primary Diagnosis	Enter the ICD 10 Code and description of the primary diagnosis	Standard Format and Open text
Additional Diagnosis	Enter the ICD 10 Code and description of the additional diagnosis	Standard Format and Open text
Co-morbidities	Enter the ICD 10 Code and description of the co-morbidities	Standard Format and Open text
b) ICD 10 PCS		
Procedure 1	Enter the ICD 10 PCS and description of the first procedure	Standard Format and Open text
Procedure 2	Enter the ICD 10 PCS and description of the second procedure	Standard Format and Open text

SECTION C – DETAILS OF AILMENT DIAGNOSED (PRIMARY) (CONTD.)

Procedure 3	Enter the ICD 10 PCS and description of the third procedure	Standard Format and Open text
Details of Procedure	Enter the details of the procedure	Open text
c) Present Ailmentisa Complication of PED	Indicate whether present ailment is a complication of some pre-existing disease	Tick Yes or No
d) Pre-authorization obtained	Indicate whether pre-authorization obtained	Tick Yes or No
e) Pre-authorization Number	Enter pre-authorization number	As allotted by TPA
f) If authorization by network hospital not obtained, give reason	Enter reason for not obtaining pre-authorization Number	Open text
g) Hospitalization due to injury	Indicate if hospitalization is due to injury	Tick Yes or No
Cause	Indicate cause of injury	Tick the right option
If injury due to substance abuse/alcohol consumption, test conducted to establish this	Indicate whether test conducted	Tick Yes or No
Medico Legal	Indicate whether injury is medico legal	Tick Yes or No
Reported To Police	Indicate whether police report was filed	Tick Yes or No
FIR No.	Enter first information report number	As issued by police authorities
If not reported to police, give reason	Enter reason for not reporting to police	Open text

SECTION D – CLAIM DOCUMENTS SUBMITTED-CHECK LIST

Indicate which supporting documents are submitted

SECTION E – ADDITIONAL DETAILS IN CASE OF NON NET WORK HOSPITAL

a) Address	Enter the full postal address	Include Street, City and Pin Code
b) Phone No.	Enter the phone number of hospital	Include STD code with telephone number
c) Registration No.	Enter the registration number of patient	As allocated by the Hospital
d) PAN	Enter the permanent account number	As allotted by the Income Tax department
e) Number of Inpatient Beds	Enter the number of inpatient beds	Digits
f) Facilities available in the hospital	Indicate facilities available in the hospital	Tick the right option. If others, please specify

SECTION F – DECLARATION BY THE INSURED

Read declaration carefully and mention date (indd:mm:yyformat), place (open text) and sign.

SECTION G – DECLARATION BY THE HOSPITAL

Read declaration carefully and mention date (indd:mm:yyformat), place (open text) and sign and stamp

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.

In-patient Treatment /Day Care Procedures

- ☐ Duly filled and signed Claim Form.
- ☐ Photocopy of ID card / Photocopy of current year policy.
- ☐ Original Detailed Discharge Summary with date of admission & discharge, clinical history, past history / procedure details/ Day care summary from the hospital.
- ☐ Original consolidated hospital bill with break up of each Item, duly signed by the insured.
- ☐ Original payment Receipt of the hospital bill.
- ☐ First Consultation letter and subsequent Prescriptions.
- ☐ Original bills, original payment receipts and Reports for investigation.
- ☐ Original medicine bills and receipts with corresponding Prescriptions.
- ☐ Original invoice/Sticker of implants/bills for Implants (viz. Stent /PHS Mesh/ IOL etc.) with original payment receipts.

Road Traffic Accident

In addition to the In-patient Treatment documents:

- ☐ Copy of the First Information Report from Police Department / Copy of the Medico-Legal Certificate.

In Non Medico legal cases

- ☐ Treating Doctor's Certificate giving details of injuries (How, when and where injury sustained)

In Accidental Death cases

- ☐ Copy of Post Mortem Report & Death Certificate (If conducted)

For Death Cases

In addition to the In-patient Treatment documents:

- ☐ Original 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.

Pre and Post-hospitalization expenses

- ☐ Duly filled and signed Claim Form.
- ☐ Photocopy of ID card / Photocopy of current year policy.
- ☐ Original Medicine bills, original payment receipt with prescriptions.
- ☐ Original Investigations bills, original payment receipt with prescriptions and report.
- ☐ Original Consultation documents and bills, original payment receipt with prescription.
- ☐ Copy of the Discharge Summary of the main 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.
- ☐ Original Bill with Original Payment Receipt.
- ☐ Treating Doctor's consultation prescription indicating Emergency Hospitalization.

Critical Illness Benefit

- ☐ Medical certificate confirming the diagnosis of Critical Illness
- ☐ Certificate from attending Medical Practitioner confirming that the duration of Illness
- ☐ Discharge certificate/ card from the Hospital, if any
- ☐ Investigation test reports confirming the diagnosis,
- ☐ First consultation letter and subsequent prescriptions
- ☐ Indoor case papers if applicable
- ☐ Specific documents to confirm the diagnosis of respective Critical Illness
- ☐ In the cases where Critical Illness arises due to an accident, FIR copy or medico legal certificate ,wherever conducted.

Hospital Cash Benefit

- ☐ 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)

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

CLAIM FORM –ASSAULT AND BURNS

Broker/Agent Name:

Policy No. Claim No. Date of registration:

Office Code/Service Centre Code: Code:

1. Name of the Insured
(First Name) (Middle Name) (Last Name)

2. Address of the Insured

Plot No/Door No. Building name

Road/Area City: Pin Code:

State: PAN No.:

Email ID*

3. Profession or Occupation Policy details

Sum Insured Table of Cover

Details of Accident

5. a) Name of the Insured Person dead/injured in the accident	
6. a) Date of accident: b) Time of accident: c) Place of accident: d) Name & address of the witness(if any):	
7. Particulars of the accident:	
8. Nature of injury received (if to limb or eye state whether right or left)	
9. a) Nature of disablement b) Extent of disablement c) Period of temporary total disablement d) Present state of incapacity	(From.....to.....)
10. Name and address of surgeon in attendance	
11. Where and when can a Medical Officer of this Company visit you, if necessary?	
12. a) Are you insured in any other office or offices of the Company or any other company, granting compensation for accident? b) If so state name and address of company or companies and amount of insurance	

I/We hereby declare that the foregoing statements made by me/us are true in all respects, that I/We have not attempted to conceal from the Company anything with which it ought to be made acquainted and that if I/We have made or in any further declaration the Company may require shall make any false or fraudulent statement or untrue averment whatever, the Policy shall be void and my/our right to compensation forfeited. I am/We are willing if required, to make and provide to the Company a statutory Declaration of the whole of the foregoing statement or of any other statement made in connection with this claim.

Witness (if any):Name _____ Signature _____

Signature of Insured _____ Date: _____

Documents Required for Claim Processing

1. Duly Completed Claim Form signed by Insured Person.
2. Attested copy of disability certificate from Civil Surgeon of Government Hospital stating percentage of disability.
3. Attested copy of certificate from treating Medical Practitioner specifying type of burns with percentage of burns
4. Attested copy of FIR. (If any)
5. All X-Ray / Investigation reports and films supporting to disability.
6. NEFT details & cancelled cheque of Insured Person.

CLAIM FORM – LOSS OF JOB

Type of loss of Job	Details along with Reason	Date
Termination		
Dismissal / temporary suspension		
Retrenchment		
Resignation		

List Of Documents:

For Resignation from Employment

1. Duly Completed Claim Form signed by Insured Person
2. Form 16A
3. Termination Letter/ Resignation Acceptance letter
4. NEFT details & cancelled cheque