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

(To be filled in block letters)

SECTION A

DETAILS OF PRIMARY INSURED:

a) Policy No: ______________________ b) Sl. No/ Certificate No.: ______________________

c) Company/ TPA ID No: ______________________

d) Name: ______________________

e) Address: ______________________

____

City: ______________________ State: ______________________

Pin Code: ______________________ Landline (With STD Code): ______________________

[PLEASE PROVIDE ACTIVE EMAIL ID ONLY AS CLAIMS CORRESPONDENCE WILL BE DONE TO THIS EMAIL ID.]

Mobile No.: ______________________ Email ID: ______________________

Alternate Email ID: ______________________

SECTION B

DETAILS OF INSURANCE HISTORY:

a) Currently covered by any other Mediclaim / Health Insurance: ____Yes ____No b) If yes, Policy Type: ____Individual ____Group

Company name: ______________________ Policy No.: ______________________

c) Date of commencement of first Insurance without break: ______________________

d) Sum Insured (Rs.): ______________________ e) Have you been hospitalized in the last four years since inception of the contract? ___Yes ___No Date:

Diagnosis: ______________________ f) Previously covered by any other Mediclaim / Health insurance: ___Yes ___No

g) If yes, Company Name: ______________________

SECTION C

DETAILS OF INSURED PERSON HOSPITALIZED:

a) Name: ______________________

b) Gender: _____Male _____Female c) Age: years____ months_____ d) Date of Birth: ______________________

e) Relationship to Primary insured: ___Self ___ Spouse ___ Child ___ Father ___ Mother ___ Other (Please Specify) ______________________

f) Address (if different from above): ______________________

____

City: ______________________ State: ______________________

Pin Code: ______________________ Phone No.: ______________________ Email ID: ______________________

g) Occupation: ___ Service ___ Self Employed ___ Homemaker ___ Student ___ Retired ___ Other (Please Specify) ______________________

h) Name of employer/
Firm's Name: ______________________

i) Address of the Employer/
Firm: ______________________

SECTION D

DETAILS OF HOSPITALIZATION:

a) Name & Address of Hospital where Admitted: ______________________

____

City: ______________________ State: ______________________

Pin Code: ______________________ Landmark: ______________________

b) Room Category occupied: ___ Day care ___ Single occupancy ___ Twin sharing ___ 3 or more beds per room ___ other (Please specify) ______________________

c) Hospitalization due to: ___ Injury ___ Illness ___ Maternity d) Date of Injury / Date Disease first detected /Date of Delivery: ______________________

e) Date of Admission: ______________________ f) Time: ______________________ g) Date of Discharge: ______________________ h) Time: ______________________

i) In case of maternity, i. Date of Delivery: ______________________ ii. Gravida Status______________________

j) 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 k) System of Medicine: ______________________

SECTION E

DETAILS OF CLAIM:

a) Details of Lump sum / Hospital cash benefit claimed

No of Days Claimed / No of Days admitted in Hospital		Amount Claimed	

Check List of Claim Documents to be submitted (Photocopies)* - Please tick relevant box

(For Hospital Cash benefit, photocopies of claim documents are acceptable except Claim form)

Claim form duly filled and signed	Copy of the claim intimation, if any	Hospital bill payment receipt
Hospital Main Bill	Hospital Break-up Bill	Doctor's request for investigation
Hospital Discharge Summary	Pharmacy Bill	Operation Theatre Notes
Investigation Reports (Including CT/MRI/USG/HPE/ECG)		Test report and prescription relating to first consultation for the Illness
Doctor's prescription for medicines purchased outside the hospital and investigation done outside hospital		FIR/MLC in case of accident injury and English translation of the same if it is in any other language
KYC document (Address proof, ID proof only for claims exceeding Rs. 1 Lakh)		Original Death Summary (Wherever applicable)
Cancelled Cheque leaf of the bank account held in the name of the primary insured (Mandatory)		Any Other

*Please retain copy of complete set of claim documents for your records

Note: Please attach separate sheet if necessary

If the claim is for Accidental injuries, Please provide details of date, time and circumstances of Accident event and other details as relevant:

DETAILS OF PRIMARY INSURED's BANK ACCOUNT:

SECTION G

PLEASE PROVIDE YOUR BANK DETAILS: (PLEASE ATTACH CANCELLED CHEQUE LEAF OF BANK ACCOUNT IN THE NAME OF PRIMARY INSURED WITHOUT FAIL)

a) PAN: ____________________ b) Account Number: ____________________

c) Bank Name and Branch: ____________________

d) IFSC Code: ____________________

e) Cheque/ DD Payable Details: ____________________

DECLARATION BY THE INSURED:

SECTION H

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 and for additional covers, if any. If, I have made, or in any further declaration the Company may require, shall make any false or fraudulent statement or any suppression, concealment or untrue averment whatever, the Policy shall be void and my right to compensation forfeited.

Date: ____________ Place: ____________ Signature of the Insured: ____________

GUIDANCE FOR FILLING CLAIM FORM – PART A (To be filled in by the insured)		
DATA ELEMENT	**DESCRIPTION**	**FORMAT**
SECTION A - DETAILS OF PRIMARY INSURED		
a) Policy No.	Enter the policy number	As allotted by the insurance company
b) SI. No/ Certificate No.	Enter the social insurance number or the certificate number of social health insurance scheme	As allotted by the organization
c) Company TPA ID No.	Enter the TPA ID No	License number as allotted by IRDA and printed in TPA documents.
d) Name	Enter the full name of the policyholder	Surname, First name, Middle name
e) Address	Enter the full postal address	Include Street, City and Pin Code
SECTION B - DETAILS OF INSURANCE HISTORY		
a) Currently covered by any other Mediclaim / Health Insurance?	Indicate whether currently covered by another Mediclaim / Health Insurance	Tick Yes or No
b) i. Company Name	Enter the full name of the insurance company	Name of the organization in full
ii. Policy No.	Enter the policy number	As allotted by the insurance company
c) Date of Commencement of first Insurance without break	Enter the date of commencement of first insurance	Use dd-mm-yy format
d) Sum Insured	Enter the total sum insured as per the policy	In rupees
Have you been Hospitalized in the last four years since inception of the contract?	Indicate whether hospitalized in the last four years	Tick Yes or No
f) Date	Enter the date of hospitalization	Use mm-yy format
g) Diagnosis	Enter the diagnosis details	Open Text
h) Previously Covered by any other Mediclaim/ Health Insurance?	Indicate whether previously covered by another Mediclaim / Health Insurance	Tick Yes or No
i) Company Name	Enter the full name of the insurance company	Name of the organization in full
SECTION C - DETAILS OF INSURED PERSON HOSPITALIZED		
a) Name	Enter the full name of the patient	Surname, First name, Middle name
b) Gender	Indicate Gender of the patient	Tick Male or Female
c) Age	Enter age of the patient	Number of years and months
d) Date of Birth	Enter Date of Birth of patient	Use dd-mm-yy format
e) Relationship to primary Insured	Indicate relationship of patient with policyholder	Tick the right option. If others, please specify.
f) Address	Enter the full postal address	Include Street, City and Pin Code
Phone No	Enter the phone number of patient	Include STD code with telephone number
E-mail ID	Enter e-mail address of patient	Complete e-mail address
g) Occupation	Indicate occupation of patient	Tick the right option. If others, please specify.
h) Name of the employer	Name of the employer of the insured	
i) Address of the Employer	Complete address of the employer of the insured	Include Street, City and Pin Code
SECTION D - DETAILS OF HOSPITALIZATION FOR CLAIM BEING FILED		
a) Name of Hospital where admitted	Enter the name of hospital	Name of hospital in full
b) Room category occupied	Indicate the room category occupied	Tick the right option
c) Hospitalization due to	Indicate reason of hospitalization	Tick the right option
d) Date of Injury/Date Disease first detected/ Date of Delivery	Enter the relevant date	Use dd-mm-yy format
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) In case of maternity		
i. Date of Delivery	Enter date of delivery	Use dd-mm-yy format
ii. Gravida Status	Enter gravida status	Use Standard format
j) If Injury give cause	Indicate cause of injury	Tick the right option
i. If Medico legal	Indicate whether injury is medico legal	Tick Yes or No
ii. Reported to Police	Indicate whether police report was filed	Tick Yes or No
iii. MLC Report & Police FIR attached	Indicate whether MLC report and Police FIR attached	Tick Yes or No
k) System of Medicine	Enter the system of medicine followed in treating the patient	Open Text
SECTION E - DETAILS OF CLAIM		
a) Details of Treatment Expenses	Enter the amount claimed as treatment expenses	In rupees (Do not enter paise values)
b) Claim for Domiciliary Hospitalization	Indicate whether claim is for domiciliary hospitalization	Tick Yes or No
c) Details of Lump sum/ cash benefit claimed	Enter the amount claimed as lump sum/ cash benefit	In rupees (Do not enter paise values)
d) Claim Documents Submitted-Check List	Indicate which supporting documents are submitted	Tick the right option
SECTION F - DETAILS OF BILLS ENCLOSED		
Indicate which bills are enclosed with the amounts in rupees		
SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT		
a) PAN	Enter the permanent account number	As allotted by the Income Tax department
b) Account Number	Enter the bank account number	As allotted by the bank
c) Bank Name and Branch	Enter the bank name along with the branch	Name of the Bank in full
d) IFSC Code	Enter the IFSC code of the bank branch	IFSC code of the bank branch in full
SECTION H - DECLARATION BY THE INSURED		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.		

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

DETAILS OF HOSPITAL **(To be filled in block letters)**

SECTION A

a) Name of the hospital: ______________________________

b) Hospital ROHINI ID: ______________________ c) Hospital registration number and Valid up to ______________________

d) Name of the treating doctor: ______________________________

e) Qualification: ______________________ f) Registration No. with State Code: ______________________ g) Phone No. ______________________

DETAILS OF THE PATIENT ADMITTED

SECTION B

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)

SECTION C

a)		ICD 10 Codes	Description				b)		ICD 10 PCS Codes			Description
1	Primary Diagnosis:						1	Procedure 1:				
2	Additional Diagnosis:						2	Procedure 2:				
3	Co-morbidities:						3	Procedure 3:				
4	Co-morbidities:						4	Details of Procedure:				

n) If authorization by network hospital not obtained, give reason: ______________________________

o) Hospitalization due to Injury: _____Yes ____ No If Yes, give cause: i. ______Self-inflicted _______Road Traffic Accident ________ Substance abuse / alcohol consumption _______Other

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: ______________________

g) When did the patient start suffering with the complaint: ______________________ Date of first consultation: _____/_____/__________

h) Please give previous medical history of the patient: ______________________________

i) Is the patient suffering from any of the following diseases? If "yes" Please mention the duration below.

		Say Yes/No	Duration in Year	Duration in Month
1	High or low blood pressure, Chest Pain, or any other cardiac disorder			
2	Tuberculosis, Asthma, Bronchitis or any other lung/respiratory disorder			
3	Ulcer (Stomach/Duodenal), liver or gall bladder disorder or any other digestive tract disorder			
4	Kidney Failure, Stone in kidney or urinary tract, Prostate disorder or any other kidney/ urinary tract disorder			
5	Stroke, Epilepsy (fits), Paralysis or any other nervous system (Brain, Spinal cord, etc) disorder			
6	Diabetes, Impaired glucose tolerance (Pre-diabetes), Thyroid/Pituitary Disorder or any other endocrine disorder			
7	Tumor (Swelling)-benign or malignant, any external ulcer/growth/cyst/mass anywhere in the body			
8	Arthritis, Spondylosis or any other disorder of the muscle/bone/joint			
9	Diseases of the Ear/Nose/Throat/Teeth/ Eye (please mention Dioptres in case of refractory error)			
10	HIV/AIDS or sexually transmitted diseases or any immune system disorder			
11	Anaemia, Leukaemia, Lymphoma or any other blood/lymphatic system disorder			
12	Psychiatric/Mental illnesses or sleep disorder			
13	Uterine Fibroid, Fibroadenoma breast or any other Gynaecological (Female reproductive system)/Breast disorder			
14	Any other illness or injury not mentioned above (other than common cold)			

g) Is the ailment a complication / sequel of a pre-existing disease or condition? ____________________
(If yes, please give details)

h) History of alcoholism
If yes: No of years
Quantity consumed per day

Yes No
____
____

i) History of Smoking/ Tobacco chewing
If yes: No of years
Units consumed per day

Yes No
____
____

CLAIM DOCUMENTS SUBMITTED - CHECK LIST

____Claim Form duly signed
____ CT/MR/USG/HPE investigation reports
____Copy of photo ID card of patient verified by hospital
____Hospital Discharge summary
____ Operation Theatre notes
____Hospital main bill
____Hospital break-up bill

_____ Investigation reports
_____ Doctor's reference slip for investigation
_____ ECG
_____ Pharmacy bills
_____ MLC report & Police FIR
_____ Original death summary from hospital where applicable
_____ other, please specify

SECTION D

ADDITIONAL DETAILS FROM HOSPITAL

a) Address of the Hospital: ____________________
____

City: ____________________ State: ____________________

Pincode: ____________________ 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. Round the clock Doctor/Nurses: ___Yes ___No

iv. Maintains daily record of patients: ___Yes ___No

v. Others: ____________________

SECTION E

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 F

Authorization Letter (Mandatory)

Date:

To:
The Manager/ Medical Superintendent,
Medical Records

Dear Sir / Madam,
Reg: Authorization Letter.

Name of the Patient: ______________________________

IP Number___________________________ (First admission) in _______________________________________Hospital

IP Number___________________________ (Second admission) in ____________________________________Hospital

IP Number___________________________ (Third admission) in ______________________________________Hospital

I consent and authorize M/s Magma HDI General Insurance Co. Limited and their Authorized Service Providers to seek medical information from your hospital and share copies of indoor case sheets and such other relevant medical records and/or meet/obtain statement from the Medical Practitioner who has at any time attended on the patient for the hospitalization dated .... to ....

Thanking you,

Yours sincerely.

Signature of the Proposer

Signature of the Patient

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 along with the state code	As allocated by the Medical Council of India
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 Birth	Enter date of admission	Use dd-mm-yy format
f)	Date of Admission	Enter date of admission	Use dd-mm-yy format
g)	Time	Enter time of admission	Use hh:mm format
h)	Date of Discharge	Enter date of discharge	Use dd-mm-yy format
i)	Time	Enter time of discharge	Use hh:mm format
j)	Type of Admission	Indicate type of admission of patient	Tick the right option
k)	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
l)	Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
m)	Total claimed amount	Indicate the total claimed amount	In rupees (Do not enter paise values)
	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
	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)	Whether Pre-authorization obtained	Indicate whether pre-authorization obtained	Tick Yes or No
d)	Pre-authorization Number	Enter pre-authorization number	As allotted by TPA
e)	If authorization by network hospital not obtained, give reason	Enter reason for not obtaining pre-authorization number	Open text
f)	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
g)	Complaints/ Symptoms	Indicate the date when the symptom/complaint	use dd-mm-yy format
h)	Previous medical history	Enter the medical history	Open text
i)	Specific diseases	State Yes or No	Duration should be in years and months
j)	Complication of pre-existing diseases	Indicate whether present ailment is a complication that existed prior to policy inception	Open text
k)	Alcoholism	Indicate Yes or No. If yes state quantity consumed	Open text
l)	Smoking of tobacco	Indicate Yes or No. If yes state units consumed	Open text
	SECTION D – CLAIM DOCUMENTS SUBMITTED-CHECK LIST		
Indicate which supporting documents are submitted			
	SECTION E – DETAILS IN CASE OF NON NETWORK 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. with State Code	Enter the registration number of the doctor along with the state code	As allocated by the Medical Council of India
d)	Hospital 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 HOSPITAL		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign and stamp			