redefining / general insurance

Bharti AXA General Insurance Company Limited

☎ 1800-103-2292 (Toll Free)
claims@bharti-axagi.co.in
SMS <CLAIM> to 5667700
www.bharti-axagi.co.in

CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT – PART A TO BE FILLED IN BY THE INSURED

The issue of this Form is not to be taken as an admission of liability

Important Note

Issuance of this form not to be taken as an admission of liability

Please fill this form in **Block Letters** and **Tick the Boxes** ✓ where appropriate and do not leave any column unanswered.

If any detail or information is not readily available, please do not delay despatch of this report and such particulars may be sent later.

SECTION A

1 Details of primary insured

(To be filled in block letters)

a) Policy No.

b) Company/ TPA ID No

c) Name SURNAME FIRST NAME MIDDLE NAME

d) Address of the Insured:

City: State:

Pin Code: b) Phone No. c) Email ID

SECTION B

2 Details of insurance history

a) Currently covered by any other Mediclaim / Health Insurance Yes ☐ No ☐

b) Date of commencement of first Insurance without break DD MM YYYY

c) If yes, company name

Policy No. Sum Insured (Rs.)

d) Have you been hospitalized in the last four years since inception of the contract? Yes ☐ No ☐ Date DD MM

Diagnosis

SECTION C

3 Details of insured person hospitalized

a) Name SURNAME FIRST NAME MIDDLE NAME

b) Gender Male ☐ Female ☐ c) Age: Years YY Months MM d) Date of birth DD MM YYYY

e) Relationship to Primary insured: Self ☐ Spouse ☐ Child ☐ Father ☐ Mother ☐ Other (Please Specify)

f) Occupation: Service ☐ Self Employed ☐ Homemaker ☐ Student ☐ Retired ☐ Other (Please Specify)

g) Address of the Insured:

City State

Pin Code b) Phone No. c) Email ID

Registered office address: Bharti AXA General Insurance Co. Ltd.
First Floor, Ferns Icon, Survey No. 28, Doddanekundi, Bangalore - 560 037. IRDA Reg. No. 139.
ST Registration No.: AADCB2008DST001 Co. Registration No.: U66030KA2007PLC043362

4 Details of hospitalization

a) Name of Hospital where Admitted

b) Room Category occupied: Day care ☐ Single occupancy ☐ Twin sharing ☐ 3 or more beds per room ☐

c) Hospitalization due to: Injury ☐ Illness ☐ Maternity ☐

d) Date of Injury/Date 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

SECTION D

5 Details of claim

a) Details of the treatment expenses claimed

i. Pre-hospitalization Expenses Rs.

ii. Hospitalization Expenses Rs.

iii. Post-hospitalization Expenses Rs.

iv. Health-Check up Cost Rs.

v. Ambulance Charges Rs.

vi. Others (code) ☐ Rs.

vii. Pre-hospitalization period: days

viii. Post-hospitalization period: days

b) Claim for Domiciliary Hospitalization: Yes ☐ No ☐ (If yes, provide details in annexure)

c) Details of Lump sum / cash benefit claimed:

i. Hospital Daily Cash Rs.

ii. Surgical Cash Rs.

iii. Critical Illness Benefit Rs.

iv. Convalescence Rs.

v. Pre/Post hospitalization Lump sum benefit Rs.

vi. Others

Total Rs.

SECTION E

6 Claim documents submitted - check list

Please furnish the following list of the documents for Reimbursement:

- ☐ Claim form with duly signed by insured (Part I) and treating doctor (Part II).
- ☐ Original discharge summary
- ☐ Original final bill with receipt & detailed break up towards the final bill (item wise/cost wise).
- ☐ Original lab reports with advice for investigation undergone from the treating doctor (Doctor Prescription/Consultation).
- ☐ A letter from treating consultant stating past history if any with duration of the said ailment,
- ☐ A letter from the treating consultant stating details of accident and initial assessment- alcohol intoxication if any, (if the case of injury or accident) with MLC COPY / FIR copy in case of RTA/any injury/assault/poisoning etc.
- ☐ 1st consultation paper before the admission, if any
- ☐ Hospital registration certificate if the hospital is in non-network/remote location.
- ☐ A letter from insured stating reason for delay in submission of claim documents. (If delay more than 30 days after the discharge)
- ☐ Policy copy/Health ID card/ Health TPA ID card with ID proof & Address proof for patient & proposer.
- ☐ Cancelled cheque for Electronic fund transfer in the name of proposer

For pre - post hospitalization claim: After the discharge within 60 days treatment.

- ☐ Claim form (Part I)
- ☐ Medicine bills with Doctor Prescription/Consultation.
- ☐ Original lab reports with advice for investigation undergone from the treating doctor (Doctor Prescription/Consultation). If any
- ☐ Cancelled cheque Electronic fund transfer in the name of proposer

SECTION F

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7 Details of bills enclosed

Sl. No	Bill No	Date	Issued by	Towards	Amount (Rs)
1		D D M M Y Y		Hospital Main Bill	
2		D D M M Y Y		Pre-hospitalization Bills: Nos	
3		D D M M Y Y		Post-hospitalization Bills: Nos	
4		D D M M Y Y		Pharmacy Bills	
5		D D M M Y Y			
6		D D M M Y Y			
7		D D M M Y Y			
8		D D M M Y Y			
9		D D M M Y Y			
10		D D M M Y Y			

8 NEFT Declaration:

Insured / proposer details :

Insured full name
(As in Bank Account)

PAN Number (10 digits)

Mobile Number

Email ID

Particulars of Bank Account :

Bank Name

Name of the Branch

Bank branch IFSC code for NEFT (11 digit)

Account Number
as appearing on
cheque book

Mandatory Requirement: Cancelled blank Cheque- for ensuring accuracy of name of the bank, branch name, Account number and IFSC code. If name / IFSC code / account number of the payee is not printed on the cheque leaf, please attach copy of the first page of the bank passbook.

9 Declaration by the insured

I / We, the undersigned, hereby declare that the particulars provided above have been filled-in / provided by me / us and hereby further declare that the said particulars are correct and complete and no blanks have been left. If the transaction is delayed or not effected at all for reason of incomplete or incorrect information I / we would not hold Bharti AXA General Insurance Company Limited responsible for the same.

I / We further undertake to refund, at any time, any excess amount whether demanded by Bharti AXA General Insurance Company Limited or not, which has been credited to my account [due to any reason whatsoever] by Bharti AXA General Insurance Company Limited, in excess of (i) the amount due to me, or (ii) in excess of amount for which I gave mandate, and or (iii) Any other payment.

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I / We agree that the payment will be endeavoured to be credited starting from the date of next payment cycle and issuance of relevant credit instruction for electronic payment from Bharti AXA General Insurance Company Limited into the aforesaid account will be valid discharge to Bharti AXA General Insurance Company Limited for having paid (i) the amount due to me, or (iii) Any other payment.

I / We further confirm that we understand this mode as a method of payment introduced by Reserve Bank of India, which provides us an option to receive the amount and or to collect our payments by electronic payment mode directly through my/our bank accounts.

I / We further confirm that I/we understand, Bharti AXA General Insurance Company Limited, shall make electronic payment to my account by issuing the Payment instruction electronically through its banker to the Clearing Authority and the Clearing Authority would ensure credit to my/our specified bank account provided hereinabove.

I / We further undertake to inform Bharti AXA General Insurance Company Limited with an advance notice of at-least 6 weeks, to withdraw from this mode of electronic payment.

I / We further confirm that Bharti AXA General Insurance Company Limited will have, at its sole discretion, the right to return back to the option of paying to me/us by way of cheque if there are more than 2 consecutive failures in remittances for no fault of Bharti AXA General Insurance Company Limited.

Data Privacy Notice:
I/We hereby provide consent to the Company for collecting/retaining any information relating to Me/Us including Sensitive Personal Information (“hereinafter cumulatively referred to as “INFORMATION”), that is either available with the Company or disclosed by Me/Us while obtaining the policy of Insurance from the company or otherwise. I/We further understand that the Company may use the INFORMATION for servicing the Insurance policy obtained by Me/Us and for same may share the INFORMATION with any reinsurer, insurance association, medical authorities, other Insurers, statutory authorities, court, governmental body, regulator etc., or with services provider(s) engaged by the Company for servicing the Insurance policy, underwriting the risk, settlement of claim etc. without obtaining our specific consent for such sharing and we hereby provide our consent to Company for same.

I/We understand that whenever I/We would like to update/correct the INFORMATION, we will intimate the Company for the same, so as to enable the Company to amend/correct the INFORMATION accordingly. Further in the event I/We would like to withdraw My/Our consent provided herein, I/We would intimate the Company of the same in writing and also understand that, in the event of such withdrawal by Me/Us, the Company reserves the right to not provide Me/Us the Services for which it has sought the INFORMATION.

After Bharti AXA General Insurance Company Limited issues the Payment instruction electronically through its banker, for whatever reasons, if I/we do not get the credit to my/our account, then same shall neither constitute the default in (i) Payment of amount requested by me, or (ii) Payment of amount due to me/us, or (iii) Payment of Any other payment by Bharti AXA General Insurance Company Limited nor constitute default of any terms and Conditions which may have been entered between I / We and Bharti AXA General Insurance Company Limited. I, We the Undersigned have read the above mentioned declarations / conditions and provide my / our free consent to the same.

Date D D M M Y Y Y Y   Place ____________   Signature of the Insured

SECTION I

10 Customer Identification Procedure (as per KYC norms of IRDA)

Please submit the following documents in case of claim amount exceeds Rs. 1,00,000	
Legal name and any other names used (Any one of the mentioned documents)	Passport/ PAN Card/ Voter’s Identity Card/ Letter from a recognized public authority or public servant verifying the identity and residence of the customer/ AADHAAR card
Address Proof (Any one of the mentioned documents)	Telephone bill/ Bank account statement (not more than 6 months)/ Letter from any recognized public authority/ Electricity bill/ Ration card / Registered Lease and License agreement / Agreement for sale

SECTION J

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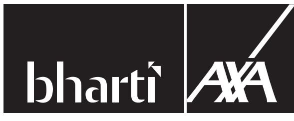
Guidance for filling claim form – PART A (To be filled in by the insured)

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) Date of Commencement of first Insurance without break	Enter the date of commencement of first insurance	Use dd-mm-yy format
c) Company Name	Enter the full name of the insurance company	Name of the organization in full
Policy No.	Enter the policy number	As allotted by the insurance company
Sum Insured	Enter the total sum insured as per the policy	In rupees
d) 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
Date	Enter the date of hospitalization	Use mm-yy format
Diagnosis	Enter the diagnosis details	Open Text
e) Previously Covered by any other Mediclaim/ Health Insurance?	Indicate whether previously covered by another Mediclaim / Health Insurance	Tick Yes or No
f) 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) Occupation	Indicate occupation of patient	Tick the right option. If others, please specify.
g) Address	Enter the full postal address	Include Street, City and Pin Code
h) Phone No	Enter the phone number of patient	Include STD code with telephone number
i) E-mail ID	Enter e-mail address of patient	Complete e-mail address
SECTION D - DETAILS OF HOSPITALIZATION		
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) If Injury give cause	Indicate cause of injury	Tick the right option
If 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
MLC Report & Police FIR attached	Indicate whether MLC report and Police FIR attached	Tick Yes or No
j) 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) Cheque/ DD payable details	Enter the name of the beneficiary the cheque/ DD should be made out to	Name of the individual/ organization in full
e) 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.		



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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

Important Note

Issuance of this form not to be taken as an admission of liability

Please fill this form in **Block Letters** and **Tick the Boxes** ✓ where appropriate and do not leave any column unanswered.

If any detail or information is not readily available, please do not delay despatch of this report and such particulars may be sent later.

SECTION A

1 Details of Hospital

(To be filled in block letters)

a) Name of the hospital

b) Hospital ID (in case of networked hospital)

c) Type of Hospital: Network ☐ Non Network ☐ **(If non network fill section E)**

d) Name of the treating doctor SURNAME FIRST NAME MIDDLE NAME

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

SECTION B

2 Details of the Patient admitted

a) Name of the Patient SURNAME FIRST NAME MIDDLE NAME

b) IP Registration Number c) Gender Male ☐ Female ☐ d) Age: Years YY Months MM e) Date of birth DDMMYY

f) Date of Admission DDMMYY g) Time: HH : MM h) Date of Discharge: DDMMYY i) Time: HH : MM

j) Type of Admission: Emergency ☐ Planned ☐ Day Care ☐ Maternity ☐ k) If Maternit Date of Delivery DDMMYY Gravida Status

l) Status at time of discharge: Discharge to home ☐ Discharge to another hospital ☐ Deceased ☐ m) Total claimed amount

SECTION C

3 Details of Ailment Diagnosed (primary)

	ICD 10 Codes	Description
i) Primary diagnosis		
ii) Procedure done with Anastasia		
iii) Treatment given if no surgery		

c) Pre-authorization obtained: Yes ☐ No ☐ d) Pre-authorization Number:

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

f) Hospitalization due to Injury: Yes ☐ No ☐ If Yes, give cause Self-inflicted ☐ Road Traffic Accident ☐ Substance abuse / alcohol consumption ☐

If Injury due to Substance abuse / alcohol consumption, Test Conducted to establish this: Yes ☐ No ☐ (If Yes, attach reports) If Medico legal: Yes ☐ No ☐

FIR no. If not reported to police give reason:

Registered office address: Bharti AXA General Insurance Co. Ltd.
First Floor, Ferns Icon, Survey No. 28, Doddanekundi, Bangalore - 560 037. IRDA Reg. No. 139.
ST Registration No.: AADCB2008DST001 Co. Registration No.: U66030KA2007PLC043362

4 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: OT : Yes No

ICU : Yes No Others :

SECTION D

5 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.

Data Privacy Notice:
I/We hereby provide consent to the Company for collecting/retaining any information relating to Me/Us including Sensitive Personal Information (“hereinafter cumulatively referred to as “INFORMATION”), that is either available with the Company or disclosed by Me/Us while obtaining the policy of Insurance from the company or otherwise. I/We further understand that the Company may use the INFORMATION for servicing the Insurance policy obtained by Me/Us and for same may share the INFORMATION with any reinsurer, insurance association, medical authorities, other Insurers, statutory authorities, court, governmental body, regulator etc., or with services provider(s) engaged by the Company for servicing the Insurance policy, underwriting the risk, settlement of claim etc. without obtaining our specific consent for such sharing and we hereby provide our consent to Company for same.

I/We understand that whenever I/We would like to update/correct the INFORMATION, we will intimate the Company for the same, so as to enable the Company to amend/correct the INFORMATION accordingly. Further in the event I/We would like to withdraw My/Our consent provided herein, I/We would intimate the Company of the same in writing and also understand that, in the event of such withdrawal by Me/Us, the Company reserves the right to not provide Me/Us the Services for which it has sought the INFORMATION.

Date D D M M Y Y

Place

Signature and Seal of the Hospital Authority

SECTION E

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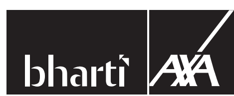
Guidance for filling claim form – PART B (to be filled in by the hospital)

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) 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
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		

CLAIM FORM/HOSPITAL/THINQ/01-16. Insurance is the subject matter of solicitation.



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