Checklist for submission of Claim

Family Health Plan Insurance TPA Limited

Srinilaya - Cyber Spazio, Ground Floor, Road No. 2,
Banjara Hills, Hyderabad - 500 034

Toll-free : 1800-425-4033 (or) 1800-102-4033 Fax: 040 23556262; Website: www fhpl net

CHECK LIST OF ENCLOSURES FOR SUBMISSION OF CLAIMS UNDER INDIVIDUAL POLICY

[Please tick (P) the appropriate box]

Name of the Claimant: _____

UHID Number: _____ Policy Number: _____

Insurance Company: _____ No. of Enclosures: _____

- ☐ Duly filled in Claim Form
- ☐ Photocopy of ID card

General:

- ☐ Original copy of consolidated bill on pre-printed stationery with serial number and IP number of hospital, with breakup
- ☐ Original copy of the receipt of payment
  All original prescriptions for the bills attached
- ☐ All the Original Investigation Reports
- ☐ Original Discharge summary in pre-printed stationery of hospital, duly signed by the treating doctor, with hospital seal and registration number
- ☐ Original invoice for Implants (viz. Stent / PHS mesh / IOL etc.)
- ☐ First consultation letter for the presenting complaints
- ☐ Original copies of doctor's consultation prescription / notes
  Treating Doctor's certificate regarding presenting complaints its etiology, past history of presenting complaints along with duration
- ☐ Cancelled cheque along with IFSC details (or) copy of the Bank pass book.
- ☐ Submission of Photo Id & address proof is mandatory.

- ☐ Pre-hospitalization prescriptions
- ☐ Original prescription / doctor notes of previous treatment for the presenting complaint
- ☐ Date of previous operation (if any) alon g with copy of discharge summary

For Death Cases:

- ☐ Attested copy of death summary in pre -printed stationery of hospital signed by the treating doctor with hospital seal and registration number
- ☐ Attested copy of death certificate from competent authority
- ☐ Legal heir certificate / Letter from the underwriting office directing FHPL to settle the claim in the name of the nominee / dependent(s)

For Maternity Cases:

- ☐ Original copy of treating doctor certificate regarding obstetric history (Gravida, Para, Living children, Abortions, Death)

For RTA:

- ☐ Attested copy of MLC report
- ☐ Attested copy of FIR
- ☐ Original copy of treating doctor's certificate with circumstances and injuries sustained due to RTA
- ☐ Original copy of treating doctor's certificate for any evidence of influence of alcohol / other narcotics substance during the accident

Do you have any other Health Insurance Policy? Yes / No
Sum Insured:

If yes, please specify policy number:
Insurance Company:

Undertaking:

I / we hereby confirm that the above -mentioned documents in support of the **claimed amount** have been submitted in full and final. No other documents would be submitted on a later date, that will alter / enhance the claimed value.

Date:
Place: Signature
Full Name: _____
Address: _____
_____
City: _____ Pin: _____
Contact Number: (Res)
(Mobile)
Email: _____

Disclaimer:

We acknowledge receipt of your claim and confirm that it has been registered with us on the basis of the above -mentioned documents. However, the above acknowledgement does not guarantee settlement / payment of the claimed amount. This claim will be subjected to pass through medical and commercial scrutiny, which may call for additional documents that needs to be submitted within the stipulated time frame on intimation.

Date: Signature Signature
Place: Claimant For FHPL