

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

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Navi General Insurance Limited

☐ Others



SECTION - F DETAILS OF BILLS ENCLOSED

S. No .	Bill No .			Do	ate			Issued by	Towards		Ame	ount	(Rs)	
		D	D	М	М	У	У		Hospital Main Bill					
									Pre Hospitalisation Bills (Nos)					
									Post Hospitalisation Bills (Nos)					
									Pharmacy Bills					

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 f MICR No security Insured Stank Account b Account Number b Account Number c Bank Name/Branch s Please attach a cancelled cheque pertaining to the same s Please attach a cancelled cheque pertaining to the same

Note

It is agreed that the Policyholder/Claimant will intimate in writing to DHFL General Insurance Limited. about any change in bank account details.

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



DATA ELEMENT	OR FILLING CLAIM FORM - PART A (To be filled in by the insure DESCRIPTION	FORMAT
	SECTION A - DETAILS OF PRIMARY INSURED	
a) Policy No.	Enter the policy number	As allotted by the insurance
		company
SI. No/Certificate No.	Enter the social insurance number or the certificate	As allotted by the organization
,	number of social health insurance scheme	3
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/	Indicate whether currently covered by another Mediclaim/	Tick Yes or No
Health Insurance?	Health Insurance	
Date of Commencement of first Insurance	Enter the date of commencement of first insurance	Use dd-mm-yy format
without break		
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 compo
Sum Insured	Enter the total sum insured as per the policy	In rupees
Have you been Hospitalized in the last four	Indicate whether hospitalized in the last four years	Tick Yes or No
years since inception of the contract	god.o	· · · · · · · ·
Date	Enter the date of hospitalization	Use mm-yy format
Diagnosis	Enter the diagnosis details	Open Text
Previously Covered by any other Mediclaim/	Indicate whether previously covered by another Mediclaim/	Tick Yes or No
Health Insurance?	Health Insurance	
Company Name	Enter the full name of the insurance company	Name of the organization in full
	CTION C - DETAILS OF INSURED PERSON HOSPITALIZED	Name of the organization in fair
i) Name	Enter the full name of the patient	Surname, First name, Middle name
o) Gender	Indicate Gender of the patient	Tick Male or Female
c) Age	Enter age of the patient	Number of years and months
I) 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,
Relationship to primary insured	maleate relationship of patient with policyholder	please specify.
Occupation	Indicate ecoupation of patient	· · · ·
Occupation	Indicate occupation of patient	Tick the right option. If others,
Addison	Futurable full marked address.	please specify. Include Street, City and Pin Code
g) Address	Enter the full postal address	
n) Phone No	Enter the phone number of patient	Include STD code with telephone
) [110		number
E-mail ID	Enter e-mail address of patient	Complete e-mail address
Name of Hoomital whore admitted	SECTION D - DETAILS OF HOSPITALIZATION	Name of booking in full
Name of Hospital where admitted	Enter the name of hospital	Name of hospital in full
n) Room category occupied	Indicate the room category occupied	Tick the right option
Hospitalization due to	Indicate reason of hospitalization	Tick the right option
Date of Injury/Date Disease first detected/	Enter the relevant date	Use dd-mm-yy format
Date of Delivery		
Date of admission	Enter date of admission	Use dd-mm-yy format
) Time	Enter time of admission	Use hh:mm format
Date of discharge	Enter date of discharge	Use dd-mm-yy format
n) Time	Enter time of discharge	Use hh:mm format
) 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
) System of Medicine	Enter the system of medicine followed in treating the patient	Open Text
	SECTION E - DETAILS OF CLAIM	
ı) Details of Treatment Expenses	Enter the amount claimed as treatment expenses	In rupees (Do not enter paise value
) Claim for Domiciliary Hospitalization	Indicate whether claim is for domiciliary hospitalization	Tick Yes or No
e) Details of Lump sum/cash benefit claimed	Enter the amount claimed as lump sum/cash benefit	In rupees (Do not enter paise value
) =		
I) Claim Documents Submitted-Check List	Indicate which supporting documents are submitted	Tick the right option



DATA ELEMENT	DESCRIPTION	FORMAT											
SECTIO	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	Name of the individual/organization											
	be made out to	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 d	d:mm:yy format), place (open text) and sign.												

Insurance is the subject matter of solicitation. For more details on risk factors, terms and conditions, please read sales brochure carefully before concluding a sale.



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 ${\sf A}$

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iii Co-morbidities			П									iii	Proce	dure	e 3				\top	T	Τ	П	\sqcap	\neg							
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f If authorization by network hospital not obtained, give reason 9 Hospitalisation due to Injury YES No i If yes, give cause 1 1 1 1 1 1 1 1 1																															
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iii Medico Legal					УΕ	s	N	o iv	Repo	orted	d to F	Polic	е				УЕ	3	T	No	v	_	R No					П	УES		No
vi If not reported to Polic	e give	rea	sons	s		T																									
SECTION D - CLAIM DOCUMENTS SUBMITTED - CHECKLIST Claim form duly filled and signed Investigation reports 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																															
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Navi General Insurance Limited



SECTION G - 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:	Treating Doctor Signature and seal of the Hospital Authority



		FILLING CLAIM FORM - PART B (To be filled in by the hospi	FORMAT
	DATA ELEMENT	DESCRIPTION	FORMAI
Ĺ		SECTION A - DETAILS OF HOSPITAL	
_	Name of Hospital	Enter the name of hospital	Name of hospital in full
_	Hospital ID	Enter ID number of hospital	As allocated by the TPA
<u>-)</u>	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	As allocated by the Medical Counci
		the state code	of India
a)	Phone No.	Enter the phone number of doctor	Include STD code with telephone
-			number
		SECTION B - DETAILS OF THE PATIENT ADMITTED	
al	Name of Patient	Enter the name of hospital	Name of hospital in full
_	IP Registration Number	Enter insurance provider registration number	As allotted by the insurance provide
_	Gender	Indicate Gender of the patient	Tick Male or Female
_	Age	Enter age of the patient	Number of years and months
_	Date of Birth	Linter age of the patient	Number of gears and months
Ĺ			
_	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
n .	Total claimed amount	Indicate the total claimed amount	In rupees (do not enter paise values
Ĺ	SECT	ON C - DETAILS OF AILMENT DIAGNOSED (PRIMARY)	
aj	ICD 10 Code	PETALES OF ALEMENT DIAGNOSED (FRIMARY)	
<u> </u>		Enter the ICD 10 Code and description of the	Standard Format and Open text
_	Primary Diagnosis		Standard Format and Open text
		primary diagnosis	
	Additional Diagnosis	primary diagnosis Enter the ICD 10 Code and description of the	Standard Format and Open text
	Additional Diagnosis	primary diagnosis Enter the ICD 10 Code and description of the additional diagnosis	Standard Format and Open text
	Additional Diagnosis Co-morbidities	primary diagnosis Enter the ICD 10 Code and description of the	·
	Additional Diagnosis	primary diagnosis Enter the ICD 10 Code and description of the additional diagnosis	Standard Format and Open text
b)	Additional Diagnosis Co-morbidities	primary diagnosis Enter the ICD 10 Code and description of the additional diagnosis	Standard Format and Open text
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Navi General Insurance Limited



DATA ELEMENT	DESCRIPTION	FORMAT
:	SECTION E - DETAILS IN CASE OF NON NETWORK HOSPITA	AL .
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 patient	As allocated by the Hospital
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 INSURED	<u> </u>
Read declaration carefully and mention date	(in dd:mm:yy format), place (open text) and sign.	
	SECTION G - DECLARATION BY THE HOSPITAL	
Read declaration carefully and mention date	(in dd:mm:yy format), place (open text) and sign and stamp	D.