RELIANCE HEALTH INSURANCE

HEALTH CLAIM FORM - A
UIN: UIIHLIP18012V011718

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. (To be filled in BLOCK letters)

SECTION A - DETAILS OF PRIMARY INSURED

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

c) Policy Type.: ☐ Individual ☐ Group

d) Name:

e) Address:

City: State: Pin Code:

Phone No: Email:

SECTION B - 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 (₹.):

d) Have you been hospitalised in the last four years since inception of the contract? ☐ Yes ☐ No Date: MM/YYYY

Diagnosis:

e) Previously covered by any other Mediclaim / Health insurance: ☐ Yes ☐ No

f) If yes, Company Name:

SECTION C - DETAILS OF INSURED PERSON HOSPITALISED

a) Name: UHID No.:

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

e) Relationship with Primary Insured: ☐ Self ☐ Spouse ☐ Child ☐ Father ☐ Mother ☐ Other

(Please Specify):

f) Occupation: ☐ Service ☐ Self-employed ☐ Homemaker ☐ Student ☐ Retired ☐ Other

(Please specify):

g) Address (if different from above):

Contact No.: Email:

SECTION D - DETAILS OF HOSPITALISATION

a) Name of Hospital where admitted:

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

c) Hospitalisation Due to: ☐ Injury ☐ Illness ☐ Maternity

d) Date of Injury/Date of Disease first detected /Date of Delivery: DD/MM/YYYY

e) Date of Admission: DD/MM/YYYY f) Time: HH : MM Hrs

g) Date of Discharge: DD/MM/YYYY h) Time: HH : MM Hrs

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 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: ____ days

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

c) Details of Lump Sum / Cash Benefit claimed:

(i)	Hospital Daily Cash:	₹
(ii)	Surgical Cash:	₹
(iii)	Critical illness benefit:	₹
(iv)	Convalescence:	₹
(v)	Pre/Post hospitalisation Lump sum benefit	₹
(vi)	Others(code): _____ :	₹
		Total : ₹

Original Claim Documents Submitted – Checklist:

(i)	Claim form Duly signed	☐ Yes ☐ No	(viii)	Operation Theatre Notes	☐ Yes ☐ No
(ii)	Authorisation Form	☐ Yes ☐ No	(ix)	Photo Identity proof	☐ Yes ☐ No
(iii)	Hospital Main bill	☐ Yes ☐ No	(x)	Doctor's request for Investigation	☐ Yes ☐ No
(iv)	Hospital Break-up Bill	☐ Yes ☐ No	(xi)	Investigation on reports (including CT/MRI/USG/HPE)	☐ Yes ☐ No
(v)	Hospital Bill Payment Receipt	☐ Yes ☐ No	(xii)	Doctor's Prescriptions	☐ Yes ☐ No
(vi)	Hospital Discharge Summary	☐ Yes ☐ No	(xiii)	Others	☐ Yes ☐ No
(vii)	Pharmacy bill	☐ Yes ☐ No			

SECTION F - DETAILS OF BILLS ENCLOSED

Sr.No.	Bill No.	Date	Issued by	Towards	Amount(₹)
1		(DD/MM/YYYY)		Hospital main bill	
2		(DD/MM/YYYY)		Pre-hospitalisation bills: _____ Nos.	
3		(DD/MM/YYYY)		Post-hospitalisation bills: _____ Nos.	
4		(DD/MM/YYYY)		Pharmacy bills	
5		(DD/MM/YYYY)			
6		(DD/MM/YYYY)			
7		(DD/MM/YYYY)			
8		(DD/MM/YYYY)			
9		(DD/MM/YYYY)			
10		(DD/MM/YYYY)			

SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

a) Name of the Account holder:

b) PAN: c) Account No.:

d) Bank Name and Branch:

e) Cheque/DD Payable Details: f) IFSC Code:

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-hospitalisation claim, if any.

Date: DD/MM/YYYY

Place:

Signature of the Insured

GUIDANCE FOR FILING 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) Sl. No/ Certificate No.	Enter the Social Insurance number or the certificate number of Social Health Insurance scheme	As allotted by the organisation
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) i. Company Name	Enter the full name of the Insurance Company	Name of the organisation in full
ii. Policy No.	Enter the Policy Number	As allotted by the Insurance Company
iii. Sum Assured:	Enter the total sum insured as per the Policy	In Rupees
d) Have you been Hospitalised in the last four years since inception of the contract?	Indicate whether hospitalised in the last four years	Tick Yes or No
i. Date	Enter the Date of hospitalisation	Use MM/YY format
ii. 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

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) Contact No.	Enter the phone number of patient	Include STD code in case of telephone number
i) Email	Enter e-mail address of patient	Complete e-mail address
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) Contact No.	Enter the phone number of patient	Include STD code in case of telephone number
i) Email	Enter e-mail address of patient	Complete e-mail address
SECTION D - DETAILS OF HOSPITALISATION 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) Hospitalisation 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
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 Hospitalisation	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 No.	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/organisation 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/YYYY format), place (open text) and sign.		

RELIANCE HEALTH INSURANCE

HEALTH CLAIM FORM - B
UIN: UIIHLIP18012V011718

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 pre-authorisation request form in lieu of PART A. (To be filled in BLOCK letters)

SECTION A - DETAILS OF HOSPITAL

a) Hospital Name b) Hospital Id:
c) Type of Hospital: ☐ Network ☐ Non-Network (If non-network, fill Section E)
d) Name of Treating Doctor:
e) Qualification: f) Registration No. with State Code: g) Contact No.:

SECTION B - DETAILS OF PATIENT ADMITTED

a) Patient Name: b) IP Registration No.:
c) Gender: ☐ Male ☐ Female d) Years: YYYY Months: MM e) Date of Birth: DD/MM/YYYY
f) Date of Admission: DD/MM/YYYY g) Time: HH : MMHrs h) Date of Discharge: DD/MM/YYYY i) Time: HH : MMHrs
j) Type of Admission: ☐ Emergency ☐ Planned ☐ Day Care ☐ Maternity
k) If Maternity, (i) Date of Delivery: DD/MM/YYYY (ii) Gravida Status:
l) Status at Time of Discharge: ☐ Discharge to Home ☐ Discharge to another Hospital ☐ Deceased
m) Total Claimed Amount(₹):

SECTION C - DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a)	(i)	Primary Diagnosis:	ICD 10 Code:	Description:
	(ii)	Additional Diagnosis:	ICD 10 Code:	Description:
	(iii)	Co-Morbidities:	ICD 10 Code:	Description:
	(iv)	Co-Morbidities:	ICD 10 Code:	Description:
b)	(i)	Procedure 1:	ICD 10 PCS:	Description:
	(ii)	Procedure 2:	ICD 10 PCS:	Description:
	(iii)	Procedure 3:	ICD 10 PCS:	Description:
	(iv)	Details of Procedure:		

c) Pre-authorisation obtained: ☐ Yes ☐ No d) Pre-authorisation No.:
e) If authorisation by Network Hospital not obtained, Give reason:
f) Hospitalisation due to injury: ☐ Yes ☐ No
(i) If yes, give cause: ☐ Self Inflicted ☐ Road Traffic Accident ☐ Substance Abuse/Alcohol Consumption
(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:

SECTION D - CLAIM DOCUMENTS SUBMITTED CHECKLIST

(i) Claim Form Duly Signed:	☐ Yes ☐ No	(ix) Investigation Report:	☐ Yes ☐ No
(ii) Original Pre-authorisation Request:	☐ Yes ☐ No	(x) CT/MRI/USG/HPE investigation reports:	☐ Yes ☐ No
(iii) Copy of Pre-authorisation Approval Letter:	☐ Yes ☐ No	(xi) Doctor's reference slip for Investigation:	☐ Yes ☐ No
(iv) Copy of Photo Id card of patient verified by Hospital:	☐ Yes ☐ No	(xii) ECG:	☐ Yes ☐ No

(v) Hospital Discharge Summary:	☐ Yes ☐ No	(xiii) Pharmacy Bills:	☐ Yes ☐ No
(vi) Operation Theatre Notes	☐ Yes ☐ No	(xiv) MLC Report & Police FIR	☐ Yes ☐ No
(vii) Hospital Mail Bill	☐ Yes ☐ No	(xv) Original death summary from Hospital, where applicable	☐ Yes ☐ No
(viii) Hospital Break-up Bill	☐ Yes ☐ No	(xvi) Any other, Please specify _____	☐ Yes ☐ No

SECTION E - DETAILS IN CASE OF NON-NETWORK HOSPITAL (ONLY TO BE FILL IN CASE OF NON-NETWORK HOSPITAL)

a) Hospital Address:

b) Contact 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) Others:

SECTION F - 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: DD/MM/YYYY

Place:

Signature & Seal of the Hospital Authority

GUIDANCE FOR FILING CLAIM FORM – PART B (TO BE FILLED IN BY THE HOSPITAL)		
DATA ELEMENT	**DESCRIPTION**	**FORMAT**
SECTION A – DETAILS OF HOSPITAL		
a) Hospital Name	Enter the Name of Hospital	Full Name of Hospital
b) Hospital Id	Enter Id number of Hospital	As allocated by the TPA
c) Type of Hospital	Indicate whether Network or Non-network Hospital	☑ Tick the right option
d) Name of Treating Doctor	Enter the Name of the Treating Doctor	Full Name of Doctor
e) Qualification	Enter the Qualifications of the Treating Doctor	Abbreviations of Educational qualification
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) Contact No.	Enter the Contact number of doctor	Include STD code with Telephone number
SECTION B – DETAILS OF PATIENT		
a) Patient Name	Enter Patient Name	Full Name of Patient
b) IP Registration No.	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 Birth of Patient	Follow DD/MM/YYYY format
f) Date of Admission	Enter Date of Admission of Patient	Follow DD/MM/YYYY format
g) Time	Enter Time of Admission of Patient	Follow DD/MM/YYYY format
h) Date of Discharge	Enter Date of Discharge of Patient	Follow DD/MM/YYYY format
i) Time	Enter Time of Discharge of Patient	Use HH:MM 24 Hrs 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 case of maternity	Follow DD/MM/YYYY format
Gravida Status	Enter Gravida status, if case of maternity	Use Standard Format
l) Status at Time of Discharge	Indicate status of Patient at Time of	☑ Tick the right option
	Discharge	
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	Standard Format and Open text
	of the Primary Diagnosis	
Additional Diagnosis	Enter the ICD 10 Code and description	Standard Format and Open text
	of the Additional Diagnosis	
Co-Morbidities	Enter the ICD 10 Code and description	Standard Format and Open text
	of the Co-Morbidities	
b) ICD 10 PCS		
Procedure 1	Enter the ICD 10 PCS and description of	Standard Format and Open text
	the First procedure	
Procedure 2	Enter the ICD 10 PCS and description of	Standard Format and Open text
	the Second procedure	
Procedure 3	Enter the ICD 10 PCS and description of	Standard Format and Open text
	the Third procedure	
Details of Procedure	Enter the details of the Procedure	Open text
c) Pre-authorisation obtained	Indicate whether Pre-authorisation	☑ Tick Yes or No
	obtained	
d) Pre-authorisation Number	Enter pre-authorisation number	As allotted by TPA
e) If authorisation by network hospital	Enter reason for not obtaining	Open text
not obtained, give reason	Pre-authorisation number	
f) Hospitalisation due to injury	Indicate if hospitalisation is Due to Injury	☑ Tick Yes or No
Cause	Indicate Cause of Injury	☑ Tick the right option
If injury due to Substance	Indicate whether Test conducted	☑ Tick Yes or No
Abuse/Alcohol Consumption,		
Test conducted to establish this		
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	Enter reason for not Reporting to police	Open Text
reason		
SECTION D – CLAIM DOCUMENTS SUBMITTEDCHECKLIST		
Indicate which supporting documents are submitted.		
SECTION E – DETAILS IN CASE OF NON-NETWORK HOSPITAL		
a) Hospital Address	Enter the Full postal address	Include Street, City and Pin Code
b) Phone No.	Enter the Phone number of hospital	Include STD code in case of telephone no.
c) Registration No. with State Code	Enter the Registration number of the	As allocated by the Medical Council of India
	Doctor along with the State code	
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/YYYYformat), place (open text) and sign and stamp.