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Ab Health Hamesha

Claim Form - 'SECURE'

Part A

1. In case You have submitted Original Documents to any other Insurance Company, kindly refer point (b) of note under clause 6.3 (b) of the Policy Terms and Conditions.
2. Please attach any other information which will assist us in our consideration of your Claim.
3. Where there is insufficient space on this claim form to provide a complete answer to a question, please attach your answer on a separate piece of paper and attach it to the claim form. All attachments will form part of the claim form and be subject to the Declaration below.
4. Your Insurance adviser will advise you on where to send this claim form. If you have any doubts, you may contact us on 1800-200-4488.

Section A - Details of Primary Insured

a) Policy No. :

b) SL No./Certificate No.: c) Company/TPA ID No.:

d) Name :
(Surname) (First Name) (Middle Name)

e) Address :

City :

State : Pin Code :

Landline : - Mobile :

E-mail :

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 Number : Sum Insured (Rs.):

d) Have you ever been hospitalized in the last 4 years since inception of the contract? ☐ Yes ☐ No

- Date : / / (DD/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

Title : ☐ Mr. ☐ Ms.

a) Name :
(Surname) (First Name) (Middle Name)

b) Gender : ☐ M ☐ F c) Age : / (YY/MM) d) Date of Birth : / /

e) Relationship with Primary Insured : ☐ Self ☐ Spouse ☐ Child ☐ Father ☐ Mother
☐ Others (Please Specify) ______________________________

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

g) Address :
(if different from above)

City :

State : Pin Code :

h) Landline : - Mobile :

i) E-mail :

h) Gross annual earnings :

Ver. May/14

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 Disease first detected/Date of Delivery : __ / __ / ____ (DD/MM/YYYY)

e) Date of Admission : __ / __ / ____ (DD/MM/YYYY) f) Time of Admission : __ : __ (HH:MM)

g) Date of Discharge : __ / __ / ____ (DD/MM/YYYY) h) Time of Discharge : __ : __ (HH:MM)

i) If Injury, give cause : ☐ Self Inflicted ☐ Road Traffic Accident ☐ Substance Abuse/Alcohol Consumption

i) Medico Legal : ☐ Yes ☐ No ii) Reported to Police : ☐ Yes ☐ No

iii) MLC Report & Police FIR attached : ☐ Yes ☐ No j) System of Medicine : ____________

k) Name of the witness : ____________

Section E - Details of Claim

Claim made for :

Benefit	Yes / No	Benefit	Yes / No
Accidental Death		Domestic Road Ambulance	
Permanent Total Disablement		Nursing Care	
Permanent Partial Disablement		Reconstructive Surgery	
Fractures		Repatriation of Mortal Remains	
Child Education		Accidental Hospitalization (Add-on Benefit)	
Major Diagnostics Tests		a) Hospitalization Expenses	
Disappearance		b) Daily Allowance	
Mobility cover		c) Compassionate visit	
Burns			

a) Description of incidence : ____________

b) Details of the treatment expenses claimed

(i) Hospitalization Expenses : Rs.

(ii) Ambulance Charges : Rs.

(iii) Others (code) : Rs.

Total : Rs.

c) Details of Lump sum/cash benefit claimed :

(i) Hospital Daily Cash : Rs.

Total : Rs.

d) Claim Documents Submitted - Checklist

(i) Claim Form Duly signed : ☐

(ii) Copy of the claim intimation, if any : ☐

(iii) Hospital Main Bill : ☐

(iv) Hospital Break-up Bill : ☐

(v) Hospital Bill Payment Receipt : ☐

(vi) Hospital Discharge Summary / Death Summary : ☐

(vii) Pharmacy Bill : ☐

viii) Operation Theatre Notes : ☐

(ix) ECG : ☐

(x) Doctor's request for investigation : ☐

(xi) Investigation Reports (Including CT MRI/USG/HPE) : ☐

(xii) Doctor's Prescriptions : ☐

(xiii) Copy of ID card : ☐

(xiv) Ambulance Bill with Payment receipt : ☐

(xv) Employer Certificate : ☐

(xvi) Disability Certificate : ☐

(xvii) Copy of First Information Report(FIR) : ☐

(xviii) Copy of the medico-legal certificate : ☐

(xix) Copy of PAN card : ☐

(xx) Policy Copy : ☐

(xxi) Nominee certificate For Accidental death cases : ☐

(xxii) Death Summary : ☐

(xxiii) Post mortem report (if conducted) : ☐

(xxiv) Copy of the legal heir certificate, if the claim is for the death of the principle insured : ☐

(xxv) Death Certificate : ☐

(xxvi) Others : ☐

e) Nature of Claim : ☐ Non-Fatal Injury ☐ Fatal Injury

Non-fatal Injury

(i) Nature of Injury : ______

(ii) Nature of disablement : ______

(iii) Extent of disablement : ______

(iv) Percentage of disability as assessed by the attending doctor: ______

(v) Period of temporary total disablement : ☐☐☐ days

Fatal Injury

(i) Cause of death as per attending doctor : ______

(ii) Post mortem - date (if conducted) : ______

(iii) Hospital where conducted : ______

(i) Are the injuries referred to the sole and direct cause of your being rendered completely disabled from attending to your usual business or occupation? ☐ Yes ☐ No

If Yes, I was totally disabled : From ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY) To ☐☐ / ☐☐ / ☐☐☐☐

(ii) Have you, since the accident been able to attend to your business or occupation in Part only? Yes or No

If Yes, I was partially disabled : From ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY) To ☐☐ / ☐☐ / ☐☐☐☐

(iii) What hours and duties are you working ? ☐☐☐ Days ☐☐ Hours

Nature of work/activities : ______

(iv) During the 24 hours before the injury, did you drink any alcohol or take any drugs? ☐ Yes ☐ No

State types & quantities : ______

(v) Are you at present totally disabled? ☐ Yes ☐ No

If Yes, when do you consider you will be able to attend to : ______

Some of your Business or Occupation: On ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)

The whole of your Business or Occupation: On ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)

(vi) Is this condition die to injury or sickness arising out of your employment? ☐ Yes ☐ No

If yes, how exactly did it occur?

(vii) Have you ever had this or a similar condition in the past? ☐ Yes ☐ No

Details of Doctor

a) Name : ______

b) Gender : ☐ M ☐ F

c) Qualification : ______

d) Address : ______

City : ______

State : ______ Pin Code : ______

Landline : ______ - ______ Mobile : ______

E-mail : ______

Name and contact details of other doctors whom you have consulted

a) Name :

Contact No. (O): (R) :

b) Name :

Contact No. (O): (R) :

c) Name :

Contact No. (O): (R) :

d) Name :

Contact No. (O): (R) :

Section F - Details of Bills Enclosed

S No.	Bill No.	Date	Issued by	Towards	Amount (INR)
1		(DD/MM/YYYY)			
2		(DD/MM/YYYY)			
3		(DD/MM/YYYY)			
4		(DD/MM/YYYY)			
5		(DD/MM/YYYY)			
6		(DD/MM/YYYY)			
7		(DD/MM/YYYY)			
8		(DD/MM/YYYY)			
9		(DD/MM/YYYY)			
10		(DD/MM/YYYY)			

In case of more details, please attach a separate sheet.

Section G - Details of Primary Insured's Bank Account

a) PAN :

b) Account Number :

c) Bank Name & Branch :

d) Cheque/DD payable details :

e) 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-hospitalization claim, if any.

I hereby authorize the physician or hospital or police authorities or governmental agency or any other institute to provide to Religare Health Insurance Company Limited, or its offices or legal advisers or any investigative agency or their representative acting on its behalf, information regarding the deceased's state of health, employment, finances or insurance, advice, treatment provided to the deceased or any information that may be required concerning the health of the deceased including information relating to mental illness, use of drugs, use of alcohol. A Photostat copy of this authorization shall be considered as effective and valid as the original.

Date : / / (DD/MM/YYYY)

Signature of the Insured : ____________________

Place : ____________________

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 Hospitalised 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 Hospitalised		
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 with 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) Landline	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
h) Gross annual earnings	Enter the total sum insured as per the policy	In rupees
Section D - Details of Hospitalisation		
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
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
k) Name of the witness	Enter the full name of the witness	Name
Section E - Details of Claim		
a) Description of incidence	Enter the description of incidence	Open Text
b) Details of Treatment Expenses	Enter the amount claimed as treatment expenses	In rupees (Do not enter paise values)
c) Claim for Domiciliary Hospitalization	Indicate whether claim is for domiciliary hospitalization	Tick Yes or No
d) Details of Lump sum/cash benefit claimed	Enter the amount claimed as lump sum/cash benefit	In rupees (Do not enter paise values)
e) Nature of claim	Enter details whether fatal or non-fatal injury	Open Text
Details of Doctor	Enter details of the doctor	Open Text
Section F - Details of Bills Enclosed		
Indicate which bills are enclosed with the amounts in rupees		

Data Element	Description	Format
	Section G - Details of Primary Insuredís 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.		

Claim Form - 'SECURE'
Part B

1. To be filled in by the hospital.
2. The issue of this Form is not to be taken as an admission of liability.
3. Please include the original pre-authorization request form in lieu of PART A.
4. To be filled in block letters.

Section A - Details of Hospital

a) Name of the Hospital :

b) Hospital ID :

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) Contact No. :

Section B - Details of the Patient Admitted

a) Name of the Patient:
(Surname) (First Name) (Middle Name)

b) IP Registration No. :

c) Gender : ☐ M ☐ F d) Age : / (YY/MM) e) Date of Birth : / /

f) Date of Admission : / / (DD/MM/YYYY) g) Time of Admission : : (HH:MM)

h) Date of Discharge : / / (DD/MM/YYYY) i) Time of Discharge : : (HH:MM)

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 the time of discharge : ☐ Discharge to home ☐ Discharge to another hospital ☐ Deceased

m) Total Claimed Amount :

n) Is the patient still disabled?

(i) If NO, when did the patient return to work?

(ii) If YES, how long will the patient be

Totally disabled (unable to perform any part of their occupation)

From / / (DD/MM/YYYY) To / /

Partially disabled (able to perform part of their occupation)

From / / (DD/MM/YYYY) To / /

If partially disabled, what duties could the patient perform and for how many hours a week?

____

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) Present ailment is a complication of PED : ☐ Yes ☐ No

If yes, specify details : ____________________

d) Pre-authorization obtained : ☐ Yes ☐ No

e) Pre-authorization no. : ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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

____

g) Hospitalization 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) Duly signed Claim Form : ☐

(ii) Original Pre-authorization request : ☐

(iii) Copy of Pre-authorization approval letter : ☐

(iv) Copy of photo ID card of patient verified by hospital : ☐

(v) Hospital Discharge Summary : ☐

(vi) Operation Theatre notes : ☐

(vii) Hospital Main Bill : ☐

(viii) Hospital Break-up Bill : ☐

(ix) Investigation Reports : ☐

(x) CT/ MRI/ USG /HPE investigation reports : ☐

(xi) Doctor's reference slip for investigation : ☐

(xii) ECG : ☐

(xiii) Pharmacy Bills : ☐

(xiv) MLC report & Police FIR : ☐

(xv) Original death summary from hospital where applicable : ☐

(xvi) Any other, please specify____________________ : ☐

Section E - 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) Contact No. : ☐☐☐☐☐ - ☐☐☐☐☐☐☐☐☐☐

c) Registration No. with State Code : ☐☐☐☐☐☐☐☐☐☐☐☐

d) Hospital PAN : ☐☐☐☐☐☐☐☐☐☐

e) No. 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

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)

Signature & Seal of the Hospital Authority : ____________________

Place : ____________________

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	Name of 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) Contact No.	Enter the phone number of doctor	Include STD code with telephone number
h) Name and contact details of other doctors whom you have consulted	Enter the name & contact details	Enter the details of the doctor
	Section B - Details of 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 Birth of patient	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)
n) Is the patient still disabled	Enter the details	Open text
	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) PED	Indicate whether present ailment is a combination of PED	Tick Yes or No
If yes, specify details	Enter the details of PED	Open text
d) Pre-authorization obtained	Indicate whether pre-authorization obtained	Tick Yes or No
e) Pre-authorization Number	Enter pre-authorization number	As allotted by TPA
f) If authorization by network hospital not obtained, give reason	Enter reason for not obtaining pre-authorization number	Open text
g) 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
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
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 - Claims Document Submitted Checklist	
Indicate which supporting documents are submitted		

Data Element	Description	Format
	Section E - Details in case of Non-Network Hospital	
a) Address	Enter the full postal address	Include Street, City and Pin Code
b) Contact 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		