Claim Form - Part A

TO BE FILLED IN BY THE INSURED

The issue of this Form is not to be taken a s 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) Company / TPA ID No.

d) Name SURNAME FIRST NAME MIDDLE NAME

e) Address

City State

Pin Code Phone No. Email ID

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 D D M M Y Y

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 D D M M Y Y

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

f) If yes, company name

SECTION - C

DETAILS OF INSURED PERSON HOSPITALIZED

a) Name SURNAME FIRST NAME MIDDLE NAME

b) Gender Male Female c) Age Years Y Y Months M M d) Date of birth D D M M Y Y

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 (if different from above)

City State

Pin Code Phone No. Email ID

SECTION - D

DETAILS OF HOSPITALIZATION

a) Name ol 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

e) Date of Admission D D M M Y Y f) Time H H M M g) Date of Discharge D D M M Y Y h) Time H H M M

i) If Injury give cause Self inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption 1. If Medico legal Yes No

2. Reported to police Yes No 3. MLC Report & Police FIR attached Yes No j) System of Medicine

SECTION - E

DETAILS OF CLAIM

a) Details of the treatment expenses claimed

1) Pre-hospitalization Expenses Rs. 2) Hospitalization Expenses Rs.

3) Post-hospitalization Expenses Rs. 4) Health-Check up Cost Rs.

5) Ambulance Charges Rs. 6) Others (code) Rs.

Total Rs.

7) Pre-hospitalization period Rs. 8) 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

1) Hospital Daily Cash Rs. 2) Surgical Cash Rs.

3) Critical Illness Benefit Rs. 4) Convalescence Rs.

5) Pre/Post hospitalization Lump sum benefit Rs. 6) Others Rs.

Total Rs.

Claim Documents Submitted- Check List

- Claim Form Duly signed
- Copy of the claim intimation, if any
- Hospital Main Bill
- Hospital Break-up Bill
- Hospital Bill Payment Receipts
- Hospital Discharge Summary
- Pharmacy Bill
- Operation Theatre Notes
- ECG
- Doctor's request for investigation
- Investigation Reports (Including CT/ MRI / USG / HPE)
- Doctor's Prescriptions
- Other- For Personal Accident refer to Annexure I

SECTION - F

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			

SECTION - G

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

a) PAN b) Account Number

c) Bank name and branch

d) Cheque/ DD Payable details e) IFSCCode

(IMPORTANT: PLEASE TURN OVER)

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 no.	Open text
f) Hospitalization due to injury	Indicate if hospitalization is due to injury	Tick Yes o r 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 o r No
Medico Legal	Indicate whether injury is medico legal	Tick Yes o r 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 - Part B

TO BE FILLED IN BY THE HOSPITAL

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 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 treating doctor SURNAME FIRST NAME MIDDLE NAME

e) Qualification f) Registration No. with State code g) Phone no.

SECTION - B

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient SURNAME FIRST NAME MIDDLE NAME

b) IP Registration No. c) Gender Male Female d) Age Years Months e) Date of birth D D M M Y Y

f) Date of Admission D D M M Y Y g) Time H H M M h) Date of Discharge D D M M Y Y i) Time H H M M

j) Type of Admission Emergency Planned Day Care Maternity k) If Maternity 1. Date of Delivery D D M M Y Y 2. Gravida Status

l) Status at time of discharge Discharge to home Discharge to another hospital Deceased m) Total claimed amount D D M M Y Y

SECTION - C

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a)	ICD10 Codes	Description	b)	ICD 10 PCS	Description
1. Primary Diagnosis			1. Procedure 1		
2. Additional Diagnosis			2. Procedure 2		
3. Co-morbidities:			3. Procedure 3		
4. Co-morbidities			4. Details of Procedure		

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

e) If authorisation by network hospital not obtained, give reason

f) Hospitalization due to Injury Yes No 1. If Yes, give cause Self inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption

2. If Injury due to Substance abuse / alcohol consumption, Test Conducted to establish this Yes No (If Yes, attach reports) 3. If Medico legal Yes No 4. Reported to Police Yes No

5. FIR no. 6. If not reported to police give reason

SECTION - D

CLAIM DOCUMENTS SUBMITTED - CHECK LIST

- Claim Form duly signed
- Original Pre-authorization request
- Copy of the Pre-authorization approval letter
- Copy of photo ID card of patient verified by hospital
- Hospital Discharge summary
- Operation Theatre notes
- Hospital main bill
- Hospital break-up bill
- Investigation reports
- CT/MR/USG/HPE investigation reports
- Dodor's reference slip for investigation
- ECG
- Pharmacy bills
- MLC report & Police FIR
- Original death summary from hospital where applicable
- 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) Phone No. c) Registration No. with State code

d) Hospital PAN e) Number of impatients beds f) Facilities available in the hospital 1. OT Yes No 2. ICU Yes No

3. 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 D D M M Y Y Place

Signature and Seal of the Hospital Authority

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 Place Signature of the Insured

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.		

Annexure-I

1. **Please enclose the following documents**

a) Accidental Death

i) Duly filled and signed claim form

ii) Original Death Certificate (issued by the office of Registrar of Births and Deaths)

iii) Copy of First Information Report (FIR)/Panchnama/Inquest report duly attested by the concerned police station

iv) Copy of Medico Legal Certicate duly attested by the concerned hospital.

v) Copy of Post Mortem report wherever applicable (provided Post Morten was conducted)

vi) Newspaper cutting / news articles covering the accident (if available)

b) Accidental Permanent Total Disability and Accidental Permanent Partial Disability

i) Duly filled and signed claim form

ii) Hospital Discharge Summary (in original)/ self attested copies if the originals are submitted with another insurer

iii) Medical consultations and investigations done from outside the hospital

iv) Original certificate of Disability issued by a Medical Board duly constituted by the Central and the State Government.

v) Copy of First Informatin Report (FIR)/Panchnama/Inquest report duly attested by the concerned police station

vi) Copy of Medico Legal Certificate duly attested by the concerned hospital

vii) Newspaper cuttings / news articles covering the accident (if available)

c) Accidental Temporary Total Disability

i) Duly filled and signed claim form

ii) Hospital Discharge Summary (in original)/ self attested copies if the originals are submitted with another insurer

iii) Copy of First Informatin Report (FIR)/Panchnama/Inquest report duly attested by the concerned police station

iv) Copy of Medico Legal Certificate duly attested by the concerned hospital

v) Attendance record of employer / Certificate of employer confirming period of absence

vi) Latest salary certificate with grade and designation

vii) Newspaper cuttings / news articles covering the accident (if available)

d) Fixed Medical Expenses (not linked to basic benefits)

i) Duly filled and signed claim form

ii) Hospital Discharge Summary (in original)/self attested copies if the originals are submitted with another insurer

iii) Copy of First Informatin Report (FIR)/Panchnama/Inquest report duly attested by the concerned police station

iv) Copy of Medico Legal Certificate duly attested by the concerned hospital

v) Final Hospital bill with receipt

vi) Bills with supporting prescriptions and reports for investigations done outside the hospital

vii) Bills with supporting prescriptions for medicines purchased from outside the hospital

vii) Newspaper cuttings / news articles covering the accident (if available)

e) Variable Medical Expenses (linked to basic benefits)

In addition to the documents required for the Accidental Death, Accidental Permanent Total Disability, Accidental Permanent Partial Disability or Temporary Total Disability:

i) Final Hospital bill with receipt / copies attested by other insurer if the originals are submitted with them

ii) Original bills with supporting prescriptions and reports for investigations done outside the hospital/ copies attested by other insurer if the originals are submitted with them

iii) Original bills with supporting prescriptions for medicines purchased from outside the hospital/copies attested by other insurer if the originals are submitted with them

f) Residential Accommodations and Vehicle Modification

i) Duly filled and signed claim form

ii) Documents required for Accidental Permanent Total Disability (if not already submitted)

iii) Bills of Residential Accommodation or Vehicle Modification

iv) Narration from architect/ civil engineer/affidavit from the customer detailing the modification done to the house (if applicable)

v) Narration from vehicle workshop detailing the modification done (if applicable)

g) Family Transportation

i) Duly filled and signed claim form

ii) Documents required for Accidental Death or Accidental Permanent Total Disability (if not already submitted)

iii) Copy of ticket and invoice

vi) Copy of boarding pass (if journey performed by air)

h) Last Rites

i) Duly filled and signed claim form

ii) Documents required for Accidental Death (if not already submitted)

i) Broken Bones Cover

i) Duly filled and signed claim form

ii) Hospital Discharge Summary (in original)/ self attested copies if the originals are submitted with another insurer / Consultation notes (if hospitalization has not occurred)

iii) X-Ray and MRI films along with reports

iv) Copy of First Information Report (FIR)/Panchnama/Inquest report duly attested by the concerned police station

v) Copy of Medico Legal Certicate (MLC) duly attested by the concerned hospital

vi) Narration of events of accident if no FIR / MLC available

vii) Newspaper cuttings / news articles covering the accident (if available)

j) Education Allowance for Children

i) Duly filled and signed claim form

ii) Document requied for Accidental Death or Accidental Permanent Total Disability (if not submitted already)

iii) Letter from employer or group administrator confirming the number of children of Insured Person

Max Bupa Health Insurance

Max Bupa Health Insurance Company Limited
Registered Office: Max House, 1 Dr. Jha Marg, Okhla, New Delhi -110 020.
Corporate Office: Block B1/I-2, Mohan Cooperative Industrial Estate, Mathura Road, New Delhi -110044
Insurance is the subject matter of solicitation.