Claim Form - 'GROUP CARE'

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 : ☐☐☐☐☐☐☐

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 Code : ☐☐☐☐ Description : _____

(ii) Procedure 2 : ICD 10 Code : ☐☐☐☐ Description : _____

(iii) Procedure 3 : ICD 10 Code : ☐☐☐☐ 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 - Additional 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 : _____