

Request for Cashless Hospitalization for Health Insurance Policy

Details of the third party administrator (To be filled in block letters)

- a) Name of TPA / Insurance company:
- b) Toll free phone number:
- c) Toll free FAX:

TO BE FILLED BY THE INSURED / PATIENT

- a) Name of the Patient:
- b) Gender: Male Female c) Age: Years Month d) Date of Birth
- e) Contact number: f) Contact number of attending relative
- g) Insured card ID number
- h) Policy number / Name of corporate i) Employee ID
- j) Currently do you have any other Medicaclaim / Health insurance Yes No Company Name
Give details
- k) Do you have a family physician l) Name of the family physician:
- m) Contact number, if any (Please complete declaration on the reverse side of this form)

TO BE FILLED BY THE TREATING DOCTOR / HOSPITAL

- a) Name of the treating doctor b) Contact number
- c) Nature of ILLNESS/Disease with presenting complaints
- d) Relevant clinical findings
- e) Duration of the present ailment Days i. Date of first consultation
- ii. Past history of present ailment if any
- f) Provisional diagnosis:
- i. ICD 10 Code:
- g) Proposed line of treatment Medical Management Surgical Management Intensive care Investigation Non allopathic treatment
- h) If Investigation &/or Medical Management provide details
- i) Route of drug administration
- j) If Surgical, name of surgery
- i. ICD 10 PCS Code:
- j) If other treatments provide details
- k) How did injury occur
- l) In case of accident: i. Is it RTA: Yes No ii. Date of injury
- iii. Reported to Police Yes No iv. FIR No.
- v. Injury/Disease caused due to substance abuse/alcohol consumption Yes No
- vi. Test conducted to establish this: Yes No (If Yes attach reports) l) In case of Maternity: G P L A
- Date of Delivery:

Details of the patient admitted

- a) Date of admission b) Time
- c) Is this an emergency / a planned hospitalization event? Emergency Planned
- d) Expected no. of days stay in hospital: Days e) Room Type:
- f) Per Day Room Rent + Nursing & Service Charges + Patient's Diet: Rs.
- g) Expected cost for investigation + diagnostics Rs. h) ICU Charges Rs.
- i) OT Charges Rs. j) Professional fees Surgeon + Anesthetist Fees + consultation Charges Rs.
- k) Medicines + Consumables + Cost of Implants (if applicable please specify). Other hospital expenses if any Rs.
- l) All inclusive package charges if any applicable Rs.
- m) Sum Total expected cost of hospitalization Rs.

Mandatory: Past History of any chronic illness If yes, since (month / year)

- | | | | |
|---|-------------------------------------|---|-------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="text" value="MMYYYY"/> | <input type="checkbox"/> Heart Disease | <input type="text" value="MMYYYY"/> |
| <input type="checkbox"/> Hypertension | <input type="text" value="MMYYYY"/> | <input type="checkbox"/> Hyperlipidemias | <input type="text" value="MMYYYY"/> |
| <input type="checkbox"/> Osteoarthritis | <input type="text" value="MMYYYY"/> | <input type="checkbox"/> Asthma / COPD / Bronchitis | <input type="text" value="MMYYYY"/> |
| <input type="checkbox"/> Cancer | <input type="text" value="MMYYYY"/> | <input type="checkbox"/> Alcohol or drug abuse | <input type="text" value="MMYYYY"/> |
- Any HIV or STD / Related ailments
- Any other Ailment give details

(PLEASE READ VERY CAREFULLY)

DECLARATION

We confirm having read understood and agreed to the Declarations on the reverse of this form

- a) Name of the treating doctor
- b) Qualification:
- c) Registration No. with State Code

Hospital Seal
(Must include Hospital ID)

Patient / Insured Name & Signature

(IMPORTANT: PLEASE TURN OVER)

DECLARATION BY THE PATIENT / REPRESENTATIVE

1. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Insurer/TPA after the discharge. I agree to sign on the Final Bill & the Discharge Summary, before my discharge.
2. Payment to hospital is governed by the terms and conditions of the policy. In case the Insurer / TPA is not liable to settle the hospital bill, I undertake to settle the bill as per the terms and conditions of the policy.
3. All non-medical expenses and expenses not relevant to current hospitalization and the amounts over & above the limit authorized by the Insurer/TPA not governed by the terms and conditions of the policy will be paid by me.
4. I hereby declare to abide by the terms and conditions of the policy and if at any time the facts disclosed by me are found to be false or incorrect I forfeit my claim and agree to indemnify the Insurer / TPA
5. I agree and understand that TPA is in no way warranting the service of the hospital & that the Insurer / TPA is in no way guaranteeing that the services provided by the hospital will be of a particular quality or standard.
6. I hereby warrant the truth of the forgoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppression or concealment with respect to the claim, my right to claim reimbursement of the said expenses shall be absolutely forfeited.
7. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer / TPA.

a) Patient's / Insured's Name: _____

b) Contact number: _____ d) Patient's / Insured's Signature: _____

HOSPITAL DECLARATION

1. We have no objection to any authorized TPA / insurance company official verifying documents pertaining to hospitalization.
2. All valid original documents duly countersigned by the insured / patient as per the checklist below will be sent to TPA / insurance company within 7 days of the patient's discharge.
3. All non medical expenses , or expenses not relevant to hospitalization or illness, or expenses disallowed in the authorization letter of the TPA / insurance co, or arising out of incorrect information in the pre-authorisation form will be collected from the patient.
4. We agree that TPA / insurance company will not be liable to make the payment in the event of any discrepancy between the facts in this form and discharge summary or other documents.
5. The patient declaration has been signed by the patient or by his representative in our presence.
6. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications.
7. We will abide by the terms and conditions agreed in the MOU.

Hospital Seal

Doctor's Signature

DOCUMENTS TO BE PROVIDED BY THE HOSPITAL IN SUPPORT OF THE CLAIM

1. Detailed Discharge Summary and all Bills from the hospital
2. Cash Memos from the Hospitals / Chemists supported by proper prescription.
3. Receipts and Pathological Test Reports from Pathologists, supported by note from the attending Medical Practitioner / Surgeon recommending such pathological Tests.
4. Surgeon's Certificate stating nature of operation performed and Surgeon's Bill and Receipt.
5. Certificates from attending Medical Practitioner / Surgeon that the patient is fully cured.

ANNEXURE FOR PREAUTH CLAIMS

Dear Policyholder,

Please fill the following information along with the cashless form for your medical insurance policy.

Policy No.

Membership Number

Hospital Id
(To be filled by hospital)

DOCUMENT CHECKLIST:

- I. Copy of Photo ID, address proof and recent photo of patient. (for Valid proof of documents kindly refer KYC documents list)
KYC documents list includes PAN Card/Driving License/Voter Id. Card/Aadhar Card
- II. Past illness records (With duration of symptoms) if any
- III. First and subsequent consultation paper along with admission note.
- IV. Complete medical history along with supporting investigation reports.
- V. In case of accident, MLC/FIR copy (if applicable)
- VI. Claim consent letter

All documents mentioned above to be submitted along with the completed filled cashless form. Insurer may require further documents to process the request.

Name of the Proposer/insured

Contact No.

Signature

Name of the TPA coordinator

Date:

Place:

Signature

Consent Letter

To,

Date ____/____/____

Medical Superintendent

I, Mr./Ms _____ Age _____ Resident

of _____ State _____ Hereby

give my willful consent to Mr/ Dr _____ of Max Bupa Health

Insurance Company Limited to verify and collect necessary documents/ statements including but not limited to certified copies of medical records from your esteemed hospital for the purpose of settlement of my Insurance claim.

My other relevant details are provided below;

Detail of Insured:-

DOA:-

DOD:-

MRD/ Indoor/ IP No:-

Policy No:-

I request you to provide all the information/ documents as required by Max Bupa Health Insurance Company Ltd.

Name:-

Signature/ Thumb Impression

Witness Name & Signature

Claim form for health insurance policies other than travel and personal accident - PART A

TO BE FILLED IN BY THE INSURED

(TO BE FILLED IN BLOCK LETTERS)

The issue of this Form is not to be taken as an admission of liability

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 A

DETAILS OF INSURANCE HISTORY:

a) Currently covered by any other Mediciam / 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 (Rs.):

d) Have you been hospitalized in the last four years since inception of the contract? YES NO Date DD MM YYYY

Diagnosis:

e) Previously covered by any other Mediciam / Health insurance : YES NO

f) If yes, Company Name

SECTION B

DETAILS OF INSURED PERSON HOSPITALIZED:

a) Name: SURNAME FIRST NAME MIDDLE NAME

b) Gender: Male Female c) Age: Years YY Month MM d) Date of Birth: DD MM YY

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 C

DETAILS OF HOSPITALIZATION:

a) Name of 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: DD MM YY e) Date of Admission: DD MM YY

f) Time: HH MM g) Date of Discharge: DD MM YY h) Time: HH MM 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 D

DETAILS OF CLAIM:**a) Details of the treatment expenses claimed**

| | | | | | |
|-------------------------------------|------|----------------------|------------------------------------|----------------------|----------------------|
| i. Pre-hospitalization Expenses: | Rs. | <input type="text"/> | ii. Hospitalization Expenses: | Rs. | <input type="text"/> |
| iii. Post-hospitalization Expenses: | Rs. | <input type="text"/> | iv. Health-Check up Cost: | Rs. | <input type="text"/> |
| v. Ambulance Charges: | Rs. | <input type="text"/> | vi. Others (code): | <input type="text"/> | Rs. |
| | | | Total | Rs. | <input type="text"/> |
| vii. Pre-hospitalization period: | Days | <input type="text"/> | viii. Post-hospitalization period: | Days | <input type="text"/> |

b) Claim for Domiciliary Hospitalization: YES NO (If yes, provide details in annexure)

c) Details of Lump sum / cash benefit claimed:

| | | | | | |
|---|-----|----------------------|--------------------|----------------------|----------------------|
| i. Hospital Daily Cash: | Rs. | <input type="text"/> | ii. Surgical Cash: | Rs. | <input type="text"/> |
| iii. Critical Illness Benefit: | Rs. | <input type="text"/> | iv. Convalescence: | Rs. | <input type="text"/> |
| v. Pre/Post hospitalization Lump sum benefit: | Rs. | <input type="text"/> | vi. Others | <input type="text"/> | Rs. |
| | | | Total | Rs. | <input type="text"/> |

Claim Documents Submitted- Check List:

| | | |
|--|---|--|
| <input type="checkbox"/> Claim Form Duly signed | <input type="checkbox"/> Hospital Discharge Summary | <input type="checkbox"/> Investigation Reports (Including CT/ MRI / USG / HPE) |
| <input type="checkbox"/> Copy of the Claim intimation if any | <input type="checkbox"/> Pharmacy Bill | <input type="checkbox"/> Doctor's Prescriptions |
| <input type="checkbox"/> Hospital Main Bill | <input type="checkbox"/> Operation Theatre Notes | <input type="checkbox"/> Others |
| <input type="checkbox"/> Hospital Break-up Bill | <input type="checkbox"/> ECG | |
| <input type="checkbox"/> Hospital Bill Payment Receipt | <input type="checkbox"/> Doctor's request for investigation | |

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 | | | |

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT:

a) PAN b) Account Number:

c) Bank Name and Branch:

d) Cheque/ DD Payable details: e) IFSC Code:

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 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.

CLAIM FORM - PART B

TO BE FILLED IN BY THE HOSPITAL

(TO BE FILLED IN BLOCK LETTERS)

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 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) Phone No.

SECTION A

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient: SURNAME FIRST NAME MIDDLE NAME

b) IP Registration Number: c) Gender: Male Female

d) Age: Years Months e) Date of birth: DD MM YYYY

f) Date of Admission: DD MM YYYY g) Time: HH MM h) Date of Discharge: DD MM YYYY

i) Time: 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 time of discharge: Discharge to home Discharge to another hospital Deceased

m) Total claimed amount

SECTION B

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

| a) | ICD 10 Codes | Description | b) | ICD 10 PCS | Description |
|---------------------------|----------------------|----------------------|---------------------------|----------------------|----------------------|
| i. Primary Diagnosis: | <input type="text"/> | <input type="text"/> | i. Procedure 1: | <input type="text"/> | <input type="text"/> |
| ii. Additional Diagnosis: | <input type="text"/> | <input type="text"/> | ii. Procedure 2: | <input type="text"/> | <input type="text"/> |
| iii. Co-morbidities: | <input type="text"/> | <input type="text"/> | iii. Procedure 3: | <input type="text"/> | <input type="text"/> |
| iv. Co-morbidities: | <input type="text"/> | <input type="text"/> | iv. Details of Procedure: | <input type="text"/> | <input type="text"/> |

c) Pre-authorization obtained: YES NO d) Pre-authorization Number:

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

f) 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 C

CLAIM DOCUMENTS SUBMITTED - CHECK LIST

- | | |
|--|--|
| <input type="checkbox"/> Claim Form duly signed | <input type="checkbox"/> Investigation reports |
| <input type="checkbox"/> Original Pre-authorization request | <input type="checkbox"/> CT/MR/USG/HPE investigation reports |
| <input type="checkbox"/> Copy of the Pre-authorization approval letter | <input type="checkbox"/> Doctor's reference slip for investigation |
| <input type="checkbox"/> Copy of photo ID card of patient verified by hospital | <input type="checkbox"/> ECG |
| <input type="checkbox"/> Hospital Discharge summary | <input type="checkbox"/> Pharmacy bills |
| <input type="checkbox"/> Operation Theatre notes | <input type="checkbox"/> MLC report & Police FIR |
| <input type="checkbox"/> Hospital main bill | <input type="checkbox"/> Original death summary from hospital where applicable |
| <input type="checkbox"/> Hospital break-up bill | <input type="checkbox"/> Any other, please specify |

SECTION D

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) Phone No: d) Hospital PAN:

c) Registration No. with State Code: e) Number of Inpatient beds

f) Facilities available in the hospital: i. OT : YES NO ii. ICU : YES NO

iii. Others :

SECTION E

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:

Place:

Signature and Seal of the Hospital Authority:

SECTION F

**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 |
| l) 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 number | Open text |
| f) 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 |
| 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 - 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

Annexure - Claim Form for reimbursement

Do You Know?

- Non-submission of original bills and receipts is the main reason for delay in claim settlements. Please provide the originals
- Provide your bank details for direct/ Electronic Fund Transfer (EFT) for faster claim settlement.
- To receive updates on your claim status, please provide your mobile no. & E-mail ID
- You can check your claim status at: www.maxbupa.com → Claims → Claims status → Login to check status.

Dear Policyholder,

Please fill the following information along with the reimbursement claim form for your medical insurance policy.

Policy No.

Membership No.

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

Name of Accountholder:

Bank Name:

Branch:

City:

IFSC Code:

Payment option: Cheque DD NEFT

***Note:** Please submit a cancelled cheque leaf or a copy of latest bank statement or passbook with accountholder's name, account no., and IFSC code mentioned on it.

CUSTOMER IDENTIFICATION PROCEDURE (AS PER KYC NORMS OF IRDAI)

Please submit clear and legible copy of one document (valid and effective as on date of claim submission) each from Part A and Part B and your recent passport size photograph (not more than 6 months old) incase claim amount exceeds Rs 100,000

Photo

Part A Proof of legal name and any other names used

- Pan Card
- If Pan Card is not available please submit any of the documents mentioned below stating reason for not having Pan Card.
 - Passport
 - Voter's Identity Card
 - Driving License
 - Personal Identification and Certification of the employees for your identity.
 - Letter issued by Unique identification Authority of India containing details of name address and Aadhar Number
 - Job Card issued by NREGA duly signed by an officer of the State Government

**Part B
Proof of Residence**

- i. Electricity Bill not older than 6 months from the date of claim submission
- ii. Telephone Bill pertaining to any kind of telephone connection like mobile, landline, wireless etc.
Provided it is not older than 6 months from the date of claim submission
- iii. Ration Card
- iv. Valid lease agreement along with rent receipts which is not more than 3 months old as a residence proof
- v. Saving Bank Passbook with details of permanent/ present residence address (updated upto 1 month prior to claim submission document)
- vi. Statement of saving bank account with details of permanent/ present address (updated upto 1 month prior to claim submission document)

I hereby declare that I have submitted above mentioned documents and recent photograph (not more than 6 months old) for the purpose of claim and the said documents are valid and effective.

Date / /

Signature of Policyholder:

(Please attach copy of a cancelled cheque of your bank for ensuring accuracy of name of the bank, branch name, Account number and IFSC code. If name of the payee is not printed on the cheque leaf please attach copy of the first page of the bank passbook also)

Consent Letter

To,

Date ____/____/____

Medical Superintendent

I, Mr./Ms _____ Age _____ Resident

of _____ State _____ Hereby

give my willful consent to Mr/ Dr _____ of Max Bupa Health

Insurance Company Limited to verify and collect necessary documents/ statements including but not limited to certified copies of medical records from your esteemed hospital for the purpose of settlement of my Insurance claim.

My other relevant details are provided below;

Detail of Insured:-

DOA:-

DOD:-

MRD/ Indoor/ IP No:-

Policy No:-

I request you to provide all the information/ documents as required by Max Bupa Health Insurance Company Ltd.

Name:-

Signature/ Thumb Impression

Witness Name & Signature