## FORM 2: CLAIM FORM

## IFFCO TOKIO GENERAL INSURANCE COMPANY LIMITED

### CLAIM FORM - PART A (TO BE FILLED IN BY INSURED)

IFFCO-TOKIO GENERAL INSURANCE
Muskurate Raho

### INSURANCE DETAILS

| | | | | | |
|---|---|---|---|---|---|
| Policy No | | SNo/ Certificate No: | | | |
| Company/ TPA ID No | | Name of Proposer | | | |
| Address of Proposer (Primary Insured) | | | | | |
| Name of Claimant | | | | | |
| Relation to proposer | | Date of Birth | | Age | |
| Address | | | | | |
| Gender | Male / Female | Occupation | | | |
| Telephone No | | Mobile No | | | |
| E-mail ID, if any | | | | | |
| Insurance History | Date of commencement of first Insurance for the person | | | | |
| Are you presently covered with any other Mediclaim / Health Insurance? | | | Y/N | | |
| If Y, give details - Company / Policy No / Sum Insured (Attach Policy copies) | | | | | |
| Primary Insured's Bank Account particulars | | PAN No. | | | |
| Account Number | | Bank Name | | | |
| Branch | | IFSC Code | | | |

### HOSPITALIZATION DETAILS

| | | | | | |
|---|---|---|---|---|---|
| Name of the Hospital where admitted | | | | | |
| Room Type-Day care / Single / Twin sharing etc… | | | | | |
| Past Hospitalisation | Y/N | Month and Yr | | DIAGNOSIS: | |
| Hospitallisation due to: Illness / Injury / Maternity | | Details | | | |
| Date of Injury / Disease first detected / LMP | | | | | |
| If injury, how it occurred | | | | | |
| If injury, whether Medico legal | Y/N | If MLC, reported to police? | | Y/N (Enclose MLC /FIR) | |
| Is claim is for **Domiciliary Hospitalisation?** | | Y/N (If Y, provide details in annexur | | | |

### EXPENSES AND BILLING DETAILS

| | | | |
|---|---|---|---|
| Pre-hospitalisation Expenses | Rs. | Hospitalisation Expenses | Rs. |
| Post-hospitalisation Expenses | Rs. | Health-Check up Cost | Rs. |
| Ambulance Charges | Rs. | Others | Rs. |
| Details of Lumpsum / cash benefit claimed: | | | |
| Hospital Daily Cash | Surgical Cash | | Critical Illness benefit |
| Convalescence: | Pre / Post hosp lumpsum benefit: | | Others |

Details of bills enclosed (attach separate sheet, if space inadequate)

| Sl. | Bill No | Date | Issued By | Towards | Amount |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

### Details of Claim Documents submitted - CHECK LIST

| | | | | | | |
|---|---|---|---|---|---|---|
| Claim Form Duly signed | | Y | N | Pre-hosp Bills: _____ Nos | Y | N |
| Copy of the claim intimation | | Y | N | Post-hosp Bills: _____ Nos | Y | N |
| Hospital Discharge Summary | | Y | N | Investigation Reports | Y | N |
| Operation Theatre Notes | | Y | N | Doctor request for investigation | Y | N |
| Hospital Main Bill | | Y | N | ECG | Y | N |
| Hospital Break-up Bill | | Y | N | Pharmacy Bills | Y | N |
| Hospital Bill Payment Receipt | | Y | N | MLC Report & Police FIR | Y | N |
| Doctor\s Prescriptions | | Y | N | Any other, please specify | Y | N |

Date: Signature of the Primary Insured / Claimant

| CLAIM FORM - PART B | | | |
|---|---|---|---|
| **TO BE FILLED IN BY THE HOSPITAL** | | | |
| Name of the Hospital | | | Hosp ID |
| Type of Hospital | Network | Non Network | |
| In case of non network , please provide below details | | | |
| Address of the Hospital with Pin Code | | | |
| Telephone No | | Registration no. | |
| Number of Inpatient beds | | PAN | |
| Other Facilities available in the hospital | | OT | Y/N |
| ICU | Y/N | Others | |
| Details of the patient admitted | | | |
| Name of the patient | | IP Registration Number | |
| Gender | | Age | |
| Date of Admission | | Time of Admission | |
| Date of Discharge | | Time of Discharge | |
| Ailment Diagnosed (Primary) | | | |
| ICD 10-CM Code | Primary | Additional | Co- |
| Details of Procedure/s | | | |
| ICD 10 PCS Code | Proc 1 | Proc 2 | Proc 3 |
| Type of Admission | Emergency | Planned | Day-care \| Maternity |
| Date of delivery if Maternity | | Gravida Status | |
| 8. Is the treatment for an injury? If, Y, details. | | | |
| Was it self inflicted? | Y/N | Whether RTA | Y/N |
| If MLC, notified to police? | Y/N | MLC / FIR No. | |
| If MLC not notified, give reasons | | | |
| Was the Injury/ disease caused due to Substance abuse / Alcohol consumption | | | Y/N |
| If Y, whether any test was conducted to establish this? If Y, please attach Report | | | Y/N |
| Is present ailment a complication of Pre-existing disease | | Y/N | |
| If Y, specify details | | | |
| Whether Pre-authorisation obtained - Y/N | | If Y, Pre Auth Number | |
| If authorisation by network hospital not obtained, reason? | | | |
| Name of Treating Doctor | | Registration No | |
| Mobile No | | Qualification | |

| **13. Claim Documents submitted (CHECK LIST)** | |
|---|---|
| Claim Form Duly signed | Investigation Reports |
| Original Pre-authorisation request | Investigation Reports (Including CT / MRI / USG / HPE) |
| Copy of the preauthorisation approval letter | Doctor's Reference Slip for investigation |
| Hospital Discharge Summary | ECG |
| Operation Theatre Notes | Pharmacy Bills |
| Hospital Main Bill | MLC Report & Police FIR |
| Hospital Break-up Bill | Any other, please specify |
| Date: | Signature of the Primary Insured / Claimant |

## IFFCO TOKIO BILL CUM RECEIPT FORMAT

| HOSPITALIZATION DETAILS | | | | |
|---|---|---|---|---|
| 1 | Hospital Name | ..... | Hospital NSP Code: | |
| 2 | Address | | Hospital PIN Code: | |
| 3 | Bill no. | | Bill Date and Time | |
| 4 | PAN Number | | Service Tax No | |
| 5 | IP No. | | Bed Number | |
| 6 | Date and time:Admission | | Date and time: discharge | |
| 7 | Patient Name | | Member ID / Card No. | |
| 8 | Patient's Address | | Patient's Contact No | |
| 9 | Cashless Issued Amount | | Name of Insurance Co : | |

| BILL SUMMARY (Detailed Break up to provided separately as per hospital for mat) | | | | |
|---|---|---|---|---|
| SI No. | Particulars | Gross Amount | Discount | Net Amount |
| 1 | ROOM RENT SERIVICES | | | |
| 2 | ICU CHARGES | | | |
| 3 | NURSING / RMO SERVICES | | | |
| 4 | CPMSULTANT VISITS | | | |
| 5 | MEDICINE & CONSUMABLES | | | |
| 6 | INVESTIGATION CHARGES | | | |
| 7 | SURGERY / PROCEDURE CHARGES | | | |
| 8 | IMPLANTS AND EQUIPMENTS | | | |
| 9 | MISCELLANEOUS CHARGES | | | |
| 10 | PACKAGE CHARGES | | | |
| 11 | ANY OTHER (SPECIFY) | | | |
| 12 | BILLED AMOUNT: | | | |

| | | |
|---|---|---|
| 1 | Net Bill Amount after discount (A) | |
| 2 | Cashless Authorized (B) | |
| 3 | Service Tax (C) = (B*10.3%) | |
| 4 | To be paid by Insurer: B+C | |
| 5 | To be paid by Patient (A-B) | |

## PATIENTS PAYMENT RECEIPT

Received Rs..... (Rupees..... only)

by cash / cheque No.....on date..... .....towards settlement of the above bil

**Patients Signature**

**Authorized signatory-hospital with seal**