CLAIM FORM - PART A

TO BE FILLED IN BY THE INSURED

The issue of theis form is not to be taken as admission of liability

(To be filled in block letters)

DETAILS OF PRIMARY INSURED : MSEDCL/MSETCL/MSPGCL (Select One) ZONAL OFFICE / REGIONAL OFFICE:

a) Policy no: 1 6 3 6 0 0 4 8 1 8 0 8 8 0 8

b) Employee ID No

c) MDIndia ID No:

f) Emp Branch Location

d) Employee Name

e) Address:

City: Pin Code:

SECTION A

MANDATORY DETAILS **Mobile Phone No:** **Email ID:**

DETAILS OF INSURANCE HISTORY

a) Currently covered by any other Mediclaim/ Health Insurance: Yes No

b) Date of commencement of first insurance without break:

c) If yes, company name: Policy No:

Sum Insured (`): d) Have you been hospitalized in the last four years since inception of the contract? Yes No Date:

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

f) If yes, Company Name :

SECTION B

DETAILS OF INSURED PERSON HOSPITALIZED

a) Patient Name :

b) Gender : Male Female c) Age: years months d) Date of Birth:

e) Relatuionship 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:

e) Date of Admission: f) Time: : g) Date of Discharge: h) Time: :

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 treatment expenses claimed

i. Pre Hospitalization Expenses ` ii. Hospitalization Expenses `

iii. Post Hospitalization Expenses ` iv. Health Check up Cost ` Not Applicable for this Policy

v. Ambulance Charges ` vi. Others (code): `

Total `

vi. Pre hospitalization period: days vii. Pre hospitalization period: days

b) Claim for Domiciliary Hospitalization: Not Applicable for this Policy

c) Details of Lump sum / cash benefit claimed: Not Applicable for this Policy **Total** `

Claim Documents Submitted- Check List:

- Claim FormDuly signed
- Hospital Orginal Bill & Paid Receipts
- Final Hospital Bill With Break-up in details
- Implants - Invoices / BarCode Stickers
- Hospital Discharge Summary
- Pharmacy Bill & Cash Memo
- Operation Theatre Notes
- ECG, USG, X Ray Etc
- Doctor's request for investigation
- Investigation Reports (including CT / MRI / Report CD's / HPE)
- Doctor's Prescription of Medicines
- Others: MLC/FIR:

SECTION E

MANDATORY DETAILS TO BE FOLLOWED FOR ALL CLAIMS

1) All Claim Documents (on Each Page) should be Signed by the Employee or the Insured Patient before submission of the claim documents for processing

2) Valid Photo ID Proof of the Insured Patient duly Signed by the Employee should be submitted along with the claim documents for processing

3) Clear Valid Nationalized Bank Details - Cancelled Chq (With Name) or Bank Pass Book should be submitted along with the claim documents for processing

4) Valid Hospital Registration photo copy duly stamped and signed by hospital authorities

5) For Claims Above Rs 1 Lacs - No Objection Letter, Aadhar Card Copy, IPD Papers should be submitted along with claims documents for processing

DETAILS OF BILLS ENCLOSED

Sl. No.	Bill No.	Date	Issued By	Towards	Amount (`)
1				Hospital Main Bill	
2				Pre hospitalisation Bills: ___ Nos	
3				Post hospitalisation Bills: ___ Nos	
4				Pharmacy Bills:	
5					
6					
7					
8					
9					
10					

SECTION F

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.

SECTION H

Seal & Signature of the MSEB NODAL OFFICER

Name & Signature of the Insured EMPLOYEE

Date:

Place:

CLAIM FORM - PART B

TO BE FILLED IN BY THE HOSPITAL

The issue of theis form is not to be taken as admission of liability

Please include the original preauthorization request form in lieu of PART A

(To be filled in block letters)

DETAILS OF HOSPITAL — SECTION A

a) Name of the Hospital:

c) Hospital ID: **c) Type of Hospital:** In TPA Network ☐ Non Network ☐ (if non network, fill Section D)

d) Name of the treating doctor:

e) Qualification: f) Registration No. with state code: g) Phone No.

DETAILS OF PATIENT ADMITTED — SECTION B

a) Name of Patient:

b) IP Registration No.: c) Gender : Male ☐ Female ☐ d) Age: years months e) Date of Birth:

f) Date of Admission: g) Time: : **h) Date of Discharge:** i) Time: :

j) Type of Admission: Emergency ☐ Planned ☐ Day Care ☐ Maternity ☐ k) If Maternity: i. Date of Delivery: ii. Gravida Status:

l) Status at time of discharge: Discharged to home ☐ Discharged to another hospital ☐ Deceased ☐ m) Total claimed amount

DETAILS OF AILMENT DIAGNOSED (PRIMARY) — SECTION C

a)	ICD 10 Codes	Description	b)	ICD 10 PCS	Description
i. Primary Diagnosis :			i. Procedure 1 :		
ii. Additional Diagnosis :			ii. Procedure 2 :		
iii. Co-morbidities :			iii. Procedure 3 :		
iv. Co-morbidities :			iv. Details of Procedure :		

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 injurydue 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:**

DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON NETWORK HOSPITAL) — SECTION D

a) Address of the hospital:

City: **State:** **Pin Code:** **Local or State Government Licensed**

Phone No: **Hospital Registration No:** **Reg Authority:**

d) Hospital PAN **e) Number of inpatient beds** **Facilities available in the hospital** i. OT: ☐ Yes ☐ No ii. ICU: ☐ Yes ☐ No

g) Does Hospital Maintains Daily Records of Patients & Makes them Accesible to Insurance Company's Authorized Personanel **Yes** ☐ **No** ☐

DECLARATION BY THE HOSPITAL **(Please read very carefully)** — SECTION E

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, suppress or concealment of anu material fact, our right to claim under this claim shall be forfeited.

Date:

Place:

Seal & Signature of the Hospital Authority

Name & Signature of the Insured