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) 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) i. Company Name	Enter the full name of the insurance company	Name of the organization in full
ii. Policy No.	Enter the policy number	As allotted by the insurance company
c) Date of Commencement of first Insurance without break	Enter the date of commencement of first insurance	Use dd-mm-yy format
d) Sum Insured	Enter the total sum insured as per the policy	In rupees
e) Have you been Hospitalized in the last four years since inception of the contract?	Indicate whether hospitalized in the last four years	Indicate whether hospitalized in the last four years
f) Date	Enter the date of hospitalization	Use mm-yy format
g) Diagnosis	Enter the diagnosis details	Open Text
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
Phone No	Enter the phone number of patient	Include STD code with telephone number
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
Time	Enter time of admission	Use hh:mm format
f) Date of discharge	Enter date of discharge	Use dd-mm-yy format
Time	Enter time of discharge	Use hh:mm format
g) In case of maternity		
i. Date of Delivery	Enter date of delivery	Use dd-mm-yy format
ii. Gravida Status	Enter gravida status	Use Standard format
h) 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
i) 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 the right option
c) Details of Lump sum/ cash benefit claimed	Enter the amount claimed as lump sum/ cash benefit	In rupees (Do not enter paise values)
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) 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.		

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 birth	Use dd-mm-yy format
f) Type of Admission	Indicate type of admission of patient	Tick the right option
g) Date & Time of Admission	Enter date & time of admission	Use dd-mm-yy format & hh:mm format
h) Date & Time of Admission	Enter date & time of discharge	Use dd-mm-yy format & hh:mm format
I) If Maternity		
1. Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format
2.Gravida Status	Enter Gravida status if maternity	Use standard format
j) Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
SECTION C – DETAILS OF AILMENT DIAGNOSED		
a) ICD 10 Code		
1. Primary Diagnosis	Enter the ICD 10 Code and description of the primary diagnosis	Standard Format and Open text
2. Additional Diagnosis	Enter the ICD 10 Code and description of the additional diagnosis	Standard Format and Open text
3 & 4. Co-morbidities	Enter the ICD 10 Code and description of the co-morbidities	Standard Format and Open text
ICD 10 PCS		
1. Procedure 1	Enter the ICD 10 PCS and description of the first procedure	Standard Format and Open text
2. Procedure 2	Enter the ICD 10 PCS and description of the second procedure	Standard Format and Open text
3. Procedure 3	Enter the ICD 10 PCS and description of the third procedure	Standard Format and Open text
4. Details of Procedure	Enter the details of the procedure	Open text
b) Hospitalization due to injury	Indicate if hospitalization is due to injury	Tick Yes or No
1. Cause	Indicate cause of injury	Tick the right option
2. If injury due to substance abuse/alcohol consumption, test conducted to establish this	Indicate whether test conducted	Tick Yes or No
3. Medico Legal	Indicate whether injury is medico legal	Tick Yes or No
4. Reported to Police	Indicate whether police report was filed	Tick Yes or No
5. FIR No.	Enter first information report number	As issued by police authorities
6. If not reported to police, give reason	Enter reason for not reporting to police	Open Text
c) Complaints/ Symptoms	Indicate the date when the symptom/complaint first started	use dd-mm-yy format
d) Previous medical history	Enter the medical history	Open text
e) Specific diseases	State Yes or No	Duration should be in years and months
f) Complication of pre-existing diseases	Indicate whether present ailment is a complication that existed prior to policy inception	Open text
g) Alcoholism	Indicate Yes or No. If yes state quantity consumed	Open text
h) Smoking of tobacco	Indicate Yes or No. If yes state units consumed	Open text
SECTION D - 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 E - DECLARATION BY THE HOSPITAL		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign and stamp		