



Claim Form



Tata AIG General Insurance Company Limited: A-501, 5th Floor, Building No.4, Infinity Park, Gen. A.K. Vaidya Marg, Dindoshi, Malad (East), Mumbai 400 097

IMPORTANT: The Issue of this Form is not to be taken as an admission of liability

Part A (To be filled in by the Insured)

SECTION A - DETAILS OF PRIMARY INSURED

Form fields for Section A: Policy No, Sl. No/ Certificate No, Company/ TPA ID No, Name (First, Middle, Surname), Address, City, State, PIN, Phone (O), (R), Fax, Mobile, E-mail, Date of Birth, Occupation.

MediRaksha UIN: IRDA/NL-HLT/TAGI/P-H/V/99/13-14

SECTION B - DETAILS OF INSURANCE HISTORY

Form fields for Section B: a) Currently covered by any other mediclaim health insurance, b) Date of commencement of first insurance without break, 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, Diagnosis, e) Previously covered by any other Mediclaim/Health insurance, f) If yes, Company Name.

SECTION C - DETAILS OF INSURED PERSON HOSPITALISED

Form fields for Section C: Name (First, Middle, Surname), Relationship, Date of Birth, Age, Address (if different than above), Gender (Male, Female), Occupation, Phone (O), (R), Fax, Mobile, E-mail.

**SECTION D - DETAILS OF HOSPITALISATION**

Name of the Hospital where admitted

Room Category occupied  Daycare/Single Occupancy/Twin Sharing/ 3 or more beds per room

Hospitalization due to  Illness / Injury / Maternity

Date of Injury/ Date of disease first detected/ Date of delivery  D D M M Y Y Y Y

Date of admission  D D M M Y Y Y Y Time  H H M M

Date of discharge  D D M M Y Y Y Y Time  H H M M

If injury, give cause  Self Inflicted/Road Traffic Accident/ Substance Abuse/ Alcohol Consumption

If Medico legal Yes  No

Reported to police? Yes  No

MLC Report & Police FIR attached? Yes  No

System of medicine  Allopathic/Other systems of medicine

**SECTION E - DETAILS OF CLAIM**

Details of the treatment expenses claimed

Pre-hospitalisation Expenses	Rs. _____	Hospitalisation Expenses	Rs. _____
Post-hospitalisation Expenses	Rs. _____	Health-Check up Cost	Rs. _____
Ambulance Charges	Rs. _____	Others (code)	Rs. _____
		<b>Total</b>	Rs. _____
Pre-hospitalisation Period	Days _____	Post -hospitalisation Period	Days _____

Claim for Domiciliary Hospitalization Yes  No   ( if yes, please provide details in annexure

Details of Lumpsum/cash benefit claimed

Hospital Daily Cash	Rs. _____	Surgical Cash	Rs. _____
Critical Illness Benefit	Rs. _____	Convalescence	Rs. _____
Pre / Post hospitalisation	Rs. _____	Others	Rs. _____

lumpsum benefit: \_\_\_\_\_

Claim Documents Submitted- Check List:

Duly filled and signed Claim Form	<input type="checkbox"/>	Copy of intimation letter, if any	<input type="checkbox"/>
Hospital Main Bill	<input type="checkbox"/>	Hospital Break Up bill	<input type="checkbox"/>
Hospital Bill Payment Receipt	<input type="checkbox"/>	Hospital Discharge Summary	<input type="checkbox"/>
Pharmacy Bill	<input type="checkbox"/>	Operation Theater Notes	<input type="checkbox"/>
ECG	<input type="checkbox"/>	Doctor's Request for Investigation	<input type="checkbox"/>
Investigation Reports (Including CT, MRI/USG/HPE)	<input type="checkbox"/>	Doctor's Prescription	<input type="checkbox"/>
Others	<input type="checkbox"/>	_____	<input type="checkbox"/>

**SECTION - F DETAILS OF BILLS ENCLOSED**

Sr.No.	Bill No.	Date	Issued By	Towards	Amount (Rs.)
		D D M M Y Y Y Y			

**SECTION - G DETAILS OF PRIMARY INSURED'S BANK ACCOUNT**

PAN

Account Number

Bank Name/ Branch

Payable details: Cheque / DD

IFSC Code

\* Please attach a cancelled cheque pertaining to the same

MICR No.

\* Please attach a cancelled cheque pertaining to the same

**Note:**

It is agreed that the Policyholder/Claimant will intimate in writing to Tata AIG General Insurance Co. Ltd. about any change in bank account details. In an event Insured person bears expenses for treatment please provide account details of Insured Persons in the above format along with proof of incurring such expenses.

**SECTION H - 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 Insured

**GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled in by the insured)**

DATA ELEMENT	DESCRIPTION	FORMAT
<b>SECTION A - DETAILS OF PRIMARY INSURED</b>		
a) Policy No.	Enter the policy number	As allotted by the insurance company
b) Sl. 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
<b>SECTION B - DETAILS OF INSURANCE HISTORY</b>		
a) Currently covered by any Health	Indicate whether currently covered by another Mediclaim / Health Insurance	Tick Yes or Noother Mediclaim /
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 4 years	Indicate whether hospitalized in the last 4 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	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
<b>SECTION C - DETAILS OF INSURED PERSON HOSPITALIZED</b>		
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
<b>SECTION D - DETAILS OF HOSPITALIZATION</b>		
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
l) 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
<b>SECTION E - DETAILS OF CLAIM</b>		
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
<b>SECTION F - DETAILS OF BILLS ENCLOSED</b>		
Indicate which bills are enclosed with the amounts in rupees		
<b>SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT</b>		
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
<b>SECTION H - DECLARATION BY THE INSURED</b>		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.		

**TO BE FILLED IN BY THE HOSPITAL**

The issue of this Form is not to be taken as an admission of liability  
 Please include the original preauthorisation request form in lieu of PART A

**Part B**
**SECTION A - DETAILS OF HOSPITAL**

Name of the Hospital where treated

Hospital ID

Type of Hospital  Network  Non Network (If non network fill form section E)

Name of the treating Doctor

Qualification

Registration No. with state Code  Phone No.

**SECTION B - DETAILS OF PATIENT ADMITTED**

Name of the patient

IP Registration Number  Gender:  Male  Female Age  yrs.

Date of Birth  Date of Admission  Time of Admission

Date of Discharge  Time of Discharge

Type of Admission  Emergency  Planned  Daycare  Maternity

If Maternity Date of Delivery  GraVida Status

Status at time of discharge  Discharged to Home  Discharged to another Hospital  Deceased

Total Claimed Amount Rs.

**SECTION C - DETAILS OF AILMENTS DIAGNISED (PRIMARY)**

ICD 10 Code   Primary Diagnosis  Additional Diagnosis  Co-morbidities

Details procedure/s done

ICD 10 PCS   Procedure 1  Procedure 2  Procedure 3

Pre-authorization obtained  Yes  No  Pre-authorization  No

If authorization by network hospital not obtained, give reason

Hospitalisation due to Injury  Yes  No If yes, give cause

Self inflicted? Yes  No  Road Traffic Accident Yes  No

Substance Abuse /Alcohol Consumption  Yes  No

If Injury due to Substance abuse / alcohol consumption, Test Conducted to establish this:  Yes  No

(If yes, attach reports)

Medico Legal Yes  No  Reported to Policy Yes  No

FIR No.  If not reported to Policy give reasons

**SECTION D - CLAIM DOCUMENTS SUBMITTED - CHECKLIST**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Claim form duly filled and signed         | <input type="checkbox"/> Copy of photo ID card of patient verified by Hospital | <input type="checkbox"/> MLC Report & Police FIR                               |
| <input type="checkbox"/> Investigation reports                     | <input type="checkbox"/> ECG   | <input type="checkbox"/> Hospital Main Bill                                    |
| <input type="checkbox"/> Original Pre authorization Request        | <input type="checkbox"/> Hospital Discharge Summary                            | <input type="checkbox"/> Original death summary from hospital where applicable |
| <input type="checkbox"/> CT/MRI/USG/HPE investigation Report       | <input type="checkbox"/> Pharmacy Bills  | <input type="checkbox"/> Hospital break up Bill                                |
| <input type="checkbox"/> Copy of Pre-authorization approval Letter | <input type="checkbox"/> Operation Theatre Notes                               | <input type="checkbox"/> Any other, PI specify                                 |
| <input type="checkbox"/> Doctor's reference slip for Investigation |  |  |

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**SECTION E – DETAILS IN CASE OF NON NETWORK HOSPITAL**

Address of the Hospital

Phone No.

Registration No. with State Code  Hospital PAN

No. of in-patient Beds

Facilities available in Hospital OT  Yes  No ICU  Yes  No Others \_\_\_\_\_

**SECTION F - DECLARATION BY 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:

Place: \_\_\_\_\_

Signature and seal of the Hospital Authority

**GUIDANCE FOR FILLING CLAIM FORM - PART B (To be filled in by the hospital)**

DATA	DESCRIPTION	FORMAT
<b>SECTION A - DETAILS OF HOSPITAL</b>		
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
<b>SECTION B - DETAILS OF THE PATIENT ADMITTED</b>		
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 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) Type of Admission	Indicate type of admission of patient	Tick the right option
j) 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
k) Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
<b>SECTION C - DETAILS OF AILMENT DIAGNOSED (PRIMARY)</b>		
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

<p>Details of Procedure</p> <p>c) Present Ailment is a Complication of PED</p> <p>d) Pre-authorization obtained</p> <p>e) Pre-authorization Number</p> <p>f) If authorization by network hospital not obtained, give reason</p> <p>g) Hospitalization due to injury Cause</p> <p>If injury due to substance abuse/alcohol consumption, test conducted to establish this Medico Legal</p> <p>Reported To Police</p> <p>FIR No.</p> <p>If not reported to police, give reason</p>	<p>Enter the details of the procedure</p> <p>Indicate whether present ailment is a complication of some pre- existing disease</p> <p>Indicate whether pre-authorization obtained</p> <p>Enter pre-authorization number</p> <p>Enter reason for not obtaining pre-authorization number</p> <p>Indicate if hospitalization is due to injury</p> <p>Indicate cause of injury</p> <p>Indicate whether test conducted</p> <p>Indicate whether injury is medico legal</p> <p>Indicate whether police report was filed</p> <p>Enter first information report number</p> <p>Enter reason for not reporting to police</p>	<p>Open text</p> <p>Tick Yes or No</p> <p>Tick Yes or No</p> <p>As allotted by TPA</p> <p>Open text</p> <p>Tick Yes or No</p> <p>Tick the right option</p> <p>Tick Yes or No</p> <p>Tick Yes or No</p> <p>Tick Yes or No</p> <p>As issued by police authorities</p> <p>Open Text</p>
<b>SECTION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST</b>		
Indicate which supporting documents are submitted		
<b>SECTION E - DETAILS IN CASE OF NON NETWORK HOSPITAL</b>		
<p>a) Address</p> <p>b) Phone No.</p> <p>c) Registration No.</p> <p>d) PAN</p> <p>e) Number of Inpatient Beds</p> <p>f) Facilities available in the hospital</p>	<p>Enter the full postal address</p> <p>Enter the phone number of hospital</p> <p>Enter the registration number of patient</p> <p>Enter the permanent account number</p> <p>Enter the number of inpatient beds</p> <p>Indicate facilities available in the hospital</p>	<p>Include Street, City and Pin Code</p> <p>Include STD code with telephone number</p> <p>As allocated by the Hospital</p> <p>As allotted by the Income Tax department</p> <p>Digits</p> <p>Tick the right option. If others, please specify</p>
<b>SECTION F - DECLARATION BY THE INSURED</b>		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.		
<b>SECTION G - DECLARATION BY THE HOSPITAL</b>		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign and stamp		

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### CHECK LIST OF ENCLOSURES FOR SUBMISSION OF CLAIM

#### Note:

- When original bills, receipts, prescriptions, reports and other documents are submitted to the other insurer or to the reimbursement provider, verified photocopies attested by such other organisation/provider have to be submitted.
- If original bills, receipts, prescriptions, reports and other documents are submitted to Us and Insured Person requires same for claiming from other organisation/provider, then on request from the Insured Person We will provide attested copies of the bills and other documents submitted by the Insured Person.

#### In-patient Treatment / Day Care Procedures

- Duly filled and signed Claim Form.
- Photocopy of ID card / Photocopy of current year policy.
- Original Detailed Discharge Summary with date of admission & discharge, clinical history, past history / procedure details/ Day care summary from the hospital.
- Original consolidated hospital bill with break up of each Item, duly signed by the insured.
- Original payment Receipt of the hospital bill.
- First Consultation letter and subsequent Prescriptions.
- Original bills, original payment receipts and Reports for investigation.
- Original medicine bills and receipts with corresponding Prescriptions.
- Original invoice/Sticker of implants/bills for Implants (viz. Stent/PHS Mesh/IOL etc.) with original payment receipts.

#### Road Traffic Accident

In addition to the In-patient Treatment documents:

- Copy of the First Information Report from Police Department / Copy of the Medico-Legal Certificate.

#### In Non Medico legal cases

- Treating Doctor's Certificate giving details of injuries (How, when and where injury sustained)

#### In Accidental Death cases

- Copy of Post Mortem Report & Death Certificate (If conducted)

**For Death Cases**

In addition to the In-patient Treatment documents:

- Original Death Summary from the hospital.
- Copy of the Death certificate from treating doctor or the hospital authority.
- Copy of the Legal heir certificate, if the claim is for the death of the principle insured.

**Pre and Post-hospitalisation expenses**

- Duly filled and signed Claim Form.
- Photocopy of ID card / Photocopy of current year policy.
- Original Medicine bills, original payment receipt with prescriptions.
- Original Investigations bills, original payment receipt with prescriptions and report.
- Original Consultation bills, original payment receipt with prescription.
- Copy of the Discharge Summary of the main claim.

**Organ Donation/Transplantation**

In addition to the documents of general hospitalization

- Organ Function test / blood test proving organ failure.
- Treatment Certificate issued by the Transplant Surgeon of the hospital concerned.

**Ambulance Benefit**

- Duly filled and signed Claim Form.
- Photocopy of ID card / Photocopy of current year policy.
- Original Bill with Original Payment Receipt.
- Treating Doctor's consultation prescription indicating Emergency Hospitalization.

<b>Customer Identification Procedure (as per KYC norms of IRDA of India)</b>	
Please submit the following documents in case of claim amount exceeds Rs. 100,000	
Legal name and any other names used (Any one of the mentioned documents)	Passport/ PAN Card/ Voter's Identity Card/ Driving License/ Letter from a recognized public authority or public servant verifying the identity and residence of the customer Proof of Residence
(Any one of the mentioned documents)	Telephone bill/ Bank account statement/ Letter from any recognized public authority/ Electricity bill/ Ration card

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**Disclaimer:** Insurance is the subject matter of solicitation. For more details on benefits, exclusions, limitations, terms and conditions, please refer sales brochure / policy wordings carefully, before concluding a sale.

### Tata AIG General Insurance Company Limited

Registered Office: Peninsula Business Park, Tower A, 15th Floor, G.K. Marg, Lower Parel, Mumbai – 400013  
 24X7 Toll Free No: 1800 266 7780 or 1800 22 9966 (only for senior citizen policy holders) Fax: 022 6693 8170  
 Email: customersupport@tataaig.com Website: www.tataaig.com  
 IRDA of India Registration No: 108 CIN: U85110MH2000PLC128425