

Claim Form



CLAIM FORM (The issue of this Form is not to be taken as an admission of liability)

PART A

TO BE FILLED IN BY THE INSURED

★ Non-submission of original bills and receipts is the main reason for delay in claim settlements. Please provide the originals

(TO BE FILLED IN BLOCK LETTERS)

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	 ★ 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 																																							
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	d) Have you been hospitalized in the last four years since inception of the contract? Yes / No (DD/MM/YYY): D M M Y Y Y Y Y Y Y Y																																							
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17	f) If Yes, Company Name :																																							
SECTION	ECTION C - DETAILS OF THE INSURED PERSON HOSPITALISED :																																							
а) Name	:																																\perp	\perp	\perp	\perp			
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_	j) System of medicine : Allopathic																																							
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Claim Form

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_V)	Ambulance Charges	Rs.		vi) Others (code)	Rs.	
	Total	Rs.				
vii)	Pre-hospitalisation Period	Days		viii) Post -hospitalisation Perio	d Days	
Ь)	Claim for Domiciliary Hospita	lization : Yes 🔲 /	No □ (if yes, please	provide details in annexure)		
c)	Details of Lumpsum / cash be	enefit claimed :				
j)	Hospital Daily Cash	Rs.		ii) Surgical Cash	Rs.	
iii)	Critical Illness Benefit	Rs.		iv) Convalescence	Rs.	
v)	Pre/Post hospitalisation lumpsur	m benefit: Rs.		vi) Others	Rs.	
Clai	m Documents Submitted- Che	ckList:				
	Duly filled and signed Claim F	-orm	□ Copy of in	imation letter, if any		
	Hospital Main Bill		☐ Hospital Br			
	Hospital Bill Payment Receipt			scharge Summary		
	Pharmacy Bill			Threater Notes		
	ECG			equest for Investigation		
	Investigation Reports (Includi	ng CT, MRI/USG/HPE	Doctor's P	escription		
	Others					
SECTION	I - F DETAILS OF BILLS ENCI	OSED :				
SI. No.	Bill No.	Date	Issued by	Towards	5	Amount (Rs.)
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	D D	M M Y Y		Post-hospitalisation Bills:N	los	
	D D	M M Y Y		Pharmacy Bills		
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	D D	M M Y Y				
SECTION	- G DETAILS OF PRIMARY I	NSURED'S BANK AG	CCOUNT :			
a)	PAN No :		Ь)	Account No :		
c)	Bank Name :			Branch :		
d)	Payable details: Cheque □	/DD []	e)	IFSC Code :		
f)	MICR No :					
	I H - DECLARATION BY THE				th Cuch I	
				the best of my knowledge and be lation to this claim, my right to clair		
& authoriz	e TPA / insurance company, to	seek necessary medic	al information / docum	ents from any hospital / Medical Pra	actitioner who has attend	ed on the person against
	s claim is made. I hereby declare ost-hospitalisation claim, if any.	e that I have included	all the bills / receipts for	the purpose of this claim & that I w	vill not be making any sup	plementary claim except
F. C. P.	1					
Date :		Place :		6		
				Signature of Insure	a : 🛂	







CHECK LIST OF ENCLOSURES FOR SUBMISSION OF CLAIM

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 / 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/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

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.

Outpatient Benefit/Dental

- $\hfill \square$ Duly filled and signed Claim Form.
- ☐ Photocopy of ID card / Photocopy of current year policy.
- ☐ Original Medicine bills, original payment receipt.
- Original Investigations bills, original payment receipt with report.
- ☐ Original Consultation bills, original payment receipt with prescription.
- $\hfill \Box$ Details of any Outpatient Procedures, If any
- ☐ Dental X-ray film.

Daily Cash Benefit

- Duly filled and signed Claim Form.
- ☐ Photocopy of ID card / Photocopy of current year policy.

Organ Donation/Transplantation

In addition to the documents of general hospitalisation

- ☐ 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.

Maternity Expenses

In addition to the In-patient Treatment documents:

☐ Obstetric history (Gravida, Para, Living children, Abortions) from treating doctor.

Critical Illness Benefit

- Duly filled and signed Claim Form.
- ☐ Photocopy of ID card / Photocopy of current year policy.
- ☐ A medical certificate confirming the diagnosis of critical illness from a doctor not less qualified than MD/MS.
- □ Investigation reports / other related documents reflecting the critical illness diagnosis.

Health Check up

- Duly filled and signed Claim Form.
- ☐ Photocopy of ID card / Photocopy of current year policy.
- ☐ Original Investigation bills, original payment receipts with Reports.
- Original Consultation bills and original payment receipts with prescription.

Expenses for spectacles/contact lenses, hearing aids

- Duly filled and signed Claim Form.
- $\hfill \Box$ Photocopy of ID card / Photocopy of current year policy.
- Prescription of the Treating Doctor.
- Original Invoice/bills, original payment receipt of the device, appliances, lens etc.





GUIDANCE FOR FILLING CLAIM FORM - PART A:

DATA ELEMENT	DESCRIPTION	FORMAT
SECTION A - DETAILS OF PRIMARY INSU		1 CHAVI II
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	As allotted by the organization
b) si. No, certificate No.	health insurance scheme	7.5 dilotted by the organization
c) Company TPA ID No.	Enter the TPA ID No	License number as allotted by IRDA and
1 /		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 H	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 4 years	Indicate whether hospitalized in the last 4 years	Tick Yes or No
Date	Enter the date of hospitalisation	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 PER	 	
a) Name	Enter the full name of the patient	Surname, First name, Middle name
b) Relationship to primary Insured	Indicate relationship of patient with policyholder	Tick the right option. If others, please specify
c) Date of Birth	Enter Date of Birth of patient	Use dd-mm-yy format
d) Age	Enter age of the patient	Number of years and months
e) Address	Enter the full postal address	Include Street, City and Pin Code
f) Gender	Indicate Gender of the patient	Tick Male or Female
g) Occupation	Indicate occupation of patient	Tick the right option. If others, please specify
h) Phone No	Enter the phone number of patient	Include STD code with telephone
i) E-mail ID	Enter e-mail address of patient	Complete e-mail address
SECTION D - DETAILS OF HOSPITALIZAT	10N	
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 hospitalisation	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 wasfiled	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 CLIAM										
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 hospitalisation	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 INSU	RED'S BANK ACCOUNT									
a) PAN	Enter the permanent account number	As allotted by the Income Tax								
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.										

PART B

(TO BE FILLED IN BY THE HOSPITAL IN CASE OF CASHLESS CLAIMS)

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

SEC	TION A - DETAILS OF HOSPITAL
a)	Name of the Hospital where treated :
Ь)	Hospital ID : c) Type of Hospital : Network □ / Non-Network □
	(If non network fill form section E).
d)	Name of the treating Doctor : S U R N A M E F I R S T N A M E M I D D L E N A M E
e)	Qualification :
f)	Registration No with state code : g) Phone No :
SEC	TION B - DETAILS OF PATIENT ADMITTED
a)	Name of the patient :
Ь)	IP Registration Number : C) Gender: Male 🗆 / Female 🗅
d)	Age (YY/MM) : Y Y M M Date of Birth (DD/MM/YYY) : H H M M
e)	Date of Admission (DD/MM/YYY) : D D M M Y Y Y Y T
g)	Date of Discharge (DD/MM/YYY) : D D M M Y Y Y Y Y
j)	Type of Admission : Emergency □ / Planned □ / Day-care □ / Maternity □
j)	If Maternity
	i) Date of delivery (DD/MM/YYY): DDMMYYYYY ii) Gravida Status:
k)	Status at time of discharge : Discharged to Home \Box / Discharged to another Hospital \Box / Deceased \Box
	Total Claimed Amount Rs





SECTION C - DETAILS OF AILMENTS DIAGNOSED (PRIMARY)

a)					ICD 10) Codes										D	escrip)	tion										
	j)	Primary Diagnosis	:																									
	jj)	Additional Diagnos	iis :																									
	iji)	Co-morbidities :																										
	$_{\text{IV}})$	Co-morbidities :																										
Ь)					ICD 10) PCS										С	escrip)	tion										
	j)	Procedure 1 :																										
	ji)	Procedure 2 :																										
	iii)	Procedure 3 :																										
	įv)	Details of Procedu	re :																									
⊂)	Pre	-authorization obtai	ned :	Yes [d)	Pre-au	uthoriz	zatic	on No	o. : [Τ					$\overline{\top}$		$\overline{\Box}$
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f)	Ho	spitalisation due to l	njury ?	Yes		No 🗆																						
i) If Y∈	s, giv	ve cause																										
Self ir	nflict	ed? Yes 🗆 / No			-	Road Tra	affic Acci	dent	Yes		No [S	ubsta	ance A	buse	e /Alo	coh	ol Ca	onsu	ımpt	ion	Yes] /1	 0 0
ii) IIf I	njury	/ due to Substance	abuse / a	alcoho										Yes			No E											
iii) Me	edico	o Legal Yes 🔲 /	No 🗆		i	iv) Repo	rted to P	olicy	Yes		' No				V) FIR	No :											
vi) If r	not r	eported to Policy giv	e reason	ns																								
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		Copy of Pre-auth							Doc	tor's r	efere	nce :	slip for	Invest	igat	ion												
		Copy of photo IC			ıt verifie	ed by Ho	spital		ECC																			
		Hospital Discharg		iary						rmacy																		
		Operation Theatr								I Repc																		
		Hospital Main Bill								jinal de				om h	ospi	ital wi	nere a	pplic	able									
		Hospital break up	, Bill						Any	other,	Pls sp	pecif	У															
SEC	ΙΟΙ	N E - ADITIONAL I	DETAILS	S IN C	ASE OI	FNON	NETWO	ORK	HOSP	ITAL																		_
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⊂)	Reg	istration no with Sta	ite Code	: [\prod				d)	Hospi	ital F	PAN :		T		Τ		Τ	Τ			Т		
e)	No	of In-patient Beds :			ī	f) F	acilities	availa	able in	Hospit	 :al : j)	О	T · Yes		/ No	οП											J	
		ICU : Yes 🗆 / N		ii) Ot	 _{thers} . [
SEC		N F - DECLARATIO																									J	
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state	men	t, suppression or co	ncealme	nt of a	any mat	erial fac	t, our rig	ght to	claim	under	this	claim	n shall	be for	feite	ed.												
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GUIDANCE FOR FILLING CLAIM FORM - PART B :

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 qualification
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	'	'
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
i) 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 palse values)
SECTION C - DETAILS OF AILMENT DIAG	NOSED (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		Standard Format and Open text
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	
Details of Procedure	Enter the details of the procedure	Open text
c) Present Ailment is a Complication of PED	Indicate whether present ailment is a complication of some pre- existing disease	Tick Yes or No
d) Pre-authorization obtained	Indicate whether pre-authorization obtained	Tick Yes or No
e) Pre-authorization Number	Enter pre-authorization number	As allotted by TPA
f) If authorization by network hospital not obtained, give reason	Enter reason for not obtaining pre-authorization number	Open text





g) Hospitalization due to injury	Indicate if hospitalisation 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 SU	BMITTED-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.	Enter the registration number of patient	As allocated by the Hospital								
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								
SECTION F - DECLARATION BY THE INS	SURED									
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.										
SECTION G - DECLARATION BY THE HOSPITAL										
Read declaration carefully and mention	date (in dd:mm:yy format), place (open text) and sign and stan	np								

CUSTOMER IDENTIFICATION PROCEDURE (AS PER KYC NORMS OF IRDA)

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.

Photograph

Part A Proof of legal name and any other names used	 i. Pan Card ii. If Pan Card is not available please submit any of the documents mentioned below stating reason for not having Pan Card. a) Passport b) Voter's Identity Card c) Driving License d) Personal Identification and Certification of the employees for your identity. e) Letter issued by Unique identification Authority of India containing details of name address and Aadhar Number f) Job Card iss ued by NREGA duly signed by an officer of the State Government
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Part B iii. Ration Card iv. Valid lease agreement along with rent receipts which is not more than 3 months old as a residence	i. Elect ricity Bill not older than 6 months from the date of Insurance Contract ii. Telephone Bill pertaining to any kind of telephone connection like mobile, landline, wireless etc.
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 present/ present address (updated upto 1 month prior to claim su bmission document)	 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 present/ present address (updated upto 1 month

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: D D M M Y Y Y	Signature of Policyholder :	
(Please attach copy of a cancelled blank cheque of your bank for and IFSC code. If name of the payee is not printed on the che	or ensuring accuracy of name of the bank, branch name, According to the bank pass of the bank pass	ount number book also)