MedSave INDIA

Oriental insurance

CLAIM FORM - PART A

TO BE FILLED IN BY THE INSURED (To be filled in block letter)

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

SECTION A

DETAILS OF PRIMARY INSURED

a) Policy No : b) SI. No/certificate No :

c) Company / TPA ID No :

d) Name : SURNAME FIRST NAME MIDDLE NAME

e) Address :

City : State :

Pin Code : Phone No : Email ID :

SECTION B

DETAILS OF INSURANCE HISTORY

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

b) Date of commencement of first insurance without break : d d m m y y (copy of policies to be attached)

c) If Company Name : Policy No :

Sum Insured (Rs.) :

d) Have you been hospitalized in the last 4 year? ☐ Yes ☐ No Date : d d m m y y Diagnosis :

e) Previously covered by any other Mediclaim / Health Insurance : ☐ Yes ☐ No f) If Yes, Company Name :

SECTION C

DETAILS OF INSURED PERSON HOSPITALIZED

a) Name : SURNAME FIRST NAME MIDDLE NAME

b) Gender : ☐ Male ☐ Female c) Age : Year y y Months m m d) Date of Brith d d y y m m

e) Relationship to Primary Insured : ☐ Self ☐ Spouse ☐ Child ☐ Father ☐ Mother ☐ Other (Please specify)

f) Occupation : ☐ Service ☐ Self Employed ☐ Homemaker ☐ Student ☐ Retired ☐ Other (Please specify)

e) Address (if different from Above) :

City : State :

Pin Code : Phone No : Email ID :

SECTION D

DETAIL 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 : d d y y m m

e) Date of Admission : d d y y m m f) Time : h h m m g) Date Of Discharge : d d y y m m h) Time : h h m m

i) If Injury Give Cause : ☐ Self Inflicted ☐ Road Traffic Accident ☐ Substance / 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 E

DETAIL OF CLAIM

a) Details of The Treatment Expenses Claimed

i. Pre-hospitalization Expenses : Rs.

ii. Hospitalization Expenses : Rs.

iii. Post-hospitalization Expenses : Rs.

iv. Health-Check up Cost : Rs.

v. Ambulance charges : Rs.

vi. Other (code) : Rs.

Total **Rs.**

vii. Pre-hospitalisation period : days

viii. Post-hospitalization Period : days d d y y m m

b) Claim for Domiciliary Hospitalization : ☐ Yes ☐ No (If yes, provide details in annexure)

c) Details Of Lump sum / Cash Benefit Claimed:

i. Hospital Daily Cash : Rs.

ii. Surgical Cash : Rs.

ii. Critical Illness Benefit : Rs.

iv. Convalescence : Rs.

v. Pre/Post Hospitalization Lump Sum Benefit : Rs.

vi. Other : Rs.

Total **Rs.**

(IMPORTANT: PLEASE TURNOVER)

Claim Documents Submitted - Check List

- ☐ Claim Form Duly Signed
- ☐ Copy of the claim Intimation
- ☐ Hospital Main Bill
- ☐ Hospital Break-up Bill
- ☐ Hospital Bill Payment Receipt
- ☐ Hospital Discharge Summary
- ☐ Pharmacy Bill
- ☐ Operation Theater Notes
- ☐ ECG
- ☐ Doctor's Request For Investigation
- ☐ Investigation Report (Including CT / MRI/ USG / HPE)
- ☐ Other

SECTION E

DETAILS OF BILL ENCLOSED

Sl. No	Bill No	Date	Issued by	Towards	Amount (RS)
1.		d d m m y y		Hospital Main Bill	
2.		d d m m y y		Pre-hospitalization:_____Nos	
3.		d d m m y y		Pre-hospitalization:_____Nos	
4.		d d m m y y		Pharmacy Bills	
5.		d d m m y y			
6.		d d m m y y			
7.		d d m m y y			
8.		d d m m y y			
9.		d d m m y y			
10.		d d m m y y			

SECTION F

DETAILS PRIMARY INSURED'S ACCOUNT

a) Pan :

b) Account Number :

c) Bank Name and Branch :

d) Cheque/ DD Payable details :

e) IFSC Code :

SECTION G

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, 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

Date : d d m m y y

Place :

Signature of the insured

ANTI-MONEY LAUNDERING REQUIREMENT (For claim more than or equal to Rs. 1 Lakh - One Document each from (1) and (2))

1. Proposer's Identification (a) Passport (b) PAN Card (c) Voter's ID Card (d) Driving License (e) AADHAR Card
2. Proposer's Address (a) Current Telephone /Mobile Bill (b) Current Bank Passbook (c) Electricity Bill (d) Ration Card (e) Valid Rent Lease Agreement