

4 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

5 Details 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. Others (code) Rs.
- vii. Pre-hospitalization period: days
- viii. Post-hospitalization period: days
- 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.
- iii. Critical Illness Benefit Rs.
- iv. Convalescence Rs.
- v. Pre/Post hospitalization Lump sum benefit Rs.
- vi. Others
- Total Rs.

6 Claim documents submitted - check list

Please furnish the following list of the documents for Reimbursement:

- Claim form with duly signed by insured (Part I) and treating doctor (Part II).
- Original discharge summary
- Original final bill with receipt & detailed break up towards the final bill (item wise/cost wise).
- Original lab reports with advice for investigation undergone from the treating doctor (Doctor Prescription/Consultation).
- A letter from treating consultant stating past history if any with duration of the said ailment,
- A letter from the treating consultant stating details of accident and initial assessment- alcohol intoxication if any, (if the case of injury or accident) with MLC COPY / FIR copy in case of RTA/any injury/assault/poisoning etc.
- 1st consultation paper before the admission, if any
- Hospital registration certificate if the hospital is in non-network/remote location.
- A letter from insured stating reason for delay in submission of claim documents. (If delay more than 30 days after the discharge)
- Policy copy/Health ID card/ Health TPA ID card with ID proof & Address proof for patient & proposer.
- Cancelled cheque for Electronic fund transfer in the name of proposer

For pre - post hospitalization claim: After the discharge within 60 days treatment.

- Claim form (Part I)
- Medicine bills with Doctor Prescription/Consultation.
- Original lab reports with advice for investigation undergone from the treating doctor (Doctor Prescription/Consultation). If any
- Cancelled cheque Electronic fund transfer in the name of proposer



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7 Details of bills enclosed

Sl. No	Bill No	Date						Issued by	Towards	Amount (Rs)					
		D	D	M	M	Y	Y								
1		D	D	M	M	Y	Y		Hospital Main Bill						
2		D	D	M	M	Y	Y		Pre-hospitalization Bills: Nos						
3		D	D	M	M	Y	Y		Post-hospitalization Bills: 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								

8 NEFT Declaration:

Insured / proposer details :

Insured full name
(As in Bank Account)

PAN Number (10 digits)

Mobile Number

Email ID

Particulars of Bank Account :

Bank Name

Name of the Branch

Bank branch IFSC code for NEFT (11 digit)

Account Number
as appearing on
cheque book

Mandatory Requirement: Cancelled blank Cheque- for ensuring accuracy of name of the bank, branch name, Account number and IFSC code. If name / IFSC code / account number of the payee is not printed on the cheque leaf, please attach copy of the first page of the bank passbook.

9 Declaration by the insured

I / We, the undersigned, hereby declare that the particulars provided above have been filled-in / provided by me / us and hereby further declare that the said particulars are correct and complete and no blanks have been left. If the transaction is delayed or not effected at all for reason of incomplete or incorrect information I / we would not hold Bharti AXA General Insurance Company Limited responsible for the same.

I / We further undertake to refund, at any time, any excess amount whether demanded by Bharti AXA General Insurance Company Limited or not, which has been credited to my account [due to any reason whatsoever] by Bharti AXA General Insurance Company Limited, in excess of (i) the amount due to me, or (ii) in excess of amount for which I gave mandate, and or (iii) Any other payment.



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I / We agree that the payment will be endeavoured to be credited starting from the date of next payment cycle and issuance of relevant credit instruction for electronic payment from Bharti AXA General Insurance Company Limited into the aforesaid account will be valid discharge to Bharti AXA General Insurance Company Limited for having paid (i) the amount due to me, or (iii) Any other payment.

I / We further confirm that we understand this mode as a method of payment introduced by Reserve Bank of India, which provides us an option to receive the amount and or to collect our payments by electronic payment mode directly through my/our bank accounts.

I / We further confirm that I/we understand, Bharti AXA General Insurance Company Limited, shall make electronic payment to my account by issuing the Payment instruction electronically through its banker to the Clearing Authority and the Clearing Authority would ensure credit to my/our specified bank account provided hereinabove.

I / We further undertake to inform Bharti AXA General Insurance Company Limited with an advance notice of at-least 6 weeks, to withdraw from this mode of electronic payment.

I / We further confirm that Bharti AXA General Insurance Company Limited will have, at its sole discretion, the right to return back to the option of paying to me/us by way of cheque if there are more than 2 consecutive failures in remittances for no fault of Bharti AXA General Insurance Company Limited.

Data Privacy Notice:

I/We hereby provide consent to the Company for collecting/retaining any information relating to Me/Us including Sensitive Personal Information ("hereinafter cumulatively referred to as "INFORMATION"), that is either available with the Company or disclosed by Me/Us while obtaining the policy of Insurance from the company or otherwise. I/We further understand that the Company may use the INFORMATION for servicing the Insurance policy obtained by Me/Us and for same may share the INFORMATION with any reinsurer, insurance association, medical authorities, other Insurers, statutory authorities, court, governmental body, regulator etc., or with services provider(s) engaged by the Company for servicing the Insurance policy, underwriting the risk, settlement of claim etc. without obtaining our specific consent for such sharing and we hereby provide our consent to Company for same.

I/We understand that whenever I/We would like to update/correct the INFORMATION, we will intimate the Company for the same, so as to enable the Company to amend/correct the INFORMATION accordingly. Further in the event I/We would like to withdraw My/Our consent provided herein, I/We would intimate the Company of the same in writing and also understand that, in the event of such withdrawal by Me/Us, the Company reserves the right to not provide Me/Us the Services for which it has sought the INFORMATION.

After Bharti AXA General Insurance Company Limited issues the Payment instruction electronically through its banker, for whatever reasons, if I/we do not get the credit to my/our account, then same shall neither constitute the default in (i) Payment of amount requested by me, or (ii) Payment of amount due to me/us, or (iii) Payment of Any other payment by Bharti AXA General Insurance Company Limited nor constitute default of any terms and Conditions which may have been entered between I / We and Bharti AXA General Insurance Company Limited. I, We the Undersigned have read the above mentioned declarations / conditions and provide my / our free consent to the same.

Date Place Signature of the Insured

10 Customer Identification Procedure (as per KYC norms of IRDA)

Please submit the following documents in case of claim amount exceeds Rs. 1,00,000

Legal name and any other names used (Any one of the mentioned documents)	Passport/ PAN Card/ Voter's Identity Card/ Letter from a recognized public authority or public servant verifying the identity and residence of the customer/ AADHAAR card
Address Proof (Any one of the mentioned documents)	Telephone bill/ Bank account statement (not more than 6 months)/ Letter from any recognized public authority/ Electricity bill/ Ration card / Registered Lease and License agreement / Agreement for sale

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. b) Sl. No/ Certificate No. c) Company TPA ID No. d) Name e) Address	Enter the policy number Enter the social insurance number or the certificate number of social health insurance scheme Enter the TPA ID No Enter the full name of the policyholder Enter the full postal address	As allotted by the insurance company As allotted by the organization License number as allotted by IRDA and printed in TPA documents. Surname, First name, Middle name Include Street, City and Pin Code
SECTION B - DETAILS OF INSURANCE HISTORY		
a) Currently covered by any other Mediclaim / Health Insurance? b) Date of Commencement of first Insurance without break c) Company Name Policy No. Sum Insured d) Have you been Hospitalized in the last four years since inception of the contract? Date Diagnosis e) Previously Covered by any other Mediclaim/ Health Insurance? f) Company Name	Indicate whether currently covered by another Mediclaim / Health Insurance Enter the date of commencement of first insurance Enter the full name of the insurance company Enter the policy number Enter the total sum insured as per the policy Indicate whether hospitalized in the last four years Enter the date of hospitalization Enter the diagnosis details Indicate whether previously covered by another Mediclaim / Health Insurance Enter the full name of the insurance company	Tick Yes or No Use dd-mm-yy format Name of the organization in full As allotted by the insurance company In rupees Tick Yes or No Use mm-yy format Open Text Tick Yes or No Name of the organization in full
SECTION C - DETAILS OF INSURED PERSON HOSPITALIZED		
a) Name b) Gender c) Age d) Date of Birth e) Relationship to primary Insured f) Occupation g) Address h) Phone No i) E-mail ID	Enter the full name of the patient Indicate Gender of the patient Enter age of the patient Enter Date of Birth of patient Indicate relationship of patient with policyholder Indicate occupation of patient Enter the full postal address Enter the phone number of patient Enter e-mail address of patient	Surname, First name, Middle name Tick Male or Female Number of years and months Use dd-mm-yy format Tick the right option. If others, please specify. Tick the right option. If others, please specify. Include Street, City and Pin Code Include STD code with telephone number Complete e-mail address
SECTION D - DETAILS OF HOSPITALIZATION		
a) Name of Hospital where admitted b) Room category occupied c) Hospitalization due to 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 If Medico legal Reported to Police MLC Report & Police FIR attached j) System of Medicine	Enter the name of hospital Indicate the room category occupied Indicate reason of hospitalization Enter the relevant date Enter date of admission Enter time of admission Enter date of discharge Enter time of discharge Indicate cause of injury Indicate whether injury is medico legal Indicate whether police report was filed Indicate whether MLC report and Police FIR attached Enter the system of medicine followed in treating the patient	Name of hospital in full Tick the right option Tick the right option Use dd-mm-yy format Use dd-mm-yy format Use hh:mm format Use dd-mm-yy format Use hh:mm format Tick the right option Tick Yes or No Tick Yes or No Tick Yes or No Open Text
SECTION E - DETAILS OF CLAIM		
a) Details of Treatment Expenses b) Claim for Domiciliary Hospitalization c) Details of Lump sum/ cash benefit claimed d) Claim Documents Submitted-Check List	Enter the amount claimed as treatment expenses Indicate whether claim is for domiciliary hospitalization Enter the amount claimed as lump sum/ cash benefit Indicate which supporting documents are submitted	In rupees (Do not enter paise values) Tick Yes or No In rupees (Do not enter paise values) 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 b) Account Number c) Bank Name and Branch d) Cheque/ DD payable details e) IFSC Code	Enter the permanent account number Enter the bank account number Enter the bank name along with the branch Enter the name of the beneficiary the cheque/ DD should be made out to Enter the IFSC code of the bank branch	As allotted by the Income Tax department As allotted by the bank Name of the Bank in full Name of the individual/ organization in full 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.		

CLAIM FORM/OTHER THAN PA & TRAVEL/THINQ/01-16. Insurance is the subject matter of solicitation.



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Bharti AXA General Insurance Company Limited

1800-103-2292 (Toll Free)
claims@bharti-axagi.co.in
SMS <CLAIM> to 5667700
www.bharti-axagi.co.in

CLAIM FORM – PART B
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 preauthorization request form in lieu of PART A

Important Note

Issuance of this form not to be taken as an admission of liability

Please fill this form in Block Letters and Tick the Boxes where appropriate and do not leave any column unanswered.

If any detail or information is not readily available, please do not delay despatch of this report and such particulars may be sent later.

1 Details of Hospital

(To be filled in block letters)

a) Name of the hospital
b) Hospital ID (in case of networked hospital)
c) Type of Hospital: Network Non Network (If non network fill section E)
d) Name of the treating doctor SURNAME FIRST NAME MIDDLE NAME
e) Qualification f) Registration No. with State Code g) Phone No.

2 Details of the Patient admitted

a) Name of the Patient SURNAME FIRST NAME MIDDLE NAME
b) IP Registration Number c) Gender Male Female d) Age: Years Months e) Date of birth DDMMYY
f) Date of Admission DDMMYY g) Time: HH:MM h) Date of Discharge: DDMMYY i) Time: HH:MM
j) Type of Admission: Emergency Planned Day Care Maternity k) If Maternit Date of Delivery DDMMYY Gravida Status
l) Status at time of discharge: Discharge to home Discharge to another hospital Deceased m) Total claimed amount

3 Details of Ailment Diagnosed (primary)

Table with 2 columns: ICD 10 Codes, Description. Rows for Primary diagnosis, Procedure done with Anastasia, Treatment given if no surgery.

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 If Yes, give cause Self-inflicted Road Traffic Accident Substance abuse / alcohol consumption
If Injury due to Substance abuse / alcohol consumption, Test Conducted to establish this: Yes No (If Yes, attach reports) If Medico legal: Yes No
FIR no. If not reported to police give reason:

SECTION A
SECTION B
SECTION C

4 Additional details in case of non-network hospital (only fill in case of non-network hospital)

a) Address of the Hospital: _____

City: _____ State: _____
Pin Code: _____ b) Phone No. _____ c) Registration No. with State Code: _____
d) Hospital PAN: _____ e) Number of Inpatient beds _____ f) Facilities available in the hospital: OT : Yes No
ICU : Yes No Others : _____

5 Declaration by the hospital (PLEASE READ VERY CAREFULLY)

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.

Data Privacy Notice:

I/We hereby provide consent to the Company for collecting/retaining any information relating to Me/Us including Sensitive Personal Information ("hereinafter cumulatively referred to as "INFORMATION"), that is either available with the Company or disclosed by Me/Us while obtaining the policy of Insurance from the company or otherwise. I/We further understand that the Company may use the INFORMATION for servicing the Insurance policy obtained by Me/Us and for same may share the INFORMATION with any reinsurer, insurance association, medical authorities, other Insurers, statutory authorities, court, governmental body, regulator etc., or with services provider(s) engaged by the Company for servicing the Insurance policy, underwriting the risk, settlement of claim etc. without obtaining our specific consent for such sharing and we hereby provide our consent to Company for same.

I/We understand that whenever I/We would like to update/correct the INFORMATION, we will intimate the Company for the same, so as to enable the Company to amend/correct the INFORMATION accordingly. Further in the event I/We would like to withdraw My/Our consent provided herein, I/We would intimate the Company of the same in writing and also understand that, in the event of such withdrawal by Me/Us, the Company reserves the right to not provide Me/Us the Services for which it has sought the INFORMATION.

Date

Place _____

Signature and Seal of the Hospital Authority

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 b) Hospital ID c) Type of Hospital d) Name of treating doctor e) Qualification f) Registration No. with State Code g) Phone No.	Enter the name of hospital Enter ID number of hospital Indicate whether In network or non network hospital Enter the name of the treating doctor Enter the qualifications of the treating doctor Enter the registration number of the doctor along with the state code Enter the phone number of doctor	Name of hospital in full As allocated by the TPA Tick the right option Name of doctor in full Abbreviations of educational qualifications As allocated by the Medical Council of India Include STD code with telephone number
SECTION B – DETAILS OF THE PATIENT ADMITTED		
a) Name of Patient b) IP Registration Number c) Gender d) Age e) Date of Birth f) Date of Admission g) Time h) Date of Discharge i) Time j) Type of Admission k) If Maternity Date of Delivery Gravida Status l) Status at time of discharge m) Total claimed amount	Enter the name of hospital Enter insurance provider registration number Indicate Gender of the patient Enter age of the patient Enter date of admission Enter date of admission Enter time of admission Enter date of discharge Enter time of discharge Indicate type of admission of patient Enter Date of Delivery if maternity Enter Gravida status if maternity Indicate status of patient at time of discharge Indicate the total claimed amount	Name of hospital in full As allotted by the insurance provider Tick Male or Female Number of years and months Use dd-mm-yy format Use dd-mm-yy format Use hh:mm format Use dd-mm-yy format Use hh:mm format Tick the right option Use dd-mm-yy format Use standard format Tick the right option In rupees (Do not enter paise values)
SECTION C – DETAILS OF AILMENT DIAGNOSED (PRIMARY)		
a) ICD 10 Code Primary Diagnosis Additional Diagnosis Co-morbidities b) ICD 10 PCS Procedure 1 Procedure 2 Procedure 3 Details of Procedure c) Pre-authorization obtained d) Pre-authorization Number e) If authorization by network hospital not obtained, give reason f) Hospitalization due to injury Cause If injury due to substance abuse/alcohol consumption, test conducted to establish this Medico Legal Reported To Police FIR No. If not reported to police, give reason	Enter the ICD 10 Code and description of the primary diagnosis Enter the ICD 10 Code and description of the additional diagnosis Enter the ICD 10 Code and description of the co-morbidities Enter the ICD 10 PCS and description of the first procedure Enter the ICD 10 PCS and description of the second procedure Enter the ICD 10 PCS and description of the third procedure Enter the details of the procedure Indicate whether pre-authorization obtained Enter pre-authorization number Enter reason for not obtaining pre-authorization number Indicate if hospitalization is due to injury Indicate cause of injury Indicate whether test conducted Indicate whether injury is medico legal Indicate whether police report was filed Enter first information report number Enter reason for not reporting to police	Standard Format and Open text Standard Format and Open text Standard Format and Open text Standard Format and Open text Standard Format and Open text Standard Format and Open text Open text Tick Yes or No As allotted by TPA Open text Tick Yes or No Tick the right option Tick Yes or No Tick Yes or No Tick Yes or No As issued by police authorities Open Text
SECTION D – CLAIM DOCUMENTS SUBMITTED-CHECK LIST		
Indicate which supporting documents are submitted		
SECTION E – DETAILS IN CASE OF NON NETWORK HOSPITAL		
a) Address b) Phone No. c) Registration No. with State Code d) Hospital PAN e) Number of Inpatient beds f) Facilities available in the hospital	Enter the full postal address Enter the phone number of hospital Enter the registration number of the doctor along with the state code Enter the permanent account number Enter the number of inpatient beds Indicate facilities available in the hospital	Include Street, City and Pin Code Include STD code with telephone number As allocated by the Medical Council of India As allotted by the Income Tax department Digits Tick the right option. If others, please specify
SECTION F - DECLARATION BY THE HOSPITAL		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign and stamp		

CLAIM FORM/HOSPITAL/THINQ/01-16. Insurance is the subject matter of solicitation.



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