Liberty Videocon General Insurance

CLAIM FORM - PART B

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

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

SECTION A

DETAILS OF HOSPITAL

a) Name of Hospital :

b) Hospital ID : c) Type of Hospital : ☐ Network ☐ Non Network (If non network section E)

d) Name of the treating doctor : SURNAME FIRST MIDDLE NAME

e) Qualification : f) Registration No. with State Code :

g) Phone No :

SECTION B

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient : SURNAME FIRST MIDDLE NAME

b) IP Registration Number : c) Gender : ☐ Male ☐ Female d) Age : Year (yy) Months (mm)

e) Date of Brith : (dd mm yy) f) Date of Admission : (dd mm yy) g) Time : (hh mm)

h) Date of Discharge : (dd mm yy) i) Time : (hh mm) j) Type of Admission : ☐ Emergency ☐ Planned ☐ Day Care ☐ Maternity

k) If Maternity : i. Date of Delivery : (dd mm yy) ii. Grade of status :

j) Status at time of discharge : : ☐ Discharge to home ☐ Discharge to another hospital ☐ Deceased

SECTION C

DETAIL OF AILMENT DIAGNOSED (PRIMARY)

a)	ICD 10 Codes	Description	b)	ICD 10 Codes	Description
i) Primary Diagnosis :			i) Procedure 1 :		
ii) Additional Diagnosis :			ii) Procedure 2 :		
iii) Co-morbidities :			iii) Procedure 3 :		
iv) Co-morbidities :			iv) Details of Procedure :		

c) Present ailment is a complication of PED? ☐ Yes ☐ No i) (If Yes, Specify Details) : _____

d) Pre-authorization obtained : ☐ Yes ☐ No e) Pre-authorization Number :

f) If authorization by network hospital not obtained, give reason :

g) Hospitalization due to Injury : ☐ Yes ☐ No i) (If Yes, give cause) ☐ Self-inflicted ☐ Road Traffic Accident ☐ Substance abuse/ alcohol consumption

i) If injury due to substance abuse/ alcohol consumption, Test Conducted to establish this : ☐ Yes ☐ No (If Yes, Attach Report) iii) If Medico Legal : ☐ Yes ☐ No

v) FIR no : vi) If not reported to police give reason: _____

SECTION D

CLAIM DOCUMENTS SUBMITTED - CHECK LIST

- ☐ Claim From Duly Singed
- ☐ Original Pre-authorization request
- ☐ Copy of Pre-authorization Approval latter
- ☐ Copy of photo ID card of patient verified by hospital
- ☐ Hospital Discharge summary
- ☐ Operation Theater notes
- ☐ Hospital main bill
- ☐ Hospital break-up bill
- ☐ Investigation report
- ☐ CT/MR/USG/HPE investigation report
- ☐ Doctor's reference slip for investigation
- ☐ ECG
- ☐ Pharmacy bills
- ☐ MLC report & Police FIR
- ☐ Original death summary from hospital where applicable
- ☐ Any other, please specify

(IMPORTANT : PLEASE TURN OVER)

Liberty Videocon General Insurance

SECTION E

DETAILS IN CASE OF NON NETWORK HOSPITAL

a) Address of Hospital :

City : State :

Pin Code : b) Phone No : c) Registration No :

d) PAN e) Number of Inpatient beds : f) Facilities available in the hospital : i) OT : ☐ Yes ☐ No ii) ICU : ☐ Yes ☐ No

iii) Other :

SECTION F

DECLARATION BY THE INSURED

(PLEASE READ VERY CAREFULLY)

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.

Date : d d m m y y Place : Signature of the insured

SECTION G

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 my 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. The signature of the insured is taken on this form after Claim Form B is fully filled up by us.

Date : d d m m y y

Place : Signature and Seal of the hospital Authority