Narayana Health Insurance

Claim form for health insurance policies other than travel and personal accident

CLAIM FORM - PART A

TO BE FILLED IN BY THE INSURED

(TO BE FILLED IN BLOCK LETTERS)

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

DETAILS OF PRIMARY INSURED:

SECTION A

a) Policy No. a) Sl. 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

DETAILS OF INSURANCE HISTORY:

SECTION B

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 Y Y

c) If yes, Company name Policy No.

Sum Insured (Rs.)

d) Have you been hospitalised in the last four years since inception of the contract? YES NO D D M M Y Y

Diagnosis

e) Previously covered by any other Mediclaim/Health Insurance YES NO

f) If yes, Company name

DETAILS OF INSURED PERSON HOSPITALISED:

SECTION C

a) Name SURNAME FIRST NAME MIDDLE NAME

b) Gender Male M Female F Third Gender T c) Age Y Y Month M M d) Date of Birth D D M M Y Y

e) Relationship to Primary Insured Self Spouse Child Father Mother Other

(Please specify)

f) Occupation Service Self-employed Homemaker Student Retired Other

(Please specify)

g) Address (if different from above)

City State

Pin Code Phone No. Email ID

DETAILS OF HOSPITALISATION:

SECTION D

a) Name of Hospital where admitted

b) Room category occupied Day care Single occupancy Twin sharing 3 or more beds per room

c) Hospitalisation due to Injury Illness Maternity

d) Date of injury/Date first detected/Date of delivery D D M M Y Y e) Date of admission D D M M Y Y

f) Time H H M M g) Date of discharge D D M M Y Y h) Time H H M M 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 MLC Report & Police FIR attached YES NO j) System of medicine

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DETAILS OF CLAIM:

SECTION E

a) Details of the treatment expenses claimed

i. Pre-hospitalisation expenses	Rs.	ii. Hospitalisation expenses	Rs.
iii. Post-hospitalisation expenses	Rs.	iv. Health checkup cost	Rs.
v. Ambulance charges	Rs.	vi. Others (code)	Rs.
		Total	Rs.
vii. Pre-hospitalisation period	Days	viii. Post-hospitalisation period	Days

b) Claim for domiciliary hospitalisation ☐ 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	Rs.
		Total	Rs.

Claim Documents Submitted- Check List:

☐ Claim Form Duly Signed	☐ Hospital Discharge Summary	☐ Investigation Reports (Including CT MRI / USG / HPE)
☐ Copy of the Claim Intimation, if any	☐ Pharmacy Bill	
☐ Hospital Main Bill	☐ Operation Theatre Notes	☐ Doctor's Prescriptions
☐ Hospital Break-up Bill	☐ ECG	☐ Others
☐ Hospital Bill Payment Receipt	☐ Doctor's Request for Investigation	

DETAILS OF BILLS ENCLOSED:

SECTION F

Sl No.	Bill No.	Date	Issued by	Towards	Amount (Rs)
				Hospital Main Bill	
				Pre-hospitalisation Bills: Nos	
				Post-hospitalisation Bills: Nos	
				Pharmacy Bills	

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT:

SECTION G

a) PAN b) Account No.

c) Bank name and branch

d) Cheque/DD Payable details e) IFSC code

DECLARATION BY THE INSURED:

SECTION H

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 D D M M Y Y Place

Signature of the Insured

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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.	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 health insurance scheme	As allotted by the organization
c) Company TPA ID No.	Enter the TPA ID No.	Surname, First name, Middle name
d) Name	Enter the full name of the policy holder	Surname, First name, Middle name
e) Address	Enter the full postal address	Include Street, City, and Pin Code

SECTION B - DETAILS OF INSURANCE 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 hospitalised in the last four years since inception of the contract?	Indicate whether hospitalised in the last four 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 PERSON HOSPITALIZED		
a) Name	Enter the full name of the patient	Surname, First name, Middle name
b) Gender	Indicate Gender of the patient	Tick Male, Female or Third Gender
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

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SECTION B - DETAILS OF INSURANCE HISTORY		
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) hospitalisation 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 date 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 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

SECTION E - DETAILS OF CLAIM		
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

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	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/ DDshould 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.

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CLAIM FORM - PART B

TO BE FILLED IN BY THE HOSPITAL

(TO BE FILLED IN BLOCK LETTERS)

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

DETAILS OF HOSPITAL:

SECTION A

a) Name of the hospital

b) Hospital ID

c) Type of Hospital: Network ☐ Non Network ☐ (If non network, fill section E)

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

h) Qualification

f) Registration No. with State Code

g) Phone No.

DETAILS OF THE PATIENT ADMITTED:

SECTION B

a) Name of the Patient SURNAME FIRST NAME MIDDLE NAME

b) IP Registration No.

c) Gender Male [M] Female [F] Third Gender [T]

d) Age Years [YY] Months [YY]

e) Date of Birth [DDMMYYYY]

f) Date of admission [DDMMYYYY]

g) Time [HHMM]

h) Date of discharge [DDMMYYYY]

i) Time [HHMM]

j) Type of admission: Emergency ☐ Planned ☐ Day care ☐ Maternity ☐

k) If maternity i. Date of delivery [DDMMYYYY] ii. Gravida status

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

m) Total claimed amount

DETAILS OF AILMENT DIAGNOSED (PRIMARY):

SECTION C

a)	ICD 10 Codes	Description	b) I	CD 10 PCS	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) Pre-authorization obtained YES ☐ NO ☐ d) Pre-authorization No.

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

f) hospitalisation due Injury: YES ☐ NO ☐ i) If Injury give cause: Self-inflicted ☐ Road traffic accident ☐ Substance abuse/alcohol consumption ☐

ii. If Injury due to Substance abuse / alcohol consumption, Test Conducted to establish this YES ☐ NO (If Yes, attach reports) ☐

iii. If medico legal ☐ YES ☐ NO iv. Reported to Police ☐ YES ☐ NO v. FIR no

vi. If not reported to police give reason

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CLAIM DOCUMENTS SUBMITTED - CHECK LIST:

SECTION D

- ☐ Claim Form duly signed
- ☐ Original pre-authorization request
- ☐ Copy of the pre-authorization approval letter
- ☐ Copy of photo ID card of patient verified by hospital
- ☐ Hospital Discharge summary
- ☐ Operation Theatre notes
- ☐ Hospital main bill
- ☐ Hospital break-up bill
- ☐ Investigation reports
- ☐ CT/MR/USG/HPE investigation reports
- ☐ Doctor's reference slip for investigation
- ☐ ECG
- ☐ Pharmacy bills
- ☐ MLC report & Police FIR
- ☐ Original death summary from hospital where applicable
- ☐ Any other, please specify

ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL):

SECTION D

a) Address of the Hospital

City State

Pin Code b) Phone No. c) Hospital PAN

d) Registration No. with State Code e) Number of Inpatient beds

f) Facilities available in the hospital i. OT ☐ YES ☐ NO ii. ICU ☐ YES ☐ NO

iii. Others

DECLARATION BY THE HOSPITAL:

(PLEASE READ VERY CAREFULLY)

SECTION E

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 D D M M Y Y Y Y

Place

Signature and Seal of the Hospital Authority:

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

SECTION B - DETAILS OF THE PATIENT ADMITTED		
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, Female or Third Gender
d) Age	Enter age of the patient	Number of years and months
e) Date of Birth	Enter time of admission	Use dd-mm-yy format
f) Date of admission	Enter time of admission	Use dd-mm-yy format
g) Time	Enter time of admission	Use hh:mm format
h) Date of discharge	Enter time of discharge	Use dd-mm-yy format
l) 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 paise values)

SECTION C - DETAILS OF AILMENT DIAGNOSED (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		
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	Enter the ICD 10 PCS and description of the second procedure

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SECTION C - DETAILS OF AILMENT DIAGNOSED (PRIMARY)		
Procedure 3	Enter the ICD 10 PCS and description of the third procedure	Standard Format and Open text
Details of procedure	Enter the details of the procedure	Standard Format and Open text
Details of procedure	Indicate whether pre-authorization obtained	Tick Yes or No
d) Pre-authorization No.	Enter pre-authorization number	As allotted by TPA
e) If authorization by network hospital not obtained, give reason	Enter reason for not obtaining pre authorization number	Open text
f) 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.	Indicate 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 SUBMITTED-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. with State Code	Enter the registration number of the doctor along with the state code	As allocated by the Medical Council of India
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 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

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REQUEST FOR CASHLESS HOSPITALISATION FOR HEALTH INSURANCE POLICY

TO BE FILLED IN BLOCK LETTERS

Name of the hospital:

Hospital location: Hospital ID:

Hospital email ID: ROHINI ID:

DETAILS OF THE THIRD PARTY ADMINISTRATOR / INSURER / HOSPITAL

a) Name of Insurer: **Narayana Health Insurance Limited** b) Phone no.: **+91 9821034071** c) Email ID: **preauth@narayanahealth.insurance**

TO BE FILLED BY INSURED/PATIENT

ABHA ID (If available):

a) Name of the patient:

b) Gender: Male Female Third Gender c) Contact no.: d) Alternate contact no.:

e) Age: Years Y Y Months M M f) Date of birth: D D M M Y Y Y Y g) Insurer ID card no.:

h) Policy number/Name of Corporate: i) Employee ID:

j) Currently do you have any other medical claim/health Insurance: Yes No j. 1) Insurer Name:

j.2) Give details:

k) Do you have a family physician, if yes: Name: k.1) Contact no.:

l) Occupation of insured patient:

m) Address of insured patient:

TO BE FILLED BY THE TREATING DOCTOR/HOSPITAL

a) Name of the treating Doctor: b) Contact no.:

c) Name of Illness/disease with presenting complaints:

d) Relevant clinical findings:

e) Duration of the present ailment: days e.1) Date of first consultation: D D M M Y Y Y Y

e.2) Past history of present ailment if any:

f) Provisional diagnosis:

f.1) ICD 10 code:

g) Proposed line of treatment: Medical management Surgical management Intensive care Investigation Non-Allopathic treatment

h) If investigation and/or medical management, provide details:

i) If Surgical, name of surgery:

i.1) ICD 10 PCS code:

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j) If other treatments provide details:

k) How did injury occur:

L) In case of accident: I. Is it RTA: ☐ Yes ☐ No ii. Date of injury: D D M M Y Y Y Y iii. Reported to Police: ☐ Yes ☐ NO iv. FIR no:

v) Injury/Disease caused due to substance abuse/alcoholconsumption ☐ Yes ☐ NO ☐ Yes ☐ NO

m) In case of maternity: G P L A n) Expected date of delivery: D D M M Y Y Y Y

DETAILS OF THE PATIENT ADMITTED

a) Date of admission: D D M M Y Y Y Y b) Time of admission: H H M M c) This is ☐ an emergency/ ☐ a planned hospitalization event

d) Expected no. of days stay in hospital: Days e) Days in ICU: Days f) Room Stay:

g) Per Day Room Rent + Nursing & Service charges + Patient's Diet: Rs.

h) Expected cost for investigation + diagnostics: Rs.

i) ICU Charges: Rs.

j) OT Charges: Rs.

k) Professional fees Surgeon + Anesthetist fees + Consultation charges: Rs.

L) Medicines + Consumables cost of Implants: (specify if applicable) Rs.

m) Other hospital expenses if any: Rs.

n) All-inclusive package charges if any applicable: Rs.

o) Sum Total expected cost of hospitalization Rs.

p. Mandatory past historyof any chronic illness. If yes (since month/year)

☐ 1. Diabetes M M Y Y

☐ 2. Heart Disease M M Y Y

☐ 3. Hypertension M M Y Y

☐ 4. Hyperlipidemias M M Y Y

☐ 5. Osteoarthritis M M Y Y

☐ 6. Asthma/ COPD / Bronchitis M M Y Y

☐ 7. Cancer M M Y Y

☐ 8. Alcohol or drug abuse M M Y Y

☐ 9. Any HIV or STD / related ailments M M Y Y

10. Any other ailment give details:

DECLARATION (PLEASE READ VERY CAREFULLY)

We confirm having read understood and agreed to the declaration of this form

a) Name of the treating doctor:

b) Qualification: c) Registration No. with State code:

DECLARATION BY THE PATIENT / REPRESENTATIVE:

a. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Insurer after the discharge. I agree to sign on the Final Bill & the Discharge Summary, before my discharge.
b. Payment to the hospital is governed by the terms and conditions of the policy. In case we are not able to settle the hospital bill, I undertake to settle the bill as per the terms and conditions of the policy.
c. All non-medical expenses and expenses not relevant to current hospitalization and the amounts over & above the limit authorized by the Insurer not governed by the terms and conditions of the policy will be paid by me.
d. I hereby declare to abide by the terms and conditions of the policy and if at any time the facts disclosed by me are found to be false or incorrect I forfeit my claim and agree to indemnify the insurer.
e. I agree and understand that the Insurer is in no way guaranteeing that the services provided by the hospital will be of a particular quality or standard.
f. I hereby warrant the truth of the forgoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppression or concealment with respect to the claim, my right to claim reimbursement of the said expenses shall be absolutely forfeited.
g. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer. "I/We authorize Insurance Company to contact me/us through mobile/email for any update on this claim"

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a) Patient's / Insured's name:

b) Contact number:

c) Email ID: (Optional)

d) Patient's / Insured's signature:

Date: D D M M Y Y Y Y Time: H H M M

HOSPITAL DECLARATION

a. We have no objection to any Insurance Company official verifying documents pertaining to hospitalization.
b. All valid original documents duly countersigned by the insured / patient as per the checklist below will be sent to Insurance Company within 7 days of the patient's discharge.
c. We agree that the Insurance Company will not be Liable to make the payment in the event of any discrepancy between the facts in this form and discharge summary or other documents.
d. The patient declaration has been signed by the patient or by his representative in our presence.
e. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications.
f. We will abide by the terms and conditions agreed in the MOU.
g. We confirm that no additional amount would be collected from the insured in excess of Agreed Package Rates except costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility choosing separate line of treatment which is not envisaged/ considered in package).
h. We confirm that no recoveries would be made from the deposit amount collected from the insured except for costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility/ choosing separate line of treatment which is not envisaged/considered in package).
i. In the event of unauthorized recovery of any additional amount from the Insured in excess of Agreed Package Rates, the Insurance Company reserves the right to recover the same from us (the Network Provider) and,/or take necessary action, as provided under the MOU or applicable laws.

DOCUMENTS TO BE PROVIDED BY THE HOSPITAL IN SUPPORT OF THE CLAIM

1. Detailed Discharge Summary and all Bills from the hospital.
2. Cash Memos from the Hospitals / Chemists supported by proper prescription.
3. Receipts and Pathological Test Reports from Pathologists, supported by note from the attending Medical Practitioner / Surgeon recommending such pathological Tests.
4. Surgeon's Certificate stating nature of Operation performed and Surgeon's Bill and Receipt.
5. Certificates from attending Medical Practitioner / Surgeon that the patient is fully cured.

Hospital seal:

Doctor's signature:

Date: D D M M Y Y Y Y Time: H H M M