HDFC ERGO General Insurance Company Limited

Claim Form

HDFC ERGO
Take it easy!

Corona Kavach Policy, HDFC ERGO (Group)

CLAIM FORM – PART A TO BE FILLED IN BY THE INSURED

Issuance of this form is not a proof of admissibility of liability

SECTION A - DETAILS OF OF PRIMARY INSURED

Reported under Policy Number/ Certificate:

Company/ TPA ID No.:

Name

Address

City | State

Pin Code | Phone | Mobile

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 Y Y
c) If Yes, Company Name	
Policy No.	
Sum Insured	
d) Have you been hospitalized in the last four years since inception of the contract	Yes No D D M M Y Y 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 HOSPITALISED

a) Name					
a) Relationship(Self/spouse/Child/Father/Mother/Other)		c) Date of Birth		d) Age	Mths/yrs
e) Address (If different than above)					
f) Gender	Male Female	g) Occupation		Service/Self-employed/Homemaker/student/ Retired/ Others	
h) Telephone No		i) Mobile No			
j) E-mail ID, if any					

SECTION D - DETAILS OF HOSPITALISATION

a) Name of the Hospital where admitted			
b) Room Category occupied		Daycare/Single Occupancy/Twin Sharing/ 3 or more beds per room	
c) Hospitalization due to		Illness / Injury/ Maternity	
d) Date of Injury/ Date of disease first detected/ Date of delivery		DD/MM/YYYY	
e) Date of admission		DD/MM/YYYY	
f) Time		HH/MM	
g) Date of discharge		DD/MM/YYYY	
h) Time		HH/MM	
i) If injury, give cause		Self-Inflicted/Road Traffic Accident/ Substance Abuse/ Alcohol Consumption	
I) If Medico legal E-mail ID, if any	Yes No	ii) Reported to police?	Yes No
iii) MLC Report, & Police FIR attached?	Yes No	j) System of medicine	Allopathic/Other systems of medicine

SECTION E - DETAILS OF CLAIM

A.Claim			
i) COVID Hospitalization	Yes No	ii) Home Care Treatment	Yes No
iii) AYUSH Treatment	Yes No	iv) Pre Hospitalization	Yes No
v) Post Hospitalization	Yes No		
Please tick the applicable Optional Cover claimed:			
i) Hospital Cash	Yes No	<<Please provide details>>	

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Claim Documents Submitted Check List: Hospitalization Claim		
☐ Duly filled and signed Claim Form	☐ Copy of intimation letter ,if any	☐ Copy of Insured Person's passport
☐ Hospital Main Bill	☐ Original Hospital bill break up	☐ Medical Practitioner prescription advising admission
☐ Original Hospital Bill Payment Receipt	☐ Original Hospital Discharge summary	☐ Test reports from Authorized diagnostic Centre for COVID
☐ Pharmacy Bill	☐ Operation theatre notes	☐ Indoor case papers if applicable
☐ Original Investigation / diagnostic Reports with original bills and payment receipt	☐ Doctors request for investigations	☐ ECG
☐ Prescriptions	☐ Government Issued Photo ID and Age proof	☐ Death Summary with Death Certificate (In death claims only)
☐ Copy of the Network Provider's Registration Certificate	☐ KYC Documents	☐ implant stickers for all implants used during surgeries

SECTION F - DETAILS OF BILLS ENCLOSED

Sr.no.	Bill No.	Date	Issued By	Towards	Amount (Rs)
		D D M M Y Y Y Y			

SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

a) PAN		b) Account Number
c) Bank Name/ Branch		d) Payable details: Cheque/ DD
e) IFSC Code		e) *please attach a cancelled cheque pertaining to the same
f) MICR No		*please attach a cancelled cheque pertaining to the same

Note:
It is agreed that the Policyholder/Claimant will intimate in writing to HDFC ERGO General Insurance Co. Ltd. about any change in bank account details.
In an event Insured person bears expenses for treatment please provide account details of Insured Persons in the above format along with proof of incurring such expenses..

SECTION H - 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 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 Y Y

Place:______________

Signature of Insured

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 pre-authorization request form in lieu of PART A

SECTION A - DETAILS OF HOSPITAL

Name of the Hospital where treated

Hospital ID

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

Name of the treating Doctor

Qualification

Registration No with state Code

Phone

SECTION B - DETAILS OF PATIENT ADMITTED

a) Name of the patient		b) IP Registration Number	
c) Gender	☐ Male ☐ Female	d) Age	YY/MM
e) Date of Birth	D D M M Y Y Y Y		
f) Date of Admission	D D M M Y Y Y Y	g) Time of Admission	HH/MM
h) Date of Discharge	D D M M Y Y Y Y	i) Time of Discharge	HH/MM
j) Type of Admission	Emergency/Planned/Daycare/Maternity	k) If Maternity	
i) Date of Delivery	D D M M Y Y Y Y	ii) Gravida Status	
l) Status at time of discharge	Discharged to Home Discharged to another Hospital Deceased	Total Claimed Amount	

SECTION C - DETAILS OF AILMENTS DIAGNISED (PRIMARY)

a) ICD 10 Codes	Primary Diagnosis		Additional Diagnosis		Co-morbidities		
Details of Procedure/s done							
b) ICD 10 PCS	Procedure 1		Procedure 2		Procedure 3		
i) Pre-authorization obtained	☐ Yes ☐ No		ii) Pre-authorization No				
c) If authorization by network hospital not obtained, give reason							
f) Hospitalisation due to Injury	☐ Yes ☐ No		i) If yes, give cause				
Self inflicted?	☐ Yes ☐ No	Road Traffic Accident	☐ Yes ☐ No	Substance Abuse /Alcohol Consumption		☐ Yes ☐ No	
ii) If Injury due to Substance abuse / alcohol consumption, Test Conducted to establish this:			☐ Yes ☐ No (If yes, attach reports)	iii) Medico Legal	☐ Yes ☐ No		
iv) Reported to Police	☐ Yes ☐ No		FIR No				
vi) If not reported to Police give reasons							

SECTION D - CLAIM DOCUMENTS SUBMITTED - CHECKLIST

☐ Claim form duly filled and signed	☐ Investigation reports
☐ Original Pre authorization Request	☐ CT/MRI/USG/HPE investigation Report
☐ Copy of Pre-authorization approval Letter	☐ Doctor's reference slip for Investigation
☐ Copy of photo ID card of patient verified by Hospital	☐ ECG
☐ Hospital Discharge Summary	☐ Pharmacy Bills
☐ Operation Theatre Notes	☐ Hospital break up Bill
☐ Hospital Main Bill	☐ Original death summary from hospital where applicable
☐ Any other, Pl specify	

SECTION E - DETAILS IN CASE OF NON NETWORK HOSPITAL

a) Address of the Hospital		b) Phone NO:	
c) Registration no with State Code		d) Hospital PAN	
e) No of In-patient Beds		f) Facilities available in Hospital	
i) OT	☐ Yes ☐ No	ii) ICU	☐ Yes ☐ No
iii) Others			

SECTION F - DECLARATION BY HOSPITAL

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 of Insured

LIST OF ENCLOSURES FOR SUBMISSION OF CLAIM

Note:

1. When original bills, receipts, prescriptions, reports and other documents are submitted to the other insurer or to the reimbursement provider, verified photocopies attested by such other organization/provider have to be submitted.
2. If original bills, receipts, prescriptions, reports and other documents are submitted to Us and Insured Person requires same for claiming from other organization/provider, then on request from the Insured Person We will provide attested copies of the bills and other documents submitted by the Insured Person.
3. If below mentioned documents are not provided in full or are insufficient for Us to consider the claim, then We may request additional information or documentation.

Benefits	Claims Documents Required
1.**COVID Hospitalization Cover**	I Duly filled and signed Claim Form ii Copy of Insured Person's passport, if available (All pages) iii Photo Identity proof of the patient - (if Insured Person does not own a passport) iv Medical Practitioner's prescription advising admission v Original bills with itemized break-up vi Bills and Payment receipts vii Discharge summary including complete medical history of the patient along with other details. viii Investigation reports including Insured Person's test reports from Authorized diagnostic centre for COVID ix. OT notes or Surgeon's certificate giving details of the operation performed, wherever applicable x. Sticker/Invoice of the Implants, wherever applicable. xi NEFT Details (to enable direct credit of claim amount in bank account) and cancelled cheque xii KYC (Identity proof with Address) of the proposer, where claim liability is above Rs 1 Lakh as per AML Guidelines xiii Legal heir/succession certificate, wherever applicable xiv Any other relevant document required by Company for assessment of the claim.

Benefits	Claims Documents Required
2.**Home Care Treatment expenses**	i. Duly filled and signed Claim Form ii. Copy of **Insured Person's** passport, if available (All pages) iii. Photo Identity proof of the patient - (if **Insured Person** does not own a passport) iv. **Medical Practitioners'** prescription advising **Hospitalization** v. A certificate from **Medical Practitioner** advising treatment at home or consent from the**Insured Person** on availing home care benefit. vi. Discharge Certificate from **Medical Practitioner** specifying date of start and completion of home care treatment. vii. Daily monitoring chart including records of treatment administered duly signed by the treating doctor is maintained.

Customer Identification Procedure (as per KYC norms of IRDAI)	
Please submit the following documents in case of claim amount exceeds Rs. 100,000	
Legal name and any other names used (Any one of the mentioned documents)	Passport/ PAN Card/ Voter's Identity Card/ Driving License/ Letter from a recognized public authority or public servant verifying the identity and residence of the customer
Proof of Residence (Any one of the mentioned documents)	Telephone bill/ Bank account statement/ Letter from any recognized public authority/ Electricity bill/ Ration card