HDFC General Insurance Limited
(Formerly L&T General Insurance Company Limited)
An HDFC ERGO Company

Claim Form - my:health Super Top Up Insurance

GUIDELINES TO FILL THE FORM

1. Please fill the form in BLOCK LETTERS. Please answer all questions fully and correctly. All details with * are mandatory.
2. Please leave one box blank between two words while writing the ADDRESS.
3. Kindly contact the Company's Office or TPA for any doubts or clarifications on the claim form.

PLEASE USE ONLY ORIGINAL CLAIM FORM. PHOTO COPIES WILL NOT BE ACCEPTED BY THE COMPANY.

CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT – PART A

TO BE FILLED IN BY THE INSURED

(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. Sl. No / Certificate No.:

c. Company/TPA ID No :

d. Name: S U R N A M E F I R S T M I D D L E

e. Address:

Block/Flat No.*: Floor No.: Building Name*:

Street Name*: Locality:

Landmark*:

City/Village*: Pincode*:

Post Office: Fax No.:

Mobile No.: Landline*: S T D

Email ID 1*:

Email ID 2*:

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 hospitalised in the last four years since inception of the contract? ☐ Yes ☐ No

If Yes, Date: 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: S U R N A M E F I R S T M I D D L E

b. Gender: ☐ Male ☐ Female c. Age: Years: Y Y Months: M M d. Date of Birth: D D M M Y Y Y Y

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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):

Block/Flat No.*: Floor No.: Building Name*:

Street Name*: Locality:

Landmark*:

City/Village*: Pincode*:

Post Office: Fax No.:

Mobile No.*: Landline*: S T D

Email ID 1*:

Email ID 2:

SECTION D - DETAILS OF HOSPITALISATION

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 Disease first detected/Date of Delivery: D D M M Y Y Y Y

e. Date of Admission: D D M M Y Y Y Y f. Time: H H : M M

g. Date of Discharge: D D M M Y Y 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 iii) MLC Report & Police FIR attached: ☐ Yes ☐ No

j. System of Medicine:

SECTION E - DETAILS OF CLAIM

a. Details of the treatment expenses claimed

i. Pre-hospitalisation Expenses: ₹

ii. Hospitalisation Expenses: ₹

iii. Post-hospitalisation Expenses: ₹

Total ₹

DOCUMENT CHECK LIST FOR HOSPITALISATION CLAIM

BASIC CLAIM DOCUMENTS

1. Claim form duly filled with requisite information and signed by Insured & Hospital. ☐
2. Copy of the claim intimation. ☐
3. Original hospital main bill. ☐
4. Original hospital bill break up (Where issued by the Hospital). ☐
5. Original Hospital Bill Payment Receipt. ☐

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6. Hospital Discharge Card/Summary. ☐

7. Original Pharmacy Bill with supporting prescriptions. ☐

8. Medical Investigation report: ECG / X-Ray / USG / CT / MRI / Histopathology / Pathological and all other medical investigation report in support of diagnosis as advised by the treating doctor. ☐

9. All Doctor's consultation note: confirming provisional & final diagnosis / advise for admission / medical complication / proposed line of treatment / past medical history. ☐

10. Proof of all previous and/or current medical expenses already incurred.

a) In case previous medical expenses are settled by any other insurer settlement proof along with the medical papers confirming aliment and it's commencement should be submitted as proof of expenses already incurred. ☐

b) If previous medical expenses were not incurred, copy of the bills and receipt along with the medical papers confirming ailment and it's commencement should be submitted as proof of expenses already incurred. ☐

PRE & POST HOSPITALISATION CLAIM DOCUMENTS

1. Duly filled claim form(s) (If claimed separately). ☐

2. Pharmacy Bills with supporting prescriptions. ☐

3. Medical investigation test reports and payment receipts with doctor's advice note for such investigations. ☐

4. All Doctor's consultation note with original bills and receipts for claiming doctors fees. ☐

Note: Know Your Customer (KYC) documents viz. (address proof of claimant (nominee) and photo ID) would be required for all admissible Claims more than ₹100000/-.

SECTION F - DETAILS OF BILLS ENCLOSED

Sr. No.	Bill No.	Date	Issued by	Towards	Amount (₹)
1				Hospital Main Bill	
2				Pre-hospitalisation Bills:_____Nos	
3				Post-hospitalisation Bills:_____Nos	
4				Pharmacy Bills	
5					
6					
7					
8					
9					
10					

SECTION G -DETAILS OF POLICY HOLDER'S BANK ACCOUNT

a. PAN No.:

b. Account Number:

c. Bank Name and Branch:

d. Cheque/DD Payable details:

e. IFSC Code:

Enclose cancelled cheque of policy holder for NEFT payment.

Please note, NEFT would depend on location and bank of the insured. Alternatively, cheque will be issued. Please note providing cheque details/cancelled cheque does not indicate admission of liability. The same would be applicable if the claim is tenable as per the terms and condition of the Policy.

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REASON FOR DELAY / NO INTIMATION

If claim is not intimated or intimated beyond stipulated time given in the Policy, provide reason for the same .....

.....

If the claim is submitted beyond stipulated time period given in the Policy document, provided reason for the same .....

.....

SECTION H - DECLARATION BY THE INSURED/CLAIMANT:

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 & authorise 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-hospitalisation claim, if any.

Place: .....

Date: D | D | M | M | Y | Y

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 organisation
c) Company TPA ID No.	Enter the TPA ID No	License number as allotted by IRDA and printed in TPA documents
d) Name	Enter the full name of the policyholder	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	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 organisation 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 dd-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 organisation in full
SECTION C - DETAILS OF INSURED PERSON HOSPITALISED		
a) Name	Enter the full name of the patient	Surname, First name, Middle name
b) Gender	Indicate Gender of the patient	Tick Male or Female
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
SECTION D - DETAILS OF HOSPITALISATION		
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

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GUIDANCE FOR FILLING CLAIM FORM – PART A (To be filled in by the insured)		
DATA ELEMENT	**DESCRIPTION**	**FORMAT**
SECTION D - DETAILS OF HOSPITALISATION		
h) Time	Enter time 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 Hospitalisation	Indicate whether claim is for domiciliary hospitalisation	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 / DD should 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
(The issue of this form is not to be taken as an admission of liability)
(To be filled in block letters)

SECTION A - DETAILS OF HOSPITAL

a. Name of the hospital: SURNAME | FIRST | MIDDLE

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

d. Name of the treating doctor: SURNAME | FIRST | MIDDLE

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

b. IP Registration Number: ☐ c. Gender: ☐ Male ☐ Female d. Age: Years: YY Months: MM

e. Date of birth: DD/MM/YYYY f. Date of Admission: DD/MM/YYYY g. Time: HH:MM

h. Date of Discharge: DD/MM/YYYY i. Time: HH:MM

j. Type of Admission: ☐ Emergency ☐ Planned ☐ Day Care ☐ Maternity

k. If Maternity i. Date of Delivery: DD/MM/YYYY ii. Gravida Status: ☐

l. Status at time of discharge: ☐ Discharge to home ☐ Discharge to another Hospital ☐ Deceased

m. Total claimed amount: ☐

SECTION C -DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a. ICD 10 Codes — Description

i. Primary Diagnosis: ☐ .....

ii. Additional Diagnosis: ☐ .....

iii. Co-morbidities: ☐ .....

iv. Co-morbidities: ☐ .....

b. ICD 10 PCS — Description

i. Procedure 1: ☐ .....

ii. Procedure 2: ☐ .....

iii. Procedure 3: ☐ .....

iv. Details of Procedure: .....

c. Pre-authorization obtained: ☐ Yes ☐ No d. Pre-authorization Number: ☐

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

f. Hospitalisation due to Injury: ☐ Yes ☐ No

i. If Yes, 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: .....

SECTION D - CLAIM DOCUMENTS SUBMITTED - CHECK LIST

☐ Claim Form Duly signed ☐ Investigation reports ☐ Original Pre-authorization request ☐ CT / MR / USG / HPE investigation reports

☐ Copy of the Pre-authorization approval letter ☐ Docotor's reference slip for investigation ☐ Copy of photo ID card of patient verified by hospital

☐ ECG ☐ Hospital Discharge summary ☐ Pharmacy bills ☐ Operation Theatre notes ☐ MLC report & Police FIR

☐ Hospital main bill ☐ Original death summary from hospital where applicable ☐ Hospital break-up bill

Any other, please specify: .....

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

Address of the Hospital:

Block/Flat No.*: Floor No.: Building Name*:

Street Name*: Locality:

Landmark*:

City/Village*: Pincode*:

State:

Post Office: PAN No:

Landline*: S T D Registration No. with State Code:

Hospital PAN: Number of In-patient beds:

Facilities available in the hospital: i. OT: ☐ Yes ☐ No ii. ICU: ☐ Yes ☐ No

iii. Others: .....

SECTION F - DECLARATION BY THE 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 of concealment of any material fact, our right to claim under this claim shall be forfeited.

Place: .....

Date: D D M M Y Y

Signature and seal of the Hospital Authority

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