



**CLAIM FORM FOR HEALTH INSURANCE POLICIES
OTHER THAN TRAVEL AND PERSONAL ACCIDENT**

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

(Guidance for filling claim form - Part A is available on our website: www.royalsundaram.in)

PART A

DETAILS OF PRIMARY INSURED (PROPOSER)

(TO BE FILLED IN BY THE INSURED)

a) Policy No.		b) Sl. No./ Certificate No.	
c) Membership No./ TPA ID No.			
d) Name			
e) Address			
City		State	
Pin Code		Land Line (with STD Code)	
Mobile No.		Email ID	
Alternate Email ID			

SECTION A

DETAILS OF INSURANCE HISTORY:

a) Currently covered by any other Mediciam/Health Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) If yes, Company Name	
Policy No.	c) Date of commencement of first Insurance without break
	D D M M Y Y Y Y
d) Sum Insured (Rs.)	e) Have you been hospitalized in the last four years since inception of the contract? <input type="checkbox"/> Yes <input type="checkbox"/> No
	f) Date
	M M Y Y Y Y
g) Diagnosis	

SECTION B

DETAILS OF INSURED PERSON HOSPITALIZED:

a) Name			
b) Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	c) Age	Years Y Y Months M M
d) Date of Birth	D D M M Y Y Y Y		
e) Relationship to Primary insured	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Other (Please Specify) _____		
f) Occupation	<input type="checkbox"/> Doctor <input type="checkbox"/> Service <input type="checkbox"/> Self Employed <input type="checkbox"/> Homemaker <input type="checkbox"/> Student <input type="checkbox"/> Retired <input type="checkbox"/> Other (Please Specify) _____		
g) Address (if different from above)			
City		State	
Pin Code		Land Line (with STD Code)	

SECTION C

DETAILS OF HOSPITALIZATION

a) Name & Address of Hospital where Admitted			
City		State	
Pin Code		Land Mark	
b) Room Category occupied	<input type="checkbox"/> Day care <input type="checkbox"/> Single occupancy <input type="checkbox"/> 3 or more beds per room <input type="checkbox"/> Any other category, Pls specify _____		
c) Hospitalization due to	<input type="checkbox"/> Injury <input type="checkbox"/> Illness <input type="checkbox"/> Maternity		
d) Date of Injury/Date Disease first detected	D D M M Y Y Y Y		
e) Date of Admission	D D M M Y Y Y Y	Time	H H : M M
f) Date of Discharge	D D M M Y Y Y Y	Time	H H : M M
g) In case of maternity, Date of Delivery	D D M M Y Y Y Y	Gravida Status	_____
h) If Injury, give cause	<input type="checkbox"/> Self inflicted <input type="checkbox"/> Road Traffic Accident <input type="checkbox"/> Substance Abuse/Alcohol Consumption		
	1. If Medico legal <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Reported to police <input type="checkbox"/> Yes <input type="checkbox"/> No 3. MLC Report & Police FIR attached <input type="checkbox"/> Yes <input type="checkbox"/> No		
i) System of Medicine	_____		

SECTION D

DETAILS OF CLAIM:

a) Details of the treatment expenses claimed

1. Pre-hospitalization Expenses	Rs.	<input type="text"/>	2. Hospitalization Expenses	Rs.	<input type="text"/>
3. Post-hospitalization Expenses	Rs.	<input type="text"/>	4. Health-Check up Cost	Rs.	<input type="text"/>
5. Ambulance Charges	Rs.	<input type="text"/>	6. Others	Rs.	<input type="text"/>
			Total (1 to 6)	Rs.	<input type="text"/>

b) Claim for Domiciliary Hospitalization Yes No (If yes, please provide summary of bills in separate sheet)

c) Details of Lump sum / cash benefit claimed:

1. Hospital Daily Cash	Rs.	<input type="text"/>	2. Surgical Cash	Rs.	<input type="text"/>
3. Critical Illness Benefit	Rs.	<input type="text"/>	4. Convalescence	Rs.	<input type="text"/>
5. Pre/Post hospitalization Lump sum benefit:	Rs.	<input type="text"/>	6. Others _____	Rs.	<input type="text"/>
			Total (1 to 6)	Rs.	<input type="text"/>

Claim Documents to be submitted - Check List:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Claim Form Duly signed | <input type="checkbox"/> Copy of the claim intimation, if any | <input type="checkbox"/> Hospital Main Bill | <input type="checkbox"/> Hospital Break-up Bill |
| <input type="checkbox"/> Hospital Bill Payment Receipt | <input type="checkbox"/> Hospital Discharge Summary | <input type="checkbox"/> Pharmacy Bill | <input type="checkbox"/> Doctor's request for investigation |
| <input type="checkbox"/> Investigation Reports (Including CT/MRI/USG/HPE/ECG) | <input type="checkbox"/> Doctor's prescription for medicines purchased outside the hospital | | |
| <input type="checkbox"/> Test report and prescription relating to first consultation for the illness | <input type="checkbox"/> Hospital advance and final receipts | | |
| <input type="checkbox"/> FIR/MLC in case of accident injury and English translation of the same if it is in any other language | | | |
| <input type="checkbox"/> KYC document (Address proof, ID proof, for claims exceeding Rs. 1 Lakh) | <input type="checkbox"/> Others _____ | | |

DETAILS OF BILLS ENCLOSED:

Sl. No	Bill No	Date								Issued by	Towards	Amount (Rs)
		D	D	M	M	Y	Y	Y	Y			
1											Hospital Main Bill	
2											Pre-hospitalization Bills: Nos _____	
3											Post-hospitalization Bills: Nos _____	
4											Pharmacy Bills: Nos _____	
5												
6												
7												
8												
9												
10												

Note : Please attach separate sheet if necessary

In case of claim settlement, Do you wish to settle By Cheque By NEFT

In case of NEFT, Please provide the below details:

a) PAN	<input type="text"/>	b) Account Number	<input type="text"/>
c) Bank Name and Branch	<input type="text"/>		
d) IFSC Code	<input type="text"/>		

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 Place

Signature of the Primary Insured

SECTION E

SECTION F

SECTION G

SECTION H

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
(Guidance for filling claim form- Part B is available on our website: www.royalsundaram.in)



Royal Sundaram
General Insurance

DETAILS OF HOSPITAL

a) Name of the hospital	<input type="text"/>
b) Hospital ID	<input type="text"/>
(For Office use only)	
c) Type of Hospital	<input type="checkbox"/> Network <input type="checkbox"/> Non Network (If non network fill section E)
d) Name of the treating Doctor	<input type="text"/>
e) Qualification	<input type="text"/>
f) Registration No. with State Code	<input type="text"/>
g) Phone	<input type="text"/>

SECTION A

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient:	<input type="text"/>
b) IP Registration Number	<input type="text"/>
c) Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
c) Age	Years <input type="text"/> <input type="text"/> Months <input type="text"/> <input type="text"/>
e) Date of Birth	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
f) Type of Admission	<input type="checkbox"/> Emergency <input type="checkbox"/> Planned <input type="checkbox"/> Day Care <input type="checkbox"/> Maternity
g) Date of Admission	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Time <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/>
h) Date of Discharge	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Time <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/>
i) If Maternity	
1. Date of Delivery	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Gravida Status	<input type="text"/>
j) Status at time of discharge	<input type="checkbox"/> Discharge to home <input type="checkbox"/> Discharge to another hospital <input type="checkbox"/> Deceased

SECTION B

DETAILS OF AILMENT DIAGNOSED

	ICD 10 Codes	Description	Duration
1. Primary Diagnosis	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
2. Additional Diagnosis	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
3. Co-morbidities	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
4. Co-morbidities	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
ICD 10 PCS Codes			
1. Procedure(1)	<input type="text"/>	<input type="text"/>	
2. Procedure(2)	<input type="text"/>	<input type="text"/>	
3. Procedure(3)	<input type="text"/>	<input type="text"/>	
4. Details of any other Procedure	<input type="text"/>	<input type="text"/>	

SECTION C

b) Hospitalization due to Injury Yes No If Yes, give cause

1. Self-inflicted Road Traffic Accident Substance abuse/alcohol consumption

2. If Injury due to Substance abuse/alcohol consumption, Test Conducted to establish this: Yes No

If Yes, details of tests conducted

3. If Medico legal Yes No 4. Reported to Police Yes No 5. FIR No.

6. If not reported to police, give reason

c) When did the patient start suffering with the complaint? _____ Date of first consultation (prior to hospitalisation)

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

d) Please give previous medical history of the patient

e) Is the patient suffering from any of the following diseases. If "yes" Please mention the duration below.

	Say Yes/No	Duration in Year	Duration in Month
1. Bronchial Asthma			
2. Chronic Obstructive Pulmonary disease			
3. Hypertension			
4. Diabetes			
5. Heart ailment			
6. Osteoarthritis			
7. Cerebro vascular attack			
8. Seizure disorder			
9. Renal/Kidney Disorder			
10. Any other			

f) Is the ailment a complication of a pre-existing disease or condition?

If Yes , please give details

g) History of alcoholism Yes No
If yes : No of years _____
Quantity consumed per day _____

h) History of Smoking/ Tobacco chewing Yes No
If yes : No of years _____
Units consumed per day _____

ADDITIONAL DETAILS IN CASE OF NON-NETWORK HOSPITAL

a) Address of the Hospital

b) Hospital Registration No

c) Hospital Registered with

City

 State

d) Hospital PAN

 e) Number of Inpatient beds

f) Facilities available in the hospital: 1. OT Yes No 2. ICU Yes No 3. Doctor/Round the clock Nurses Yes No
4. Others _____

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, insured's right to claim under this policy shall be forfeited.

Date

D	D	M	M	Y	Y	Y	Y
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 Place

Signature and Seal of the Hospital Authority

SECTION D

SECTION E

PRI30263/SEP13