Redefining Healthcare Services...
**Vipul Medcorp Insurance TPA Pvt Ltd.**
An ISO 9001:2015 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**

**(To be filled in block letters)**

## DETAILS OF PRIMARY INSURED:

a) PolicyNo: b) SI. No / Certificate No:

c) Company/ TPA ID No:

d)Name

e)Address:

City: State:

Pin Code: Phone No: Email ID

## DETAILS OF INSURANCE HISTORY:

a) Currently covered by any other Mediclaim / Health Insurance: ○ Yes ○ No b) Date of commencement of first Insurance without break:

c) If yes, company name Policy No:

Sum Insured (Rs.) d) Have you been hospitalized in the last four years since inception of the contract? ○ Yes ○ No Date

Diagnosis e) Previously covered by any other Mediclaim / Health insurance: ○ Yes ○ No

f) If yes, company name

## DETAILS OF INSURED PERSON HOSPITALIZED:

a)Name

b) Gender: Male Female c)Age: Years Months d) Date of birth:

e) Relationship to Primary insured: Self Spouse Child Father Mother Other (Please Specify)

f) Occupation: Service Self Employed Homemake Student Retired Other (Please Specify)

g)Address:

City: State:

Pin Code: Phone No: Email ID

## DETAILS OF HOSPITALIZATION:

a) Name ol Hospital where Admitted:

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

c) Hospitalization due to: Injury Illness Maternity d) Date of Injury / Date Disease first detected /Date of Delivery:

e) Dated of Admission: f) Time: : g) Date ol Discharge h)Time: :

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:

## DETAILS OF CLAIM:

a) Details of the treatment expenses claimed:

i. Pre-hospitalization Expenses: Rs

ii. Hospitalization Expenses: Rs

iii. Post-hospitalization Expenses: Rs

iv. Health-Checkup Cost: Rs

v. Ambulance Charges: Rs

vi. Others (code) Rs

Total Rs

vii. Pre-hospitalization period: Days

viii. Post-hospitalization period Days

b) Claim for Domiciliary Hospitalization: ○ 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 (code) Rs

Total Rs

**Claim Documents Submitted- Check List:**

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

## DETAILS OF BILLS ENCLOSED:

| S.No | Bill No | Date | Issued By | Towards | Amount (Rs) |
|---|---|---|---|---|---|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |
| 5. | | | | | |
| 6. | | | | | |
| 7. | | | | | |
| 8. | | | | | |
| 9. | | | | | |
| 10. | | | | | |

## DETAILS OF PRIMARY INSURED'S BANK ACCOUNT:

a) PAN: b) Account Number:

c) Bank Name and Branch:

d) Cheque/ DD Payable details: e) IFSC Code:

## 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 Insured

| 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 | License number a s 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 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 a s per the policy | In rupees |
| d) Have you been Hospitalized in the last four years since inception of the contract? | Indicate whether hospitalized in the last four years | Tick Yes or No |
| Date | Enter the date of hospitalization | 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 policyholder | 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 HOSPITALIZATION** | | |
| 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) Hospitalization due to | Indicate reason of hospitalization | 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 | Enter date of discharge |
| 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 a s 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 a s 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 | | |
| | | |

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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**
**Please indude the original preauthorization request form in lieu of PART A**
**(To be filled in block letters)**

## DETAILS OF HOSPITAL

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:

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

## DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient:

b) IP Registration Number c) Gender: ☐ Male ☐ Female d)Age: Years Months e) Date of birth:

f) Dated of Admission: g)Time: : h) Date ol Discharge i)Time: :

j) Type of Admission: Emergency ☐ Planned ☐ Day Care ☐ Maternity ☐ k) If Maternity i. Date of Delivery ii. Gravida Status:

I) Status at time of discharge: Discharge to home ☐ Discharge to another hospital ☐ Deceased ☐ m) Total claimed amount

## DETAILS OF AILMENT DIAGNOSED (PRIMARY)

| a) | ICD10 Codes | Description | b) | ICD 10 PCS | Description |
|---|---|---|---|---|---|
| i. Primary Diagnosis | | | i. Procedure1 | | |
| ii. Additional Diagnosis: | | | ii. Procedure2: | | |
| iii. Co-morbidities: | | | iii. Procedure3: | | |
| iv. Co-morbidities: | | | 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) Hospitalization 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

## CLAIM DOCUMENTS SUBMITTED - CHECK LIST

- ☐ 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)

a) Address of the Hospital

City: State:

Pin Code: b) Phone No: c) Registration No. with State Code

d) Hospital PAN: e) Number of inpatient beds: d) Facilities available in the Hospital : i) OT: ◯ Yes ◯ No ii) ICU: ◯ Yes ◯ No

iii) 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 fad, our right to claim under this claim shall be forfeited.**

Date :

Place :

Signature and Seal of the Hospital Authority

| GUIDANCE FOR FILLING CLAIM FORM - PART B (To be filled in by the hospital) | | |
|---|---|---|
| **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 | Abbreviations 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 or Female |
| d) Age | Enter age of the patient | Number of years and months |
| e) Date of Birth | Enter date of admission | Use dd-mm-yy format |
| f) Date of Admission | Enter date of admission | Use dd-mm-yy format |
| g) Time | Enter time of admission | Use hh:mm format |
| h) Date of Discharge | Enter date of discharge | Use dd-mm-yy format |
| i) 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 | Standard Format and Open text |
| 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 | Open text |
| c) Pre-authorization obtained | Indicate whether pre-authorization obtained | Tick Yes or No |
| d) Pre-authorization Number | 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 hospitalization 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. | Enter 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 | | |

**CONSENT FORM FOR VERIFICATION & COLLECTION OF IPD PAPERS**

To, Dated:

(Hospital Name) .....

(Address) .....

.....

Dear Sir / Madam,

SUBJECT: CONSENT FORM FOR VERIFICATION & COLLECTION OF IPD PAPERS

I hereby authorize the representative of Vipul Medcorp Insurance TPA Pvt Ltd to verify & collect photocopy of all of my IPD papers related to following hospitalization :-

Name of the Patient- .....

Hospital UHID No- .....

Date of Admission .....

Date of Discharge .....

Diagnosis as per Discharge Card .....

Self attested photo id proof of Patient/Guardian (if patient is minor) is attached

Thanking you.
Yours truly,

(Signature of the Paitent / Guardian (if the patient is minor))

Policy Holder's Details :-

Name : .....

Address : .....

.....

Contact No : .....
Policy No : .....
Vipul Card No :.....

(Signature of the Insured)

## LIST OF CLAIM DOCUMENTS:-

- Receipted Copy of the Intimation Letter / Reference number of online intimation
- Duly Filled & signed Claim Form of the underwriter as per specification of IRDA. Available in website
- Original Discharge Card / Summary issued by the hospital.
- Original Final Bill & numbered receipts of the Hospital, in support of payment.
- Original numbered Paid Receipts for investigations carried out.
- Original Investigation Reports.
- All Imaging Films, ECG Strips, Doppler / Angiogram CD etc.
- Original stickers for implants used during operation along with invoice copy.
- Original Prescriptions and corresponding Medicine bills/ cash memo mentioning expiry date & batch No. of the medicine.
- Hospital Registration Certificate in case of a unknown small hospital.
- Any other original documents related to the claim.
- MLC/FIR in case of Accident cases / Attending doctor's certificate in case MLC/FIR not done.
- Patient ID/Age Proof.
- Cancelled cheque of the POLICY HOLDER with name printed on it. Otherwise copy of the first page of bank pass book to accompany the cheque foil. PLEASE NOTE THAT IT IS MANDATORY.
- For claims valued at Rs. 1 Lac or more, document as specified by IRDA towards ID with address proof of the POLICY HOLDER must be submitted for compliance of KYC norms.
- Copy of current year & previous years policy copies.
- Copy of Aadhaar card of Proposer/Employee.
- Copy of PAN card of proposer/Employee in case of claim value is more than 50,000/-.

**Please note that the above list has been drawn without prejudice and is illustrative and not exhaustive.**

## GIPSA NETWORK-DECLARATION FORM
**(To be filled by the Hospitals)**

Name of the Hospital:……Date of Admission……

Address:……

**PATIENT NAME/INSURED NAME (BLOCK LETTERS):…… AGE/SEX ……**

**(To be filled by the Insured/policy holder/Attendant)**

1. *Do you have an Insurance policy?* *YES/NO*

*If yes, then please select: New India/ United India/ National Insurance/ Oriental Insurance/others*

*Policy No*_____
*TPA Name* _____
*TPA card No:* _____

*2. Have you contacted TPA or Insurance Company for cashless facility?* *YES/NO*

3) Whether patient opted for Eligible Room Category under Policy: *YES/NO*

***If No, then kindly mention the opted room category:……***

On my own option, I wish to avail above facility and I hereby agree to pay on my free will, after being explained in detail by the Hospital authority in my own and understandable language about the above mentioned Facility/Procedure/Treatment and associated cost of it, which is over and above the agreed tariff for the treatment. Further, if I opt to go for final bill reimbursement with insurance company, respective insurance company will reimburse only as per agreed tariff for the treatment and balance amount will be borne by me / patient only.

I have also been explained that when room service of a category other than eligible room rent is availed by the patient, not only the difference in room rent but also an equal proportion of all other charges associated with the treatment shall be borne by me/ patient only

Signature:……
Name of the Patient/Patient's attendant:

Signature:……
Name of the Hospital Representative &Hospital Seal:

Mobile No……..
E –Mail……..
PAN / Form 60: ……..
Aadhar Card Number……..

Date:

# CLAIMS E-SUBMISSION AFFIRMATION LETTER

To,

(Name of TPA

AND

Name of Insurer)

Regarding E claim submission under –

Policy number -

Name of Policyholder & Contact No: -

Patient Name -

Claim no -

Dear All,

Claim documents as above are attached herewith, and in the said context, I affirm and submit that-

- All original documents pertaining the referred Claim number being uploaded are in my possession.
- I will submit the same to the TPA after the corona related restrictions are lifted.
- I have not submitted these documents nor will I submit these documents to any other insurer or TPA or any other indemnity reimbursement scheme, for any claim except when the need arises for submitting a claim, for residual unsettled amounts for this claim.
- I am liable to repay the (name of insurer / name of TPA) the settled amounts and / or face any recovery action from the (name of insurer / name of TPA), if such an action is warranted against me.

Thanks and regards

Name of Proposer / Claimant

Place: Date:

# UNDERTAKING FOR CLAIMING REIMBURSEMENT OF <Patient Name>

I _____, employee of (if applicable) _____, with Emp ID (if applicable) _____ covered under policy number/Vipul ID Card Number _____ and understand that the current benefit of Claim processing on Scan has been extended as an additional benefit due the current Corona Outbreak crisis.

I hereby confirm that I am in possession of the claim documents in original pertaining to <Patient Name> for admission dated <Date of Admission> of <Hospital Name & Address> and shall send the document in original to TPA Name once the situation improves.

Also confirm that I have not made any claim with any other insurer or organisation for the claimed reimbursement.

TPA name reserves the right to ask for additional documents and original documents in advance for certain Scenarios as per the internal claim policy.

Further, I agree to return/refund the claim amount back to the Insurer, if at a later date a material discrepancy is noticed between the original claim documents versus the scan documents submitted by me.

Signature
Date: