CLAIM FORM - PART B			
TO BE FILLED IN BY THE HOSPITAL			
Name of the Hospital			Hosp ID
Type of Hospital	Network	Non Network	
In case of non network , please provide below details			
Address of the Hospital with Pin Code			
Telephone No		Registration no.	
Number of Inpatient beds		PAN	
Other Facilities available in the hospital		OT	Y/N
ICU	Y/N	Others	
Details of the patient admitted			
Name of the patient		IP Registration Number	
Gender		Age	
Date of Admission		Time of Admission	
Date of Discharge		Time of Discharge	
Ailment Diagnosed (Primary)			
ICD 10-CM Code	Primary	Additional	Co-
Details of Procedure/s			
ICD 10 PCS Code	Proc 1	Proc 2	Proc 3
Type of Admission	Emergency	Planned	Day-care | Maternity
Date of delivery if Maternity		Gravida Status	
8. Is the treatment for an injury? If, Y, details.			
Was it self inflicted?	Y/N	Whether RTA	Y/N
If MLC, notified to police?	Y/N	MLC / FIR No.	
If MLC not notified, give reasons			
Was the Injury/ disease caused due to Substance abuse / Alcohol consumption			Y/N
If Y, whether any test was conducted to establish this? If Y, please attach Report			Y/N
Is present ailment a complication of Pre-existing disease		Y/N	
If Y, specify details			
Whether Pre-authorisation obtained - Y/N		If Y, Pre Auth Number	
If authorisation by network hospital not obtained, reason?			
Name of Treating Doctor		Registration No	
Mobile No		Qualification	

13. Claim Documents submitted (CHECK LIST)	
Claim Form Duly signed	Investigation Reports
Original Pre-authorisation request	Investigation Reports (Including CT / MRI / USG / HPE)
Copy of the preauthorisation approval letter	Doctor's Reference Slip for investigation
Hospital Discharge Summary	ECG
Operation Theatre Notes	Pharmacy Bills
Hospital Main Bill	MLC Report & Police FIR
Hospital Break-up Bill	Any other, please specify
Date:	Signature of the Primary Insured / Claimant