Universal Sompo General Insurance
Suraksha, Hamesha Aapke Saath

# REIMBURSEMENT CLAIM FORM
## TO BE FILLED IN BY THE INSURED
**The issue of this form is not to be taken as admission of liability**

## DETAILS OF PRIMARY INSURED (To be filled in block letters)

SECTION A

a) Policy no: b) Sl. No/ Certificate No:

c) Universal Sompo Health Serve Card No:

d) Name:

e) Address:

City: State:

Pin Code: Phone No: Email ID:

## DETAILS OF INSURANCE HISTORY

SECTION B

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 (`): 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

SECTION C

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 Homemaker Student Retired Other (Please specify)

g) Address (if different from above):

City: State:

Pin Code: Phone No: Email ID:

## DETAILS OF HOSPITALIZATION

SECTION D

a) Name of 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) Date of Admission: f) Time: : g) Date of 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

SECTION E

a) Details of treatment expenses claimed

| | | | | | |
|---|---|---|---|---|---|
| i. Pre Hospitalization Expenses | ₹ | | ii. Hospitalization Expenses | ₹ | |
| iii. Post Hospitalization Expenses | ₹ | | iv. Health Check up Cost | ₹ | |
| v. Ambulance Charges | ₹ | | vi. Others (code): | ₹ | |
| | | | **Total** | ₹ | |
| vi. Pre hospitalization period: | days | | vii. Pre 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: | ₹ | | ii. Surgical Cash: | ₹ | |
| iii. Critical Illness Benefit: | ₹ | | iv. Convalescence: | ₹ | |
| v. Pre/Post hosp. Lump sum benefit: | ₹ | | vi. Others: | ₹ | |
| | | | **Total** | ₹ | |

**Claim Documents Submitted- Check List:**

- Claim FormDuly signed
- Copy of the claim intimation, if any
- Hospital Main bill
- Hospital Break-up bill
- Hospital Discharge Summary
- Pharmacy Bill
- Operation Theatre Notes
- ECG
- Doctor's request for investigation
- Investigation Reports (including CT / MRI / USG / HPE)
- Doctor's Prescription
- Others

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## DETAILS OF BILLS ENCLOSED

| Sl. 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 | | | | | |
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| 20 | | | | | |

SECTION F

## 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:

SECTION G

## 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 Universal Sompo GIC Ltd, 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:

SECTION H

| 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 Universal Sompo GIC |
| b) Sl. No/ Certificate No. | Enter the social insurance number or the certificate number of social health insurance scheme | As allotted by the organization |
| c) Universal Sonnpo Card No | Enter the Card No | License number as allotted by IRDA and printed in the 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 as per the policy | In rupees |
| d) Have you been Hospitalized in the last 4 years since inception of the contract? | Indicate whether hospitalized in the last 4 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 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 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 | Use dd-mm-yy format |
| 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 Hospitalization | Indicate whether claim is for domiciliary hospitalization | 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

**TO BE FILLED IN BY THE HOSPITAL**

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

Please include the original preauthorization request form in lieu of PART A

SECTION A

## DETAILS OF HOSPITAL (To be filled in block letters)

a) Name of the Hospital:

c) 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.

SECTION B

## DETAILS OF PATIENT ADMITTED

a) Name of Patient: b) IP Registration No.:

c) Gender : Male ☐ Female ☐ d) Age: years ☐☐ months ☐☐ e) Date of Birth: ☐☐ ☐☐ ☐☐☐☐

f) Date of Admission: ☐☐ ☐☐ ☐☐ g) Time: ☐☐ : ☐☐ h) Date of Discharge: ☐☐ ☐☐ ☐☐ i) Time: ☐☐ : ☐☐

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

k) If Maternity: i. Date of Delivery: ☐☐ ☐☐ ☐☐ ii. Gravida Status: ☐☐☐

l) Status at time of discharge: Discharged to home ☐ Discharged to another hospital ☐ Deceased ☐ m) Total claimed amount `

SECTION C

## DETAILS OF AILMENT DIAGNOSED (PRIMARY)

| a) | ICD 10 Codes | Description | b) | ICD 10 PCS | Description |
|---|---|---|---|---|---|
| i. Primary Diagnosis : | | | i. Procedure 1 : | | |
| ii. Additional Diagnosis : | | | ii. Procedure 2 : | | |
| iii. Co-morbidities : | | | iii. Procedure 3 : | | |
| 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 injurydue 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 - CHECKLIST

- ☐ 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
- ☐ Oparation Theatre Notes
- ☐ Hospital main bill
- ☐ Hospital break-up bill
- ☐ Investigation reports
- ☐ CT/ MRI/ USG/ HPE/ Investigation reports
- ☐ Doctor's referance slip
- ☐ ECG
- ☐ Pharmacy bills
- ☐ MLC report & Police FIR
- ☐ Original death summary from hospital, where applicable
- ☐ Any other, please specify

SECTION E

## 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 ☐☐☐

f) Facilities available in the hospital: i. OT: ☐ Yes ☐ No ii. ICU: ☐ Yes ☐ No iii. Others:

SECTION F

## 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, suppress or concealment of anu material fact, our right to claim under this claim shall be forfeited.

Date: ☐☐ ☐☐ ☐☐

Place: Signature & Stamp of the Hospital:

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| 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 nospital | 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 birth | 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 claim amount | Indicate total claim amount | In Rupees (Do not enter Paisa value) |
| **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) Present Ailment is a Complication of PED | Indicate whether present ailment is a complication of some pre-existing disease | Tick Yes or No |
| d) Pre-authorization obtained | Indicate whether pre-authorization obtained | Tick Yes or No |
| e) Pre-authorization Number | Enter pre-authorization number | As allotted by TPA |
| f) If authorization by network hospital not obtained, give reason | Enter reason for not obtaining pre-authorization number | Open text |
| g) 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 INSURED** | | |
| Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign. | | |