REIMBURSEMENT CLAIM FORM - PART A

TO BE FILLED IN BY THE INSURED (TO BE FILLED IN BLOCK LETTERS)

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

Claim Intimation Number:

Claim Type (tick appropriate box)

☐ **IN-PATIENT HOSPITALIZATION** ☐ **CRITICAL ILLNESS** ☐ **HOSPITAL DAILY CASH** ☐ **OTHERS**

☐ **PRE AND POST CLAIM** ☐ **OUT-PATIENT CLAIM** ☐ **HEALTH CHECK UP**

SECTION A – DETAILS OF PRIMARY INSURED

a. Policy No.	
b. Sl. No./Certificate No.	
c. Company/TPA ID No.	
d. ABHA ID No.	
e. Name	
f. Address	
g. Pin code	
h. Phone No.	
i. Email ID	
j. WhatsApp No. (with consent to communicate)	

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	DD/ MM / YYYY
c) If yes, Company name	
1. Policy No.	
2. Sum Insured	
d. Have you been hospitalized in the last three years since inception of the contract (if yes, kindly mention date)	☐ YES ☐ NO Date: MM/YYYY
e. Diagnosis	
f. Previously covered by any other Mediclaim/Health insurance	☐ YES ☐ NO
g. If yes, Company Name	

SECTION C – DETAILS OF INSURED PERSON

a. Name			
b. Gender	☐ Male ☐ Female ☐ Third Gender		
c. Age		d. Date of Birth	DD/ MM/ YYYY

e. Relationship to Primary insured	☐ Self	☐ Spouse	☐ Child	☐ Father
	☐ Mother	☐ Other (Please specify)		
f. Occupation	☐ Service	☐ Self - employed	☐ Home-maker	☐ Student ☐ Retired
	☐ Other (Please specify) _____			
g. Address (if different than above)				
h. Telephone No.		i. Mobile No. (other than above)		
j. E-mail ID, (if any other than above)				

SECTION D - DETAILS OF HOSPITALISATION

a. Name of the hospital where admitted				
b. Room category occupied (tick anyone)	☐ Daycare	☐ Single occupancy		
	☐ Twin sharing	☐ 3 or more beds per room		
c. Hospitalization due to (tick anyone)	☐ Illness	☐ Injury	☐ Maternity	
d. Date of injury/Date of disease first detected/ Date of delivery	DD MM YYYY			
e. Date of admission	DD MM YYYY			
f. Time of admission	HH MM			
g. Date of discharge	DD MM YYYY			
h. Time of discharge	HH MM			
i. If injury, give cause (tick anyone)	1. Self-inflicted?	☐ YES ☐ NO	2. Road traffic accident	☐ YES ☐ NO
	3. Substance abuse/alcohol consumption		☐ YES ☐ NO	
i. If Medico legal	☐ YES ☐ NO	ii. Reported to police?	☐ YES ☐ NO	
iii. MLC Report, & Police FIR attached?	☐ YES ☐ NO	iv. System of medicine (tick anyone)	☐ Allopathic ☐ Other systems of medicine	

SECTION E - DETAILS OF CLAIM

a) Claim under Hospitalization Cover	**Tick anyone**	**Amount (INR)**
i) Pre-hospitalization Expenses	☐ YES ☐ NO	
ii) In-Patient Hospitalization	☐ YES ☐ NO	
iii) Day Care Procedures	☐ YES ☐ NO	
iv) Post-hospitalization Expenses	☐ YES ☐ NO	
vi) Ambulance Charges	☐ YES ☐ NO	
vii) Others, If Any		
b) Claim for Domiciliary Hospitalization (If yes, provide details in annexure)	☐ YES ☐ NO	
c) Details of Lump sum / cash benefit claimed		
i) Hospital Daily Cash	☐ YES ☐ NO	
ii) Critical Illness Benefit	☐ YES ☐ NO	
iii) Others, If any		
Total Amount (INR)		

Claim documents submitted check list: Hospitalization claim			
☐ Duly filled and signed Claim Form	☐ Copy of intimation letter, if any	☐ Investigation/diagnostic Reports with bills and payment receipt	☐ Doctors request for investigations
☐ Hospital main bill	☐ Hospital bill break up	☐ ECG	☐ Doctors Prescriptions
☐ Hospital bill payment receipt	☐ Hospital discharge summary	☐ Copy of the non-network provider's registration certificate	☐ MLC/FIR copy of applicable
☐ Pharmacy bill	☐ Operation theatre notes	☐ KYC documents	☐ Implant stickers for all implants used during surgeries

Check list of additional documents for hospital cash claims
☐ Copy of discharge summary/discharge certificate along with time of admission and discharge for hospital cash benefit
☐ Cancelled cheque copy with primary insured name printed or bank pass book copy with clear name/account no./bank details

SECTION F – DETAILS OF BILLS ENCLOSED

S.No	Bill No	Date						Issued By	Towards	Amount (Rs)					
		D	D	M	M	Y	Y		Hospitalization bills: _____nos						
									Pre-Hospitalization: _____nos						
									Post-Hospitalization: _____nos						
									Pharmacy Bills: _____nos						
Total Amount															
Total Amount (In Words):															

SECTION G – DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

a) PAN number of the primary insured:

b) Name of the primary insured:

c) Account number:

d) Bank name and branch:

e) Payee Name:

f) IFSC Code:

g) Cheque/DD Payable details:

h) CKYC of the primary insured:

Note:

Enclose NEFT documents (cancelled cheque or bank passbook clear copy).

Please send all original documents along with a duly filled and signed claim form to the address mentioned on the top of the claim form. Please mention as "Health Claim Documents" on the top of the envelope and mention the complete sender address along with mobile number without fail.

*Attach a cancelled cheque pertaining to the same; the name of the account holder must be printed on the cheque.

SECTION H – DECLARATION BY THE INSURED

I hereby declare that the information furnished in this claim form is true and 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 and authorize TPA/insurance company to seek necessary medical information/documents from any hospital/medical practitioner who has attended to 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 and that I will not be making any supplementary claim except the pre/post-hospitalization claim, if any.

Date: _____ Place: _____ Signature of Insured: _____

Galaxy HEALTH INSURANCE

REIMBURSEMENT CLAIM FORM - PART B

TO BE FILLED IN BY THE HOSPITAL (TO BE FILLED IN BLOCK LETTERS)

* The issue of this form is not to be taken as an admission of liability.
Please include the original pre-authorization request form in lieu of Part A

SECTION A – DETAILS OF HOSPITAL

a) Name of the hospital where treated		b) Hospital Registration No./ Hospital ID:
c) Type of Hospital	☐ Network ☐ Non Network (If non network fill section D)	
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 the patient		b) IP registration number	
c) Gender	☐ Male ☐ Female ☐ Third Gender	d) Age	YY/MM
e) Date of birth	DD/MM/YYYY	f) Type of management:	☐ Medical ☐ Surgical
g) Date of admission	DD/MM/YYYY	h) Time of admission:	HH/MM
i) Date of discharge	DD/MM/YYYY	j) Time of discharge:	HH/MM
k) Type of admission	☐ Emergency ☐ Planned ☐ Daycare ☐ Maternity		
l) If Maternity	Date of delivery	m) Gravida status	☐ G ☐ P ☐ L ☐ A
n) Status at time of discharge	☐ Discharge to home ☐ Discharge to another hospital ☐ Deceased	o) Total claimed amount (INR)	(in rupees)

SECTION C – DETAILS OF AILMENTS DIAGNOSED (PRIMARY)

a)	ICD 10 Codes	Description	b)	ICD 10 PCS	Description
1. Primary Diagnosis			1. Procedure 1		
2. Additional Diagnosis			2. Procedure 2		
3. Co-morbidities			3. Procedure 3		
4. Co-morbidities			4. Procedure 4		

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		
g) If yes, give cause — 1. Self-inflicted?	☐ YES ☐ NO	2. Road traffic accident	☐ YES ☐ NO
3. Substance abuse /alcohol consumption	☐ YES ☐ NO		
4. If injury due to substance abuse/alcohol consumption, test conducted to establish this:	☐ Yes (if yes, attach reports) ☐ NO	5. If Medico legal	☐ YES ☐ NO
6. Reported to Police	☐ YES ☐ NO	7. FIR No	
8. If not reported to police, give reasons			

SECTION D – ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL (Only fill in case of non-network hospital)

a) Address of the Hospital:				
b) Phone No.:		c) Registration No. with State Code:		
d) Hospital PAN:				
e) No of inpatient beds:				
f) Facilities available in hospital	i) OT	☐ YES ☐ NO	ii) ICU	☐ YES ☐ NO
	iii) Others:			

SECTION E – DECLARATION BY HOSPITAL (PLEASE READ VERY CAREFULLY)

We hereby declare that the information furnished in this claim form is true and 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, our right to claim under this claim shall be forfeited.

Date: _____ Place: _____ Signature and seal of the Hospital Authority _____