Edelweiss | GENERAL INSURANCE

EDELWEISS HEALTHPLUS POLICY - CLAIM FORM A

Need to claim? We won't play the claim game!

Toll Free 1800 12000

Instructions:
1. This form has to be filled in BLOCK letters by the Insured / Policy Holder.
2. The filling up and submission of this Form does not make us liable to accept the Claim.

SECTION A – DETAILS OF THE PRIMARY INSURED / POLICYHOLDER

a) Policy Number: | | | | | | | | | | | | b) Serial No ./ Certificate No: | | | | | | | | | | |

c) Company/ TPA ID No.: | | | | | | | | | | | | | | | | | | | | | | |

d) Name: _____

e) Address: City: _____ State: _____ Landmark: _____

Pin Code: | | | | | | Phone Number: | | | | | | | | | | Email ID: _____

SECTION B – SOME DETAILS OF YOUR OTHER/PAST INSURANCE

a) Are you currently covered by any other Mediclaim/ Health Insurance : Yes ☐ No ☐

b) Date of start of the first Insurance without break: D D M M Y Y Y Y

c) If Yes, Company Name: _____ Policy Number: _____ Sum Insured (INR): _____

d) Have you been hospitalized in the last four years since the beginning of the policy? Yes ☐ No ☐

Date: M M Y Y Y Y Diagnosis: _____

e) Were you previously covered by any other Mediclaim / Health Insurance? Yes ☐ No ☐

f) If yes, Company Name: _____

SECTION C – DETAILS OF HOSPITALIZED INSURED PERSON / POLICY HOLDER

a) Name: _____

b) Gender: Male ☐ Female ☐ Third Gender ☐ c) Age: Years ☐☐ Months ☐☐ d) Date of Birth: M M Y Y Y Y

e) Relationship with Primarily 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: | | | | | | h) Phone Number: | | | | | | | | | | i) Email ID: _____

SECTION D – DETAILS OF HOSPITALIZATION

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 the Disease first detected /Date of Delivery: 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 Discharged: D D M M Y Y Y Y Time: H H : M M

g) If injury, what was the cause? Self-Inflicted ☐ Road Traffic Accident ☐ Substance Abuse/Alcohol Consumption ☐

h) Medico legal? (i)Yes ☐ No ☐ (ii) Reported to Police: Yes ☐ No ☐ iii) MLC Report & Police FIR attached: Yes ☐ No ☐

i) System of Medicine used for Treatment: _____

SECTION E – DETAILS OF YOUR CLAIM

a) Details of the treatment expenses you're claiming for.

(i) Pre-hospitalization Expenses:	₹ _____	(ii) Hospitalization Expenses:	₹ _____
(iii) Post-hospitalization Expenses:	₹ _____	(iv) OPD Consultation Expenses:	₹ _____
(v) Ambulance Charges:	₹ _____	(vi) OPD Dental Expenses:	₹ _____
(vii) Maternity Expenses:	₹ _____	(viii) Pre/Post Natal expenses:	₹ _____
(ix) Home – Care Treatment Expenses	₹ _____	(x) Pandemic Disease Lump Sum claimed	₹ _____
(xi) Vaccination Expenses cover, if opted	₹ _____	(xii) Accidental Death Benefit claimed	₹ _____
(xiii) Permanent Total Disability (PTD)	₹ _____	(xiv) Permanent Partial Disability (PPD)	₹ _____
(xv) Temporary Total Disability (TTD)	₹ _____	(xvi) Critical Illness Lump Sum claimed	₹ _____
(xvii) Pre-hospitalization period: _ _ _ days		(xviii) Post-hospitalization period: _ _ _ days	

b) Claim for Domiciliary Hospitalization: Yes No (If Yes, provide details)

c) Details of Cash benefits claimed:

(i) Hospital Daily Cash:	₹ _____	(ii) Recovery Period:	₹ _____
(ii) Please describe details of any other claimed expenses or benefits:		(iii) Others	₹ _____
		Total:	₹ _____

d) Please give us all these documents.

- ☐ Duly signed Claim Form
- ☐ Copy of the claim intimation, if any
- ☐ Original Hospital Main bill and payment receipt
- ☐ Original Hospital detailed break-up of charges bill
- ☐ Hospital Discharge / Death / Transfer summary
- ☐ Billls for consultation, nursing etc in home care treatment
- ☐ Hospital Bill Payment Receipt
- ☐ Pharmacy Bills and payment receipts
- ☐ Operation Theatre Notes
- ☐ ECG and / or Pathology reports
- ☐ Doctor's request / referral note for investigation
- ☐ Investigation Reports (Including CT/MRI / USG / HPE)
- ☐ Doctor's Prescriptions and doctor's notes in home care treatment
- ☐ Original payment receipts of expenses for home care treatment
- ☐ FIR / MLC if applicable
- ☐ Disability certificate / Fitness Certificate if applicable
- ☐ EPIC like Aadhar/PAN/Voter ID/Passport/Driving license: Please specify details
- ☐ Copy of Bank Passbook / Cheque with name printed on leaflet: Please specify details
- ☐ If you've chosen Worldwide Coverage: Passport with immigration stamping / Boarding Pass / Travel itinerary as applicable
- ☐ Self-description of incident / accident and any other additional documents: Please specify
- ☐ Any other document, please specify:

SECTION F – DETAILS OF BILLS ENCLOSED

Sl.No.	Bill No.	Date	Issued by	Towards	Amount (₹)
1		(DD/MM/YYYY)		Hospital Main bill	
2		(DD/MM/YYYY)		Pre-Hospitalization Bills: ___ Nos	
3		(DD/MM/YYYY)		Post-Hospitalization Bills: ___Nos	
4		(DD/MM/YYYY)		Pharmacy Bills	
5		(DD/MM/YYYY)		Consultation Bills	
6		(DD/MM/YYYY)		Ambulance receipt	
7		(DD/MM/YYYY)		Pathology bills	
8		(DD/MM/YYYY)		Radiology bills	
9		(DD/MM/YYYY)		Others	
10		(DD/MM/YYYY)			

SECTION G-DETAILS OF PRIMARY INSURED'S / POLICYHOLDER'S BANK ACCOUNT

a) PAN: | | | | | | | | | | | b) Account Number: | | | | | | | | | | | | | | | |

c) Bank Name and Branch: _____

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

SECTION H– DECLARATION BY THE INSURED / POLICYHOLDER (PLEASE READ VERY CAREFULLY)

I hereby declare that the information given in this claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, knowingly hidden any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be cancelled. 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: D D M M Y Y Y Y

Place: _____

Signature of the Insured

GUIDANCE FOR FILLING CLAIM FORM – PART A

(TO BE FILLED 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) Sl. No/ Certificate No.	Enter the social insurance number or the certificate number of the social health insurance scheme	As allotted by the organization
c) Company TPA ID No.	Enter the TPA ID No	License number as 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) Are you currently covered by any other __Mediclaim / Health Insurance?	Indicate whether currently covered by another Mediclaim / Health Insurance	Tick Yes or No
b) Date of Beginning of first __Insurance without break	Enter the date of beginning 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 four years since the start of the Policy?	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) Were you 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 or Third Gender
c) Age	Enter age of the patient	Number of years and months
d) Date of Birth	Enter Date of Birth of the patient	Use dd-mm-yy format
e) Relationship to primary Insured	Indicate relationship of the patient with the Policyholder	Tick the right option. If others, please specify
f) Occupation	Indicate occupation of the 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 phone number of the patient	Include STD code with telephone number
i) E-mail ID	Enter the email id of the patient	Enter the email id of the patient
SECTION D - DETAILS OF HOSPITALIZATION		
a) Name of the Hospital where admitted	Enter the name of the 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 the injury	Tick the right option
If Medico legal	Indicate whether the injury is Medico legal	Tick Yes or No
Reported to Police	Indicate whether a police report was filed	Tick Yes or No
MLC Report & Police FIR attached	Indicate whether the MLC report and Police FIR are attached	Tick Yes or No
j) System of Medicine	Enter the system of medicine followed in treating the patient	Free Text, enter details
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 Cash benefits claimed	Enter the amount claimed as a 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 IN CASE OF NON-NETWORK HOSPITAL		
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 the declaration carefully and mention the date (in dd:mm:yy format), place (open text) and sign.		