EDELWEISS GROUP HEALTH INSURANCE POLICY CLAIM FORM A

Edelweiss | GENERAL INSURANCE

Toll Free 1800 12000

Need to claim? We're here to make it easy!

Instructions:
1. This form should be filled in by the Insured Person 2. This form is not an admission of liability 3. Please fill all the details in BLOCK LETTERS

SECTION A – SOME DETAILS ABOUT YOUR POLICY

a) Policy Number: | | | | | | | | | | | b) Serial No / Certificate No: | | | | | | | | | | |
c) Company / TPA ID No: | | | | | | | | | | | | | | | | | | | | |
d) Name: _____ e) Aadhaar number: | | | | | | | | | | | |
f) Address: _____ Landmark: _____
City: _____ State: _____ Pin Code: | | | | | |
Phone Number: | | | | | | | | | | | Email ID: _____
f) Name of Corporate: _____ Employee No: _____ Branch Location: _____

SECTION B – SHARE YOUR PAST/OTHER INSURANCE INFORMATION

a) Are you currently covered by any other Mediclaim / Health Insurance: Yes ☐ No ☐
b) Date of beginning 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 start of the Policy? Yes ☐ No ☐ Date: M M Y Y Y Y
Diagnosis: _____
e) Have you been previously covered by any other Mediclaim / Health Insurance: Yes ☐ No ☐
f) If yes, Company Name: _____

SECTION C – A BIT ABOUT THE PERSON HOSPITALIZED

a) Name: _____ b) Aadhaar Card Number: | | | | | | | | | | | | |
c) Gender: Male ☐ Female ☐ Third Gender ☐ d) Age: ☐☐ years ☐☐ months e) Date of Birth: D D M M Y Y Y Y
f) Relationship with Primarily Insured: Self ☐ Spouse ☐ Child ☐ Father ☐ Mother ☐ Other (Please Specify) _____
g) Occupation: Service ☐ Self-employed ☐ Homemaker ☐ Student ☐ Retired ☐ Other (Please Specify) _____
h) Address (if different from above): _____
City: _____ State: _____ Pin Code: | | | | | |
Phone Number: | | | | | | | | | | | Email ID: _____

SECTION D – TELL US MORE ABOUT THE HOSPITALIZATION

a) Name of Hospital Admitted: _____
Address: _____
Landmark: _____
b) Room category opted for: 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: 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, give cause: Self Inflicted ☐ Road Traffic Accident ☐ Substance Abuse/Alcohol Consumption ☐
h) If Medico legal: (i)Yes ☐ No ☐ (ii) Reported to Police: Yes ☐ No ☐ (iii) MLC & Intimation to Police attached: Yes ☐ No ☐
i) System of Medicine: _____

SECTION E – WHAT DO WE NEED FOR YOUR CLAIM?

a) Details of the treatment expenses claimed for

(i) Pre-hospitalization cost: ₹ _____ (ii) Hospitalization cost: ₹ _____

(iii) Post-hospitalization cost: ₹ _____ (iv) Health-Check-up cost: ₹ _____

(v) Ambulance Charges: ₹ _____ (vi) OPD: ₹ _____

Total: ₹ _____

(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: ₹ _____ (ii) Surgical Cash: ₹ _____

(iii) Critical Illness Benefit: ₹ _____ (iv) Convalescence: ₹ _____

(v) Pre/Post hospitalization Lump sum benefit: ₹ _____ (vi) Others: ₹ _____

Total: ₹ _____

The documents we'll need

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

SECTION F – DETAILS OF BILLS ENCLOSED

Sl.No.	Bill No.	Date	Issued by	Towards	Amount (INR)
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)			
6		(DD/MM/YYYY)			
7		(DD/MM/YYYY)			
8		(DD/MM/YYYY)			
9		(DD/MM/YYYY)			
10		(DD/MM/YYYY)			

SECTION G - IN CASE IT'S AN ACCIDENT (Tick the right option)

a) Death: ☐ b) Permanent Partial Disability: ☐ c) Permanent Total Disability: ☐ d) Temporary Total Disability: ☐

SECTION H - TELL US MORE ABOUT THE ACCIDENT

a) Date and Time of Accident: D D M M Y Y Y Y and H H : M M b) Place of Accident: _____

c) Cause of Accident: _____ d) Temporary Total Disability: _____

SECTION I - THE INSURED'S OR NOMINEE'S BANK ACCOUNT DETAILS

a) PAN: _____ b) Account Number: _____

c) Bank Name and Branch: _____

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

SECTION J - DETAILS OF OUT - PATIENT COVER

a) Treatment Start Date: D D M M Y Y Y Y b) Treatment End Date: D D M M Y Y Y Y

c) Name and contact details of Treating Doctor: _____

d) Name and Address of Clinic / Hospital: _____

e) Nature of Illness / Disease: _____

f) Consultation Fees: _____ g) Pharmacy / Investigations etc: _____

SECTION K – DECLARATION BY THE INSURED / NONIMEE

(PLEASE READ VERY CAREFULLY)

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 other claim except the pre / post hospitalization claim, if any.

Date: D D M M Y Y Y Y

Place: _____

Signature of the Memeber / Nominee

SOME TIPS TO FILL THE 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 given by the insurance company
b) Sl. No / Certificate No.	Enter the social insurance number or the certificate number of social health insurance scheme	As given by the organization
c) Company TPA ID No.	Enter the TPA ID No	License number as given by IRDA and printed in TPA documents
d) Name	Enter the full name of the Policyholder	Surname, First name, Middle name
e) Aadhaar Number	Enter the Aadhaar Number	As given by The Unique Identification Authority of India
f) 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 starting of first Insurance without break	Enter the date of starting 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 given 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 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) Earlier Covered by any other Mediclaim / Health Insurance?	Tell is if earlier 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) Aadhaar Number	Enter Aadhaar Number	As given by The Unique Identification Authority of India(UIDAI)
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 of patient	Use dd-mm-yy format
f) Relationship to primary Insured	Indicate relationship of patient with Policyholder	Tick the right option. If others, please mention.
g) Occupation	Indicate occupation of patient	Tick the right option. If others, please mention.
h) Address	Enter the full postal address	Include Street, City and Pin Code
i) Phone No	Enter the phone number of patient	Include STD code with telephone number
j) E-mail ID	Enter the E-mail ID of patient	Complete e-mail address
SECTION D – SHARE SOME DETAILS OF THE 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 taken	Tick the right box
c) Hospitalization due to	Indicate reason of hospitalization	Tick the right box
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

SOME TIPS TO FILL THECLAIM FORM – PART A

(TO BE FILLED BY THE INSURED)

SECTION E - DETAILS OF CLAIM		
a) Details of Treatment Expenses	Enter the amount claimed as treatment costs	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 ACCIDENT (Tick the right option)		
a) Death	Indicate whether claim is for Death	Tick the right option
b) Permanent Partial Disability	Indicate whether claim is for PPD	Tick the right option
c) Permanent Total Disability	Indicate whether claim is for PTD	Tick the right option
d) Temporary Total Disability	Indicate whether claim is for TTD	Tick the right option
SECTION H – SHARE A FEW DETAILS OF YOUR PERSONAL ACCIDENT		
a) Date and time of accident	Indicate the date and time of accident	Use dd-mm-yy format & HH:MM
b) Place of accident	Indicate the place of accident	Mention the place of accident
c) Cause of accident	Indicate the cause of accident	Mention the cause of accident
d) Is there any accidental hospitalization	Indicate whether hospitalization was there	Mention whether hospitalization was there
SECTION I – DETAILS OF THE INSURED'S / NOMINEE'S BANK ACCOUNT		
a) PAN	Enter the permanent account number	As given by the Income Tax department
b) Account Number	Enter the bank account number	As given 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 person / organization in full
e) IFSC Code	Enter the IFSC code of the bank branch	IFSC code of the bank branch in full
SECTION J - TELL US ABOUT THE OUT-PATIENT COVER		
a) Treatment start date	Enter treatment start date	Use dd-mm-yy
b) Treatment end date	Enter treatment end date	Use dd-mm-yy
c) Name and contact details of treating doctor	Enter name and contact details of treating doctor	Name and contact details of treating doctor
d) Name and address clinic / hospital	Enter Name and address of clinic / hospital	Name and address of clinic / hospital
e) Nature of illness / disease contracted	Enter name of the disease	Name of disease / ICD code
f) Consultation fees	Enter the amount claimed as treatment costs	In rupees (Do not enter paise values)
g) Pharmacy / Investigation fees	Enter the amount claimed as treatment costs	In rupees (Do not enter paise values)
SECTION K – MAKE YOUR DECLARATION		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.		