EDELWEISS HEALTH TOP UP INSURANCE - CLAIM FORM B

So your patient needs to claim? Relax, we're here to make it easy!

Edelweiss | GENERAL INSURANCE

Toll Free 1800 12000

Instructions:
1. This form should be filled in by the hospital 2. This form is not an admission of liability
3. Fill all details in BLOCK LETTERS 4.Please add the Original Pre-authorization request form alongwith

SECTION A: ABOUT HOSPITAL

a) Name of Hospital: _____

b) Hospital ID: _____ c) Type of Hospital: Network ☐ Non-Network ☐ (If Non-Network, fill Section E)

d) Name of treating doctor: _____ e) Qualification: _____

f) Registration No. with State Code: _____ g) Phone No.: ☐☐☐☐☐☐☐☐☐☐

SECTION B: SOME DETAILS ABOUT THE PATIENT

a) Name of the Patient: _____ b) Name of Proposer / Employee _____

c) Department: _____ d) Employee No: ☐☐☐☐☐ e)Name of the corporate: _____

f) Branch: _____ g) Date of Admission: D D M M Y Y Y Y h) Time: H H : M M

i) Date of Discharge: D D M M Y Y Y Y j) Time: H H : M M

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

l) If Maternity, (i) Date of Delivery: D D M M Y Y Y Y (ii) Gravida Status: ☐☐☐

m) Status at time of discharge: Discharge to home ☐ Discharge to another hospital ☐ Deceased ☐ n) Total claim amount: _____

SECTION C: WHAT WAS THE PRIMARY AILMENT BEING TREATED?

a)	ICD 10 Codes	Description
(i) Primary Diagnosis:		
(ii) Additional Diagnosis:		
(iii) Co-morbidities:		
(iv) Co-morbidities:		
b)	**ICD 10 PCS**	**Description**
(i) Procedure 1:		
(ii) Procedure 2:		
(iii) Procedure 3:		
(iv) Details of Procedure:		

c) Pre-Authorization obtained: Yes ☐ No ☐ d) Pre-Authorization Number: _____

e) If the network hospital has not agreed, please state the reason: _____

f) Hospitalization due to injury: Yes ☐ No ☐

i) If Yes, give cause: Self-Inflicted ☐ Road Traffic Accident ☐ Substance Abuse/Alcohol Consumption ☐

ii) If injury due to Substance Abuse/Alcohol Consumption, Test conducted to prove this: Yes ☐ No ☐ (If Yes, attach reports)

iii) If Medico Legal: Yes ☐ No ☐ iv) Reported to Police: Yes ☐ No ☐

(v) If reported, FIR No.: _____ (vi) If not reported, please state the reason: _____

SECTION D: HAVE ALL THE DOCUMENTS YOU NEED?

- ☐ Signed Claim Form
- ☐ Original Pre-authorization request
- ☐ Copy of the Pre-authorization approval letter
- ☐ Copy of photo ID card of patient verified by hospital
- ☐ Discharge summary
- ☐ Operation Theatre notes
- ☐ Hospital main bill
- ☐ Hospital break-up bill
- ☐ Investigation reports
- ☐ CT/MR/USG/HPE investigation reports
- ☐ Doctor's reference slip for investigation
- ☐ ECG
- ☐ Pharmacy bills
- ☐ MLC report & Police FIR
- ☐ Original death summary from hospital where needed
- ☐ Any other, please specify: _____

SECTION E – Non-network hospital? Please help us with some details.

(ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)

a) Address of Hospital: _____

City: _____ State: _____ Pin Code: ☐☐☐☐☐☐

b) Phone No: ☐☐☐☐☐☐☐☐☐☐☐ c) Registration No. with State Code: _____

d) Hospital PAN: ☐☐☐☐☐☐☐☐☐☐ e) Number of inpatient beds: ☐☐☐

f) Facilities given in the hospital: (i) OT: Yes ☐ No ☐ (ii) ICU: Yes ☐ No ☐

(iii) Medical Store: Yes ☐ No ☐ (iv) Pathology: Yes ☐ No ☐ (v) Radiology: Yes ☐ No ☐ Other: _____

SECTION F – DECLARATION BY THE HOSPITAL

(PLEASE READ VERY CAREFULLY)

We hereby declare that the information given in this Claim Form is true & correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppressed or hidden any material fact, our right to claim under this claim shall be taken away.

Date: | D | D | M | M | Y | Y | Y | Y |

Place: _____

Signature & Seal of the Hospital Authority

SOME TIPS ON HOW TO FILL CLAIM FORM– PART B

(TO BE FILLED 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	Write if in network or non-network hospital	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	Educational qualifications in short
f) Registration No. with State Code	Enter the registration number of the doctor along with the state code	As given 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) Name of the proposer / employee	Enter the name of proposer / employee	Name of proposer / employee in full
c) Department	Enter name of Department	Name of department in full
d) Name of the corporate	Enter name of corporate	Name of corporate in full
e) Branch	Enter name of Branch	Name of Branch in Full
f) IP Registration Number	Enter insurance provider registration number	As allotted by the insurance company
g) Gender	Indicate Gender of the patient	Tick Male or Female
h) Age	Enter age of the patient	Number of years and months
i) Date of Birth	date of birth of the patient	Use dd-mm-yy format
j) Date of Admission	Enter date of admission	Use dd-mm-yy format
k) Time	Enter time of admission	Use hh:mm format
l) Date of Discharge	Enter date of release	Use dd-mm-yy format
m) Time	Enter time of release	Use hh:mm format
n) Type of Admission	Indicate type of admission of patient	Tick the right option
o) 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
p) Status at time of discharge	Indicate status of patient at time of release	Tick the right option
q) Total claimed amount	Indicate the total claimed amount	In rupees (Do not enter paise values)
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) Pre-authorization obtained	Indicate whether pre-authorization obtained	Tick Yes or No
d) Pre-authorization Number	Enter pre-authorization number	As allotted by TPA
e) If authorization by network hospital not obtained, reason	Enter reason for not obtaining pre-authorization number	Open text
f) Hospitalization due to injury Cause	Indicate if hospitalization is due to injury Indicate cause of injury	Tick Yes or No Tick the right option
If injury due to substance abuse/alcohol consumption, test conducted to establish this.	Indicate if test is done	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
If reported, 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 - NON-NETWORK HOSPITAL? PLEASE HELP US WITH SOME DETAILS.		
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	As given by the Medical Council of India
d) Hospital PAN	Code	As given by the Income Tax department
e) Number of Inpatient beds	Enter the permanent account number	Digits
f) Facilities available in the hospital	Enter the number of inpatient beds	Tick the right option. If others, please mention
SECTION F - DECLARATION BY THE HOSPITAL		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign and stamp.		