GROUP CORONA POLICY,
EDELWEISS GENERAL INSURANCE COMPANY LIMITED - CLAIM FORM B

Edelweiss | GENERAL INSURANCE

Toll Free 1800 12000

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

Just follow these simple 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 instead of Part A

SECTION A – DETAILS OF HOSPITAL/INSTITUTIONAL QUARANTINE CENTRE

a) Name of Hospital /Institutional Quarantine Centre: _____

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 – DETAILS OF THE PATIENT ADMITTED

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

c) Gender: Male ☐ Female ☐ Third Gender ☐ 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 ☐

k) Status at time of discharge: Discharge to home ☐ Discharge to another hospital ☐ Deceased ☐

l) Total claim amount: ☐☐☐☐☐☐

SECTION C – DETAILS OF THE DISEASE DIAGNOSED (PRIMARY)

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

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

e) If you're a Network Hospital but couldn't get pre-authorization, please give us the reason _____

SECTION D – CLAIM DOCUMENTS SUBMITTED – CHECKLIST

- ☐ Signed Claim Form
- ☐ Original Pre-authorization request
- ☐ Copy of the Pre-authorization approval letter
- ☐ Copy of photo ID of patient verified by the hospital
- ☐ Hospital Discharge summary
- ☐ Operation Theatre Notes if applicable
- ☐ Hospital main bill
- ☐ Hospital break-up bill
- ☐ Investigation reports
- ☐ CT/MR/USG/HPE investigation reports
- ☐ Doctor's reference slip for investigation
- ☐ ECG
- ☐ Pharmacy bills
- ☐ Original Death Summary from the Hospital, where applicable
- ☐ Original Transfer Summary from the Hospital, where applicable
- ☐ If any other, please specify: _____

SECTION E – ADDITIONAL DETAILS IN CASE OF NON-NETWORK HOSPITAL

(ONLY FILL IF YOURS IS A 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 available in the hospital: (i) OT: Yes ☐ No ☐ (ii) ICU: Yes ☐ No ☐

iii) Others: _____

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GUIDANCE FOR FILLING 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 the hospital in full
b) Hospital ID	Enter ID number of hospital	As allocated by the TPA
c) Type of Hospital	Indicate whether 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	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 the patient	Name of the patient 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 or Third Gender
d) Age	Enter age of the patient	Number of years and months
e) Date of Birth	Enter Date of Birth of the patient	Use dd-mm-yyyy format
f) Date of Admission	Enter date of admission	Use dd-mm-yyyy format
g) Time	Enter time of admission	Use hh:mm format
h) Date of Discharge	Enter date of discharge	Use dd-mm-yyyy 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) Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
l) Total claim amount	Indicate the total claim amount	In rupees (Do not enter paise values)
SECTION C - DETAILS OF DISEASE 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
Details of Procedure	Enter the details of the procedure	Open text
c) Pre-authorization obtained	Let us know whether pre-authorization was obtained	Tick Yes or No
d) Pre-authorization Number	Enter pre-authorization number	As allotted by TPA
e) If authorization by network hospital was not obtained, reason why	Let us know the reason for not obtaining pre-authorization	Open text
SECTION D - CLAIM DOCUMENTS SUBMITTED - CHECK LIST		
Let us know 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	Let us know how many beds are available	Digits
f) Facilities available in the hospital	Let us know if OT and ICU are available	Tick the right option. If others, please specify

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, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited.

Date: D D M M Y Y Y Y

Place: _____

Signature & Seal of the Hospital Authority

Edelweiss General Insurance Company Limited, Corporate Office: 5th Floor, Tower 3, Kohinoor City Mall, Kohinoor City, Kirol Road, Kurla (West), Mumbai- 400 070, Registered Office: Edelweiss House, Off CST Road, Kalina, Mumbai-400 098, IRDAI Regn. No.: 159, CIN: U66000MH2016PLC273758, Reach us on: 1800 12000, Email: support@edelweissinsurance.com, Website: www.edelweissinsurance.com, Issuing/Corporate Office: +91 22 4272 2200, Grievance Redressal Officer: +91 22 4931 4422, Dedicated Toll-Free Number for Grievance: 1800 120 216216. Trade logo displayed above belongs to Edelweiss Financial Services Limited and is used by Edelweiss General Insurance Company Limited under license. Insurance is the subject matter of solicitation.