Edelweiss | GENERAL INSURANCE

EDELWEISS GROUP HEALTH INSURANCE POLICY
CLAIM FORM B

Toll Free 1800 12000

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

Instructions:
1. This form should be filled in by the hospital 2. Issuance of this form does not imply acceptance of liability
3. Fill all details in BLOCK LETTERS 4. Please add the original pre-authorization request form with Part A

SECTION A - ABOUT THE HOSPITAL AND DOCTOR

a) Name of Hospital: _____

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

d) Name of attending 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 the member: _____ c) Department: _____

d) Employee No.: _____ e) Name of the Insured / Policyholder: _____ f) Branch: _____

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

i) Date of Discharge: D D M M Y Y Y Y j) Time of Discharge: 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 claimed amount (in ₹): _____

o) Age Y Y M M p) Gender: ☐ Male ☐ Female ☐ Third gender q) Date of Birth: D D M M Y Y Y Y

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 No.: _____

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
☐ Investigation reports
☐ CT / MR / USG / HPE investigation reports

- ☐ Copy of the pre-authorization approval letter
- ☐ Copy of photo ID card of patient, verified by hospital
- ☐ Discharge summary
- ☐ Operation theatre notes
- ☐ Main hospital bill
- ☐ Hospital bill break-up
- ☐ 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.

a) Address of Hospital: _____

_____

Landmark: _____ City: _____ State: _____ Pin Code: | | | | | | |

b) Phone No.: | | | | | | | | | | | c) Registration no. with state code: _____

d) PAN of hospital: _____ 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 (vi) 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 and / or suppressed or hidden any material fact, our right to claim shall stand forfeited.

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

Place: _____

Signature and stamp of authorized signatory

SOME TIPS ON HOW TO FILL CLAIM FORM– PART B

DATA ELEMENT	DESCRIPTION	FORMAT
SECTION A - ABOUT THE HOSPITAL AND DOCTOR		
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 attending 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 - SOME DETAILS ABOUT THE PATIENT		
a) Name of Patient	Enter the name of hospital	Name of hospital in full
b) Name of the member	Enter the name of member	Name of member in full
c) Department	Enter name of department	Name of department in full
d) Employee no.	Enter Employee No.	
e) Name of the Insured/ Policyholder	Enter the full name of the Policyholder	Surname, First name, Middle name
f) Branch	Enter Branch Location	
g) Date of Admission	Enter date of admission	Use dd-mm-yyyy format
h) Time of Admission	Enter time of admission	Use hh:mm format
i) Date of Discharge	Enter date of release	Use dd-mm-yyyy format
j) Time of Discharge	Enter time of release	Use hh:mm format
k) Type of Admission	Indicate type of admission of patient	Tick the right option
l) If Maternity		
Date of Delivery	Enter date of delivery, in case of maternity	Use dd-mm-yyyy format
Gravida Status	Enter gravida status if maternity	Use standard format
m) Status at time of discharge	Indicate status of patient at time of release	Tick the right option
n) Total claimed amount (in ₹)	Indicate the total claimed amount	In rupees (Do not enter paise values)
o) Age	Enter age of the Patient	Number of years and months
p) Gender: Male, Female, Third gender	Indicate gender of the Hospitalized person	Tick on appropriate option
q) Date of Birth	Enter date of birth of Patient	Use dd-mm-yyyy format
SECTION C - WHAT WAS THE PRIMARY AILMENT BEING TREATED?		
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 No.	Enter pre-authorization number	As allotted by TPA
e) If the network hospital has not agreed, please state the reason	Enter reason for not obtaining pre-authorization number	Open text
f) Hospitalization due to injury	Indicate if hospitalization is due to injury or not	Tick Yes or No
Cause	Indicate cause of injury	Tick the right option
If injury due to substance abuse / alcohol consumption, test conducted to establish this	Indicate if test is done or not	Tick Yes or No
medico-legal	Indicate whether injury is medico legal or not	Tick Yes or No
Reported to police	Indicate whether police report was filed or not	Tick Yes or No
If reported, FIR No.	Enter first information report number	As issued by police authorities
If not reported, please state the reason	Enter reason for not reporting to police	Open Text
SECTION D - HAVE ALL THE DOCUMENTS YOU NEED?		
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 code	As given by the Medical Council of India
d) PAN of hospital	Enter the permanent account number	As given by the Income Tax Department
e) Number of inpatient beds	Enter the number of inpatient beds	Digits
f) Facilities given in the hospital	Facilities in the hospital	Tick the right option. If others, please mention
SECTION F - DECLARATION BY THE HOSPITAL		
Read declaration carefully and mention date (in dd:mm:yyyy format), place (open text) and sign and stamp.		