

# 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:         h) Time of Admission:
- i) Date of Discharge:         j) Time of Discharge:
- k) Type of Admission: Emergency  Planned  Day Care  Maternity
- l) If Maternity, (i) Date of Delivery:         (ii) Gravida Status: \_\_\_\_\_
- m) Status at time of Discharge:  Discharge to home  Discharge to another hospital  Deceased
- n) Total claimed amount (in ₹): \_\_\_\_\_
- o) Age     p) Gender:  Male  Female  Third gender q) Date of Birth:

## 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  Investigation reports
- Original pre-authorization request  CT / MR / USG / HPE investigation reports

- |                                                                                 |                                                                             |
|---------------------------------------------------------------------------------|-----------------------------------------------------------------------------|
| <input type="checkbox"/> Copy of the pre-authorization approval letter          | <input type="checkbox"/> Doctor's reference slip for investigation          |
| <input type="checkbox"/> Copy of photo ID card of patient, verified by hospital | <input type="checkbox"/> ECG                                                |
| <input type="checkbox"/> Discharge summary                                      | <input type="checkbox"/> Pharmacy bills                                     |
| <input type="checkbox"/> Operation theatre notes                                | <input type="checkbox"/> MLC report & police FIR                            |
| <input type="checkbox"/> Main hospital bill                                     | <input type="checkbox"/> Original death summary from hospital, where needed |
| <input type="checkbox"/> Hospital bill break-up                                 | <input type="checkbox"/> 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:

Place: \_\_\_\_\_

Signature and stamp of authorized signatory

### SOME TIPS ON HOW TO FILL CLAIM FORM- PART B

| DATA ELEMENT                                                   | DESCRIPTION                                                           | FORMAT                                   |
|----------------------------------------------------------------|-----------------------------------------------------------------------|------------------------------------------|
| <b>SECTION A - ABOUT THE HOSPITAL AND DOCTOR</b>               |                                                                       |                                          |
| 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   |
| <b>SECTION B - SOME DETAILS ABOUT THE PATIENT</b>              |                                                                       |                                          |
| 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                    |
| <b>SECTION C - WHAT WAS THE PRIMARY AILMENT BEING TREATED?</b> |                                                                       |                                          |
| 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.