Corona Rakshak 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

SECTION A – DETAILS OF THE HOSPITAL

a) Name of Hospital: _____

b) Name of Treating Doctor: _____ c) Qualification: _____

d) Registration No. with State Code: _____ e) 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 | Y | Y | Months | M | M | e) Date of Birth: | D | D | M | M | Y | Y | Y | Y |

f) Date of Admission: | D | D | M | M | Y | Y | Y | Y | Time of Admission: | H | H | M | M |

g) Date of Discharge: | D | D | M | M | Y | Y | Y | Y | Time of Discharge: | H | H | M | M |

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

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 if applicable:		

SECTION D – CLAIM DOCUMENTS SUBMITTED – CHECKLIST

- ☐ Signed Claim Form
- ☐ Copy of Covid-19 positive Pathology Test Report
- ☐ Hospital Main Bill
- ☐ Hospital Bill Payment Receipt
- ☐ Any other document, as and when required by the company for assessment of the claim
- ☐ Investigation Reports if any
- ☐ Treatment Notes
- ☐ Hospital Discharge Card / Summary

_____

SECTION E – ADDITIONAL DETAILS OF THE 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: _____

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 the hospital	Name of hospital in full
b) Name of treating Doctor	Enter the name of the treating Doctor	Name of the Doctor in full
c) Qualification	Enter the qualifications of the treating Doctor	Abbreviations of educational qualifications
d) 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
e)Phone No.	Enter the Doctor's phone number	Include STD code with telephone number
SECTION B – DETAILS OF THE PATIENT ADMITTED		
a) Name of Patient	Enter 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 the date of birth	Use dd-mm-yyyy format
f) Date of Admission	Enter date of admission	Use dd-mm-yyyy format
Time of Admission	Enter time of admission	Use hh:mm format
g) Date of Discharge	Enter date of discharge	Use dd-mm-yyyy format
Time of Discharge	Enter time of discharge	Use hh:mm format
h) Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
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
SECTION D – Claim Documents Submitted - Checklist		
Tell us which supporting documents are submitted.		
SECTION E – DETAILS OF HOSPITAL		
a) Address of Hospital	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 and seal of authorized signatory