CLAIM FORM B

CLAIM FOR PART - B
TO BE FILLED IN BY THE HOSPITAL
The issue of this Form is not to be taken as an admission of liability
Please include the original pre-authorization request form in lieu of PART - A

(To be filled in BLOCK letters)

SECTION A		
DETAILS OF 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			
DETAILS OF THE PATIENT ADMITTED			
a) Name of the Patient:			
b) IP Registration Number:	c) Gender: Male / Female / Third Gender	d) Age: Years YY Months MM	
e) Date of Birth:(DD/MM/YYYY)			
f) Date of Admission:(DD/MM/YYYY)	g) Time: HH: MM	h) Date of Discharge: DD/MM/YYYY)	i) Time: HH: MM
j) Type of Admission: Emergency / Planned / Day Care / Maternity			
k) If Maternity,	(i) Date of Delivery:(DD/MM/YYYY)	(ii) Gravida Status:	
l) Status at time of discharge: Discharge to home	Discharge to another hospital	Deceased	m) Total claimed amount:

SECTION C				
DETAILS OF AILMENT DIAGNOSED (PRIMARY)				
a)	(i)	Primary Diagnosis:	ICD 10 Code:	Description:
	(ii)	Additional Diagnosis:	ICD 10 Code:	Description:
	(iii)	Co-morbidities:	ICD 10 Code:	Description:
	(iv)	Co-morbidities:	ICD 10 Code:	Description:
b)	(i)	Procedure 1:	ICD 10 PCS:	Description:
	(ii)	Procedure 2:	ICD 10 PCS:	Description:
	(iii)	Procedure 3:	ICD 10 PCS:	Description:
	(iv)	Details of Procedure:		
c) Pre-authorization obtained: Yes / No		d) Pre-authorization Number:		
e) If authorization by network hospital not obtained, give 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 establish this: Yes		No		(If Yes, attach reports)
(iii) If Medico Legal: Yes	No			
(iv) Reported to Police: Yes	No			
(v) FIR No.:				
(vi) If not reported to Police, give reason:				

SECTION D					
CLAIM DOCUMENTS SUBMITTED CHECKLIST					
(i)	Claim Form duly signed	(Yes/No)	(ix)	Investigation Report including Insured Person's test reports from Authorized diagnostic Centre for COVID	(Yes/No)
(ii)	Original Pre-authorization request	(Yes/No)	(x)	CT / MRI / USG / HPE investigation reports	(Yes/No)
(iii)	Copy of Pre-authorization approval letter	(Yes/No)	(xi)	Doctor's reference slip for investigation	(Yes/No)
(iv)	Copy of photo ID card of patient verified by hospital	(Yes/No)	(xii)	ECG	(Yes/No)

(v)	Hospital Discharge Summary	(Yes/No)	(xiii)	Pharmacy Bil	(Yes/No)
(vi)	Operation Theatre notes	(Yes/No)	(xiv)	MLC Report & Police FIR	(Yes/No)
(vii)	Hospital Mail Bill	(Yes/No)	(xv)	Original death summary from hospital, where applicable	(Yes/No)
(viii)	Hospital Break-up Bill	(Yes/No)	(xvi)	Any other, please specify _	(Yes/No)

SECTION E		
DETAILS IN CASE OF NONETWORK HOSPITAL (ONLY FILL IN CASE OF NETWORK HOSPITAL)		
a) Address of the 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:		

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 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: (DD/MM/YYYY)
Place: Signature & Seal of the Hospital Authority

GUIDANCE FOR FILING CLAIM FORMPART B (To be filled in 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 hospitals	As allocated by the TPA
c) Type of Hospital	Indicate whether 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	Abbreviations of educational qualification
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(s)	Include STD code with telephone number
SECTION B DETAILS OF THE PATIENT		
a) Name of Patient	Enter the name of hospital	Name of hospital 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
d) Age	Enter age of the patient	Number of years and months
e) Date of Birth	Enter Date of Birth of patient	Use dd-mm-yy format
f) Date of Admission	Enter date of admission	Use dd-mm-yy format
g) Time	Enter time of admission	Use hh : mm format
h) Date of Discharge	Enter date of discharge	Use dd-mm-yy 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) 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
l) Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
m) 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 OpenText
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 c-o 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, give reason	Enter reason for not obtaining pre-authorization number	Open text
f) Hospitalization due to injury	Indicate if hospitalization is due to injury	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 whether test conducted	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

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: CHECKLIST		
Indicate which supporting documents are submitted.		
SECTION E DETAILS IN CASE OF NO-NETWORK HOSPITAL		
a) Address	Enter the full postal address	Include Street, City and Pin Code
b) Phone No.	Enter the phone number of hospitals	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	Enter the number of inpatient beds	Digits
f) Facilities available in the hospital	Indicate facilities available in the hospital	Tick the right option. If others, please specify
SECTION F DECLARATION BY THE HOSPITAL		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign and stamp		