HDFC ERGO General Insurance Company Limited

Take it easy!

HDFC ERGO GENERAL INSURANCE

CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT

CLAIM FORM – 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 preauthorisation request form in lieu of PART A

(To be filled in block letters)

SECTION A – DETAILS OF HOSPITAL

a) Name of the Hospital where treated:

b) Hospital ID: c) Type of Hospital: Network ☐ Non Network ☐ (If non network fill section E)

d) Name of the treating Doctor: SURNAME FIRSTNAME MIDDLENAME

e) Qualification: f) Registration No with state Code: g) Phone No:

SECTION B – DETAILS OF PATIENT ADMITTED

a) Name of the patient: SURNAME FIRSTNAME MIDDLENAME

b) IP Registration Number: c) Gender: Male ☐ Female ☐ d) Age: YY 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 ☐ Daycare ☐ Maternity ☐ k) If Maternity: i) Date of Delivery DD MM YYYY ii) Gravida Status

l) Status at time of discharge: Discharged to Home ☐ Discharged to another Hospital ☐ Deceased ☐ Total Claimed Amount

SECTION C – DETAILS OF AILMENTS DIAGNISED (PRIMARY)

a) ICD 10 Codes		Description	b) ICD 10 PCS		Description
Primary Diagnosis			Procedure 1		
Additional Diagnosis			Procedure 2		
Co-morbidities			Procedure 3		
Co-morbidities			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: 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 ☐ No (If yes, attach reports)

iii) Medico Legal: Yes ☐ No ☐ iv) Reported to Police : Yes ☐ No ☐ v) FIR No:

vi) If not reported to Police give reasons :

SECTION D – CLAIM DOCUMENTS SUBMITTED – CHECKLIST

- ☐ Claim form duly filled and signed
- ☐ Original Pre authorization Request
- ☐ Copy of Pre-authorization approval Letter
- ☐ Copy of photo ID card of patient verified by Hospital
- ☐ Hospital Discharge Summary
- ☐ Operation Theatre Notes
- ☐ Hospital Main Bill
- ☐ Hospital break up Bill
- ☐ Investigation reports
- ☐ CT/MRI/USG/HPE investigation Report
- ☐ Doctor's reference slip for Investigation
- ☐ ECG
- ☐ Pharmacy Bills
- ☐ MLC Report & Police FIR
- ☐ Original death summary from hospital where applicable
- ☐ Any other, Pl specify

SECTION E – DETAILS IN CASE OF NON NETWORK HOSPITAL

a) Address of the Hospital:

City: State:

Pin Code: b) Phone No.: c) Registration no with State Code:

d) Hospital PAN: e) No of In-patient Beds: f) Facilities available in Hospital: i) OT: Yes ☐ No ☐ ii) ICU: Yes ☐ No ☐

iii)Others:

SECTION F – DECLARATION BY HOSPITAL

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: DD MM YYYY Place: Signature of Hospital: