Reimbursement Claim Form - Part B

(To be Filled by the Hospital)

The issue of this Form is not to be taken as an admission of liability

Treating Doctor's & Hospital Details						
Name of the Hospital				**City**		
Facilities available in the hospital (Provide the details in Nos.)	Beds	OT	ICU	**Hospital Address**		
Type of Hospital	☐ Network	☐ Non Network		**District**		
If Network Hospital, Star HOS Code				**State**		
Hospital Registration No. with state code				**Pincode**		
Hospital Rohini ID				**Phone No. / Mobile No.**		
Hospital PAN No.				**GST No.**		
Treating Doctor Name						
Treating Doctor Qualification				**Treating Doctor Registration No.**		

Details of the Patient Admitted								
Name of the Patient					**IP Registration No.**			
Gender / Age					**ABHA ID No.**			
Date of Admission			**Time**		**Date of Discharge**		**Time**	
Type of Admission	☐ Emergency	☐ Planned	☐ Day Care	☐ Maternity	**Date of Childbirth**			
Type of Management	☐ Medical		☐ Surgical		**Duration of Illness**			
Diagnosis								
Co-Morbidities								
Name of the Treatment / Procedure								
Past Medical / Surgical History								

FOR YOUR BENEFIT

Elevating your well-being is our primary goal at STAR Health. We are delighted to further enhance your experience by introducing the following supplementary services.

1. Wellness Program

- Expert dietitian advice on Diabetes Care, Hypertension Care, and Weight Management
- Get discounts on renewal premium and exciting vouchers

2. Telemedicine

- Free consultations every day, including public holidays, from 8 am to 10 pm
- Get second opinion and health guidance for both you and your family members

Avail personalized one-on-one consultation with our Experts and Specialists and they're **FREE!.**

To enrol, log into the STAR Health App, available for download on:

Android IOS

Your health is paramount, and our commitment is to ensure you receive the essential support needed.

We encourage you to make the most of these additional services, empowering yourself on the journey to a healthier, more joyful existence.

Keep Healthy, Stay Happy!

Details in case of Accident				
Cause of Accident	☐ Self Inflicted	☐ Road Accident	☐ Substance Abuse	☐ Alcohol Consumption
Reported to Police	☐ Yes / ☐ No	**FIR NO.**		
Medico Legal / AR				

Declaration by the Hospital

We affirm the accuracy and truthfulness of the details provided in this Claim Form to the best of our knowledge and belief. We understand that any misrepresentation, withholding and omission of patient information, or concealment of material facts may lead to the forfeiture of the claim. Star Health or its authorized representatives are hereby authorized to verify, inspect, or collect any records related to this claim. The insured's signature is obtained on this form after we complete Claim Form B.

Date **Place** **Signature of Proposer / Claimant** **Signature & Seal of the Hospital Authority**



Authorisation to Star Health and Allied Insurance Co. Ltd

To:

Hospital Name: _____ Place: _____

Dear Sir,

Claim No:		Patient Admission No / IP No / MRD No:	

I have undergone treatment for _____ from ____/____/____ to ____/____/____ in your Hospital. I hereby authorize M/s. Star Health and Allied Insurance Co. Ltd and its representatives, who is my Health Insurer to seek any medical information/records from you or from the Medical Practitioners who have attended on me in connection with the above ailment and the treatment given. In case they seek any such information/ records / indoor case papers, kindly oblige.

Thanking you,

Place: Yours Faithfully,

Date:

Address: **(Signature of the Proposer / Claimant)**