National Insurance Company Limited

Regd. Office: Premises No. 18-0374, Plot no. CBD-81, Rajarhat, New Town, Kolkata - 700156

National Super Top Up Mediclaim Policy

PLEASE FAX / SCAN PAGE 1 ONLY

REQUEST FOR CASHLESS HOSPITALISATION FOR MEDICLAIM INSURANCE POLICY

(To be filled in block letters)

DETAILS OF THE THIRD PARTY ADMINISTRATOR

a) Name of TPA / Insurance Company:
b) Toll free phone number:
c) Toll free Fax:

TO BE FILLED BY THE INSURED / PATIENT

a) Name of the patient:

b) Gender : ☐ Male ☐ Female ☐ Others c) Age: years ☐☐ months ☐☐ d) Date of Birth: ☐☐ ☐☐ ☐☐☐☐

e) Contact number: ☐☐☐☐☐☐☐☐☐☐ f) Contact number of attending relative ☐☐☐☐☐☐☐☐☐☐

g) Insured card ID number: ☐☐☐☐☐☐☐☐☐☐

h) Policy number / Name of corporate: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ i) Employee ID: ☐☐☐☐☐☐☐

j) Currently do you have any other Mediclaim / Helath Insurance: ☐ Yes ☐ No Company Name:

Give details:

k) Do you have a family physician? ☐ Yes ☐ No l) Name of the family physician:

m) Contact number, if any: ☐☐☐☐☐☐☐☐☐☐ (PLEASE COMPLETE DECLARATION ON THE REVERSE SIDE OF THIS FORM)

TO BE FILLED BY THE TREATING DOCTOR / HOSPITAL

a) Name of the treating doctor: b) Contact number:

c) Nature of illness/ disease with presenting complaints

d) Relevant clinical findins:

e) Duration of the present ailment: ☐☐☐ Days i. Date of first consultation: ☐☐ ☐☐ ☐☐ ii. Past history of present ailment, if any

f) Provisional diagnosis:

i. ICD 10 Code

g) Proposed line of treatment: ☐ Medical Management ☐ Surgical Management ☐ Intensive Care ☐ Investigation ☐ AYUSH Treatment (Please Specify)

h) If investigation & / or Medical Management, provide details

i. Route of drug administration:

i) If Surgical, name of surgery:

i. ICD 10 PCS Code

j) If other treatments, provide details

k) How did the injury occur?

l) In case of accident: i. Is it RTA? ☐ Yes ☐ No ii. Date of injury: ☐☐ ☐☐ ☐☐ iii. Reported to Police: ☐ Yes ☐ No iv. FIR No.:

v. Injury / Disease caused due to substance abuse / alcohol consumption: ☐ Yes ☐ No vi. Test conducted to extablish this? ☐ Yes ☐ No (If yes attach reports)

m) In case of maternity: ☐ G ☐ P ☐ L ☐ A Date of Delivery: ☐☐ ☐☐ ☐☐

Details of the patient admitted

a) Date of admission: ☐☐ ☐☐ ☐☐ b) Time: ☐☐ : ☐☐

c) Is this an emergency / a planned hospitalization event? ☐ Emergency ☐ Planned

d) Expected no. of days in hospital: ☐☐☐ Days e) Room Type:

f) Per Day Room Rent + Nursing & Service Charges + Patient's Diet: `

g) Expected cost of investigation + diagnostics: `

h) ICU Charges: `

i) OT Charges: `

j) Professional fees Surgeon + Anesthetist Fees + consultation charges: `

k) Medicines + Consumables + Cost of implants (if applicable, please specify), other hospital expenses, if any: `

l) All inclusive package charges, if any applicable: `

m) Sum Total, expected cost of hospitalization: `

Mandatory : Past history of any chronic illness — **If Yes, since (month / year)**

- ☐ Diabetes ☐☐ ☐☐☐☐
- ☐ Heart Disease ☐☐ ☐☐☐☐
- ☐ Hypertension ☐☐ ☐☐☐☐
- ☐ Hyperlipidemia ☐☐ ☐☐☐☐
- ☐ Osteoarthritis ☐☐ ☐☐☐☐
- ☐ Asthma / COPD / Bronchitis ☐☐ ☐☐☐☐
- ☐ Cancer ☐☐ ☐☐☐☐
- ☐ Alcohol or drug abuse ☐☐ ☐☐☐☐
- ☐ Any HIV or STD / Related ailments ☐☐ ☐☐☐☐

Any other Ailment, give details:

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(PLEASE READ VERY CAREFULLY)

DECLARATION

We confirm having read, understood and agreed to the Declaration on the reverse of this form

a) Name of the treating doctor:

b) Qualification:

c) Registration No. with state code:

Hospital Seal (must contain hospital ID)

Patient / Insured Name & Signature

(IMPORTANT: PLEASE TURN OVER)

DECLARATION BY THE PATIENT / REPRESENTATIVE

1. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Insurer/T.P.A after the discharge. I agree to sign on the Final Bill & the Discharge Summary, before my discharge.

2. Payment to hospital is governed by the terms and conditions of the policy. In case the Insurer / TPA is not liable to settle the hospital bill, I undertake to settle the bill as per the terms and conditions of the policy.

3. All non-medical expenses and expenses not relevant to current hospitalization and the amounts over & above the limit authorized by the Insurer/T.P.A not governed by the terms and conditions of the policy will be paid by me. In case any clarification is needed on admissibility of a particular item I shall contact T.P.A at the Toll Free Number on the reverse of this form.

4. I hereby declare to abide by the terms and conditions of the policy and if at any time the facts disclosed by me are found to be false or incorrect I forfeit my claim and agree to indemnify the Insurer / T.P.A

5. I agree and understand that T.P.A is in no way warranting the service of the hospital & that the Insurer / TPA is in no way guaranteeing that the services provided by the hospital will be of a particular quality or standard.

6. I hereby warrant the truth of the forgoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppression or concealment, my right to claim reimbursement of the said expenses shall be absolutely forfeited. I further declare that, in respect of the above treatment, no benefits are admissible under any other Medical Scheme or Insurance

7. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer / TPA.

a) Patient's / Insured's Name: _____

b) Contact number: _____ **d) Patient's / Insured's Signature:** _____

HOSPITAL DECLARATION

1. We have no objection to any authorized TPA / Insurance Company official verifying documents pertaining to hospitalization.

2. All valid original documents duly countersigned by the insured / patient as per the checklist below will be sent to TPA / Insurance Company within 7 days of the patient's discharge.

3. All non medical expenses , OR expenses not relevant to hospitalization or illness, OR expenses disallowed in the Authorization Letter of the TPA / Insurance Co, OR arising out of incorrect information in the pre-authorisation form will be collected from the patient.

4. WE AGREE THAT TPA / INSURANCE COMPANY WILL NOT BE LIABLE TO MAKE THE PAYMENT IN THE EVENT OF ANY DISCREPANCY BETWEEN THE FACTS IN THIS FORM AND DISCHARGE SUMMARY or other documents.

5. The patient declaration has been signed by the patient or by his representative in our presence.

6. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications.

7. We will abide by the terms and conditions agreed in the MOU.

Hospital Seal | **Doctor's Signature**

DOCUMENTS TO BE PROVIDED BY THE HOSPITAL IN SUPPORT OF THE CLAIM

1. Detailed Discharge Summary and all Bills from the hospital

2. Cash Memos from the Hospitals / Chemists supported by proper prescription.

3. Receipts and Pathological Test Reports from Pathologists, supported by note from the attending Medical Practitioner / Surgeon recommending such pathological Tests.

4. Surgeon's Certificate stating nature of operation performed and Surgeon's Bill and Receipt.

5. Certificates from attending Medical Practitioner / Surgeon that the patient is fully cured.

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CLAIM FORM - PART A

TO BE FILLED IN BY THE INSURED

The issue of theis form is not to be taken as admission of liability

Please submit all original documents and/ or certified copies of documents related to all hospitalisation(s) during the policy period to enable the Company to calculate the cumulative medical expenses and threshold, for determining admissibility and payment of claims.

(To be filled in block letters)

SECTION A

DETAILS OF PRIMARY INSURED

a) Policy no: b) Company/ TPA ID No:

c) Name:

d) Address:

City: State:

Pin Code: Phone No: Email ID:

SECTION B

DETAILS OF INSURANCE HISTORY

a) Currently covered by any other Mediclaim/ Health Insurance: Yes No b) Date of commencement of first insurance without break:

c) If yes, company name: Policy No:

Sum Insured (`): d) Have you been hospitalized in the last four years since inception of the contract? Yes No Date:

Diagnosis: e) Previously covered by any other Mediclaim/ Health Insurance : Yes No

f) If yes, Company Name :

SECTION C

DETAILS OF INSURED PERSON HOSPITALIZED

a) Name :

b) Gender : Male Female d) Date of Birth: d d m m y y e) Sum insured: Threshold i) CB (if any)

f) Relatuionship to Primary Insured: Self Spouse Child Father Mother Other (Please specify)

g) Occupation: Service Self Employed Homemaker Student Retired Other (Please specify)

h) Address (if different from above):

City: State:

Pin Code: Phone No: Email ID:

SECTION D

DETAILS OF HOSPITALIZATION

a) Name of Hospital where Admitted:

b) Room category occupied: Suite Deluxe room Single occupancy Twin occupancy 3 or more occupancy

c) Hospitalization due to: Injury Illness Accident d) Date of injury/ Date Disease first detected:

e) Date of Admission: f) Time: : g) Date of Discharge: h) Time: :

i) If injury, give cause: Self inflicted Road Traffic Accident Substance abuse / Alcohol Consumption i. If Medico Legal: Yes No

ii. Reported to police: Yes No iii. MLC Report & Police FIR attached: Yes No j) System of medicine: Allopathy Ayush (Please Specify)

SECTION E

DETAILS OF CLAIM

a) Details of treatment expenses claimed

i. Pre Hospitalization Expenses ₹

ii. Hospitalization Expenses ₹

iii. Post Hospitalization Expenses ₹

iv. Ambulance Charges (by road only) ₹

v. Others (code): ₹

Total ₹

vi. Pre hospitalization period: days

vii. Post hospitalization period: days

b) Claim for Day Care Procedure Yes No

c) Claim for Organ Donor's Medical Expenses Yes No

d) Claim for HIV Treatment Yes No

e) Claim for Morbid Obesity Treatment Yes No

f) Claim for Maternity Yes No

g) Details of Additional Benefits claimed:

i. Hospital Cash: ₹

ii. Home Visit Charges (as per Policy) ₹

Total ₹

Grand Total ₹

Total Cumulative Medical Expenses for which supporting documents submitted (should cross Threshold for claim to be admissible): ₹

Claim Documents Submitted- Check List:

- Claim FormDuly signed
- Copy of the claim intimation, if any
- Hospital Main bill
- Hospital Break-up bill
- Hospital Discharge Summary
- Pharmacy Bill
- Operation Theatre Notes
- ECG
- Doctor's request for investigation
- Investigation Reports (including CT / MRI / USG / HPE)
- Doctor's Prescription
- Others

SECTION F

DETAILS OF BILLS ENCLOSED

Sl. No.	Bill No.	Date	Issued By	Bill Towards	No. of bills	Amount (₹)
1					Hospital Main Bill	
2					Pre hospitalisation Bills: ___ Nos	
3					Post hospitalisation Bills: ___ Nos	
4					Pharmacy Bills:	
5					Others:	
6						
7						
8						
9						
10						

SECTION G

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

a) PAN: b) Account Number:

c) Bank Name

d) Bank Branch

e) Cheque/ DD Payable details: f) IFSC Code:

DECLARATION BY THE INSURED

National Insurance Company Limited

Regd. Office: Premises No. 18-0374, Plot no. CBD-81, New Town, Kolkata - 700156

I hereby declare that the information furnished in this claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent & authorize TPA / insurance company, to seek necessary medical information / documents from any hospital / Medical Practitioner who has attended on the person against whom this claim is made. I hereby declare that I have included all the bills / receipts for the purpose of this claim & that I will not be making any supplementary claim except the pre/post-hospitalization claim, if any.

SECTION H

Date: | | | | | | Place: | | Signature of the insured: | |

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GUIDANCE FOR FILLING CLAIM FORM – PART A (To be filled in by the insured)		
DATA ELEMENT	**DESCRIPTION**	**FORMAT**
SECTION A - DETAILS OF PRIMARY INSURED		
a) Policy No.	Enter the policy number	As allotted by the insurance company
b) Company TPA ID No.	Enter the TPA ID No	License number as allotted by IRDA and printed in TPA documents.
c) Name	Enter the full name of the policyholder	Surname, First name, Middle name
d) Address	Enter the full postal address	Include Street, City and Pin Code
SECTION B - DETAILS OF INSURANCE HISTORY		
a) Currently covered by any other Mediclaim / Health Insurance?	Indicate whether currently covered by another Mediclaim / Health Insurance	Tick Yes or No
b) Date of Commencement of first Insurance without break	Enter the date of commencement of first insurance	Use dd-mm-yy format
c) Company Name	Enter the full name of the insurance company	Name of the organization in full
Policy No.	Enter the policy number	As allotted by the insurance company
Sum Insured	Enter the total sum insured as per the policy	In rupees
d) Have you been Hospitalized in the last 4 years since inception of the contract?	Indicate whether hospitalized in the last 4 years	Tick Yes or No
Date	Enter the date of hospitalization	Use mm-yy format
Diagnosis	Enter the diagnosis details	Open Text
e) Previously Covered by any other Mediclaim/ Health Insurance?	Indicate whether previously covered by another Mediclaim / Health Insurance	Tick Yes or No
f) Company Name	Enter the full name of the insurance company	Name of the organization in full
SECTION C - DETAILS OF INSURED PERSON HOSPITALIZED		
a) Name	Enter the full name of the patient	Surname, First name, Middle name
b) Gender	Indicate Gender of the patient	Tick Male or Female
c) Age	Enter age of the patient	Number of years and months
d) Date of Birth	Enter Date of Birth of patient	Use dd-mm-yy format
e) Relationship to primary Insured	Indicate relationship of patient with policyholder	Tick the right option. If others, please specify.
f) Occupation	Indicate occupation of patient	Tick the right option. If others, please specify.
g) Address	Enter the full postal address	Include Street, City and Pin Code
h) Phone No	Enter the phone number of patient	Include STD code with telephone number
i) E-mail ID	Enter e-mail address of patient	Complete e-mail address
SECTION D - DETAILS OF HOSPITALIZATION		
a) Name of Hospital where admitted	Enter the name of hospital	Name of hospital in full
b) Room category occupied	Indicate the room category occupied	Tick the right option
c) Hospitalization due to	Indicate reason of hospitalization	Tick the right option
d) Date of Injury/Date Disease first detected	Enter the relevant date	Use dd-mm-yy format
e) Date of admission	Enter date of admission	Use dd-mm-yy format
f) Time	Enter time of admission	Use hh:mm format
g) Date of discharge	Enter date of discharge	Use dd-mm-yy format
h) Time	Enter time of discharge	Use hh:mm format
i) If Injury give cause	Indicate cause of injury	Tick the right option
If 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
MLC Report & Police FIR attached	Indicate whether MLC report and Police FIR attached	Tick Yes or No
j) System of Medicine	Enter the system of medicine followed in treating the patient	Open Text
SECTION E - DETAILS OF CLAIM		
a) Details of Treatment Expenses	Enter the amount claimed as treatment expenses	In rupees (Do not enter paise values)
b) Claim Documents Submitted-Check List	Indicate which supporting documents are submitted	Tick the right option
SECTION F - DETAILS OF BILLS ENCLOSED		
Indicate which bills are enclosed with the amounts in rupees		
SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT		
a) PAN	Enter the permanent account number	As allotted by the Income Tax department
b) Account Number	Enter the bank account number	As allotted by the bank
c) Bank Name	Enter the bank name	Name of the Bank in full
d) Bank Branch	Enter the bank branch name	Name of the Bank Branch in full
e) Cheque/ DD payable details	Enter the name of the beneficiary the cheque/ DD should be made out to	Name of the individual/ organization in full
f) IFSC Code	Enter the IFSC code of the bank branch	IFSC code of the bank branch in full
SECTION H - DECLARATION BY THE INSURED		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.		

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CLAIM FORM - PART B

TO BE FILLED IN BY THE HOSPITAL

The issue of theis form is not to be taken as admission of liability

Please include the original preauthorization request form in lieu of PART A

(To be filled in block letters)

SECTION A

DETAILS OF HOSPITAL

a) Name of the Hospital:

b) Hospital ID: c) Type of Hospital: Network ☐ Non Network ☐ (if non network, fill Section E)

d) Name of the treating doctor:

e) Qualification: f) Registration No. with state code: g) Phone No.

SECTION B

DETAILS OF PATIENT ADMITTED

a) Name of Patient:

b) IP Registration No.: c) Gender : Male ☐ Female ☐ d) Age: years ☐☐ months ☐☐ e) Date of Birth: ☐☐ ☐☐ ☐☐☐☐

f) Date of Admission: ☐☐ ☐☐ ☐☐☐☐ g) Time: ☐☐ : ☐☐ h) Date of Discharge: ☐☐ ☐☐ ☐☐☐☐ i) Time: ☐☐ : ☐☐

j) Type of Admission: Emergency ☐ Planned ☐ Day Care ☐ Maternity ☐ k) If Maternity: i. Date of Delivery: ☐☐ ☐☐ ☐☐☐☐ ii. Gravida Status: ☐☐☐

l) Status at time of discharge: Discharged to home ☐ Discharged to another hospital ☐ Deceased ☐ m) Total claimed amount ☐☐☐☐☐☐☐

SECTION C

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a)	ICD 10 Codes	Description	b)	ICD 10 PCS	Description
i. Primary Diagnosis :	☐☐☐☐☐☐☐		i. Procedure 1 :	☐☐☐☐☐☐☐	
ii. Additional Diagnosis :	☐☐☐☐☐☐☐		ii. Procedure 2 :	☐☐☐☐☐☐☐	
iii. Co-morbidities :	☐☐☐☐☐☐☐		iii. Procedure 3 :	☐☐☐☐☐☐☐	
iv. Co-morbidities :	☐☐☐☐☐☐☐		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 injurydue 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

- ☐ Claim Form duly signed
- ☐ Original Pre-authorization request
- ☐ Copy of the Pre-authorization approval letter
- ☐ Copy of photo ID card of patient verified by hospital
- ☐ Hospital discharge summary
- ☐ Oparation Theatre Notes
- ☐ Hospital main bill
- ☐ Hospital break-up bill
- ☐ Investigation reports
- ☐ CT/ MRI/ USG/ HPE/ Investigation reports
- ☐ Doctor's referance slip
- ☐ ECG
- ☐ Pharmacy bills
- ☐ MLC report & Police FIR
- ☐ Original death summary from hospital, where applicable
- ☐ Any other, please specify

SECTION E

ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL 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) 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. If we have made any false or untrue statement, suppress or concealment of anu material fact, our right to claim under this claim shall be forfeited.

Date: ☐☐ ☐☐ ☐☐

Place:

Signature and seal of the hospital authority: