FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

CLAIN FORM -PART A
TO BE FILLED IN BY THE INSURED

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

(To be filled in block letters).

DETAILS OF PRIMARY INSURED

a) Policy No. b) SI No./ Certificate No.

c) Company /TPA No

d) Name

e) Address

City State

Pin Code Phone No. Email ID

DETAILS OF INSURANCE HISTORY:

a) Currently covered by any other Mediclaim/ Health Insurance: ☐ Yes ☐ No

b) Date of commencement of first insurance without break: (copies of Policies to be attached)

c) If Yes, Company Name Policy No.

Sum Insured (Rs.)

d) Have u been hospitalized in the last 4 years? ☐ Yes ☐ No Date M M Y Y Diagnosis

e) Previously covered by any other Mediclaim Health Insurance ☐ Yes ☐ No

f) If Yes, Company Name

DETAILS OF INSURED PERSON HOSPITALIZED:

a) Name:

b) Gender: Male ☐ Female ☐ c) Age: Years Y Y Months M M

d) Date of Birth: D D M M Y Y Y Y

e) Relationship to Primary Insured: Self ☐ Spouse ☐ Child ☐ Father ☐ Mother ☐ Other ☐ Please specify

f) Occupation: Service ☐ Self Employed ☐ Homemaker ☐ Student ☐ Retired ☐ Other ☐ Please specify

g) Address:

City State

Pin Code Phone No. Email ID

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DETAILS OF HOSPITALIZATION

a) Name of Hospital where admitted:

b) Room Category Occupied: Day Care ☐ Single Occupancy ☐ Twin Sharing ☐ 3 or more beds per month ☐

c) Hospitalization due to: Injury ☐ Illness ☐ Maternity ☐

d) Date of Injury /Date of disease first detected/ Date of Delivery: D D M M Y Y Y Y

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

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

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

DETAILS OF CLAIM

a) Details of treatment expenses claimed

i Pre-hospitalization Expenses Rs. ii Hospitalization Expenses: Rs.

iii Post-hospitalization Expenses Rs. iv Health Check Up Cost Rs.

v Ambulance Charges Rs. vi Others (Code) Rs.

TOTAL Rs.

vii Pre-Hospitalization Period Days viii Post-Hospitalization Period Days

b) Claim for Domiciliary Hospitalization: ☐ Yes ☐ No (if yes provide details in Annexure)

c) Details of Lumpsum/cash benefit claimed

i Hospital Daily Cash Rs. ii Surgical Cash Rs.

iii Critical Illness Benefit Rs. ii Convalescence Rs.

i Pre/Post hospitalization lumpsum benefit Rs. vi Others (Code) Rs.

TOTAL Rs.

Claims Documents Submitted Check List

☐	Claim Form duly signed	☐	Hospital Discharge Summary
☐		☐	Operation Theatre Notes
☐	Copy of the claim	☐	ECG
☐	Hospital Break Up Bill	☐	Doctors Request for investigation
☐	Hospital Payment Receipt	☐	Investigation reports (including CT/MRI/USG/HPE)
☐	Hospital Bill	☐	Doctor's Prescrition

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DETAILS OF BILLS																			
Sl No	Bill No	Date						Issued by		Amount (Rs.)									
1																			
2																			
3																			
4																			
5																			
6																			
7																			
8																			
9																			
10																			

DETAILS OF PRIMARY ISNURED'S BANK ACCOUNT:

a) PAN: b) Account Number

c) Bank Name & Brance:

d) Cheque DD Payable Details: e) IFSC Code:

DECLARATION BY THE INSURED

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, 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.

Date: D D M M Y Y Y Y Place: Signature of Insured:

IMPORTANT NOTE:

Below KYC documents of policy proposer is mandatory if Insured is submitting reimbursement /cashless claim having claimed amount equal to or more that Rs.1 Lakh.

1) **Duly filled KYC Form**
2) **Copy of Address & Photo Identification proof.**

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GUIDELINES 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) SI No. / Certificate No.	Enter the social insurance number or the certificate number of social health insurance scheme	As allotted by the organization
c) Company TPA ID No	Enter the TPA ID No	License number as allotted by IRDAI and printed in TPA Documents.
d) Name	Enter the full name of the Policyholder	Surname, First Name, Middle Name
e) 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 u been hospitalized in the last 4 years?	Indicate whether hospitalized in the last 4 years	Tick Yes or No
Date	Enter the date of hospitalization	Use dd-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 the 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 email 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

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c) Hospitalization due to	Indicate reason of hospitalization	Tick the right option
d) Date of injury / Date of disease first detected / Date of Delivery.	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 details	Indicate cause of Injury	Tick the right option
If medico Legal	Indicate 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 for Domiciliary Hospitalization	Indicate whether claim is for domiciliary hospitalization	Tick Yes or No
c) Details of Lump sum / cash benefit claimed	Enter the amount claimed as Lumpsum /cash benefit	In Rupees (do not enter paise values)
d) 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 and Branch	Enter the bank name along with the branch	Name of the Bank in full
d) 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
e) 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 carefully and mention date (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 this form is not to be taken as an admission of liability
Please include the original preauthorization request form in lieu of PART A

(To be filled in block letter)

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 treating doctor:

e) Qualification: f) Registration No. with state Code:

g) Phone No:

DETAILS OF THE PATIENT ADMITTED

a) Name of the patient:

b) IP Registration Number: c) Gender: Male ☐ Female ☐

d) Age: Years Months e) Date of Birth: D D M M Y Y

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

h) Date of Discharge: D D M M Y Y i) Time: H H : M M

j) Type of Admission: Emergency ☐ Planned ☐ Day Care ☐ Maternity ☐

k) If maternity i. Date of Delivery D D M M Y Y ii. Gravida Status

l) Status at the time of Discharge: Discharge to Home ☐ Discharge to another hospital ☐ Deceased ☐

DETAILS OF AILMENTS DIAGNOSED

a)		ICD 10 Codes	Description
i.	Primary Diagnos		
ii	Additional Diagn		
iii	Co-morbidities		
iv	Co-morbidities		

b)		ICD 10 PCS	Description
i.	Procedure 1		
ii	Procedure 2		
iii	Procedure 3		
iv	Details of Procedure		

c) Present ailment is a complication of PED? Yes No (if yes, specify details)

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d) Pre-authorization obtained: ☐ Yes ☐ No e) Preauthorization Number:

f) If authorization by network hospital not obtained, give reason:

g) 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 report)

iii. If Medico Legal ☐ Yes ☐ No iv. Reported to Police ☐ Yes ☐ No

v. FIR No. vi. If not reported to Police, give reason

CLAIM DOCUMENTS SUBMITTED -CHECK LIST

- ☐ Claim Form Duly 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 reports
- ☐ Doctors reference slip for investigation
- ☐ ECG
- ☐ Pharmacy Bills
- ☐ MLC Report & Police FIR
- ☐ Original Death Summary from hospital where applicable
- ☐ Any other, please specify

DETAILS IN CASE OF NON-NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)

a) Address of Hospita

City State

Pin Code b) Phone No. c) Registration No

d) PAN No. e) Number of Inpatient Beds

f) Facilities available in the hospital: i OT ☐ Yes ☐ No ii. ICU ☐ Yes ☐ No

iii. Others

DECLARATION BY THE INSURED

I hereby declare that the information furnished in this claim for 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, 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.

Date D D M M Y Y **Place** Signature of Insured

DECLARATION BY THE HOSPITAL

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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. The signature of the Insured is taken on this form after claim Form B is fully filled up by us.

Date D D M M Y Y

Place

Signature and seal of Hospital Authority

GUIDELINES FOR FILLING CLAIM FORM -PART B (To be filled in by the Hospital)		
DATA ELEMENT	**DESCRIPTION**	**FORMAT**
SECTION A- DETAILS OF PRIMARY INSURED		
a) Name of Hospital	Enter the Name of Hospital	Name of Hospital in full
b) Hospital ID	Enter ID Number of Hospital	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 treating doctor	Name of doctor in full
e) Qualification	Enter the qualification of treating doctor	Abbreviations of educational qualifications
f) Registration No. with State Code	Enter the registration number of the doctor along with the state code	As allocated by medical council of India
g) Phone No.	Enter the phone number of doctor	Include STD Code with telephone number
SECTION B- DETAILS OF PATIENT ADMITTED		
a) Name of the patient	Enter the Name of Hospital	Name of Hospital in full
b) IP Registration Number	Enter insurance provider registration number	As allocated by 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 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) Type of Admission	Indicate type of admission of patient	Tick the right option
j) If maternity		
Date of delivery	Enter the date of delivery if maternity	Use dd-mm-yy format
Gravida Status	Enter gravida status if maternity	Use standard format
k) Status at the time of Discharge	Indicate status of patient at the time of Discharge	Tick the right option
SECTION C- DETAILS OF AILMETS DIAGNOSED (PRIMARY)		
a) ICD 10 Code		
Primary Diagnosis		
Additional Diagnosis		
Comorbidities		
b) ICD 10 PCS		
Procedure 1	Indicate occupation of patient	

Procedure 2		
Procedure 3		
Details of Procedure		