



# National Insurance Company Limited

Regd. Office 3, Middleton Street, Post Box 9229, Kolkata 700 071

## National Mediclaim Policy

### CLAIM FORM - PART A

TO BE FILLED IN BY THE INSURED

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

(To be filled in block letters)

#### DETAILS OF PRIMARY INSURED

a) Policy no: \_\_\_\_\_ b) Sl. No/ Certificate No: \_\_\_\_\_

c) Company/ TPA ID No: \_\_\_\_\_

d) Name: \_\_\_\_\_

e) Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Pin Code: \_\_\_\_\_ Phone No: \_\_\_\_\_ Email ID: \_\_\_\_\_

SECTION A

#### 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 B

#### DETAILS OF INSURED PERSON HOSPITALIZED

a) Name: \_\_\_\_\_

b) Gender: Male  Female  d) Date of Birth: \_\_\_\_\_ e) Sum insured: ₹ \_\_\_\_\_ i) CB (if any) \_\_\_\_\_

f) Relationship 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 C

#### DETAILS OF HOSPITALIZATION

a) Name of Hospital where Admitted: \_\_\_\_\_

b) Room category occupied: Day Care  Single occupancy  Twin sharing  3 or more beds per room

c) Hospitalization due to: Injury  Illness  Maternity  d) Date of injury/ Date Disease first detected/ Date of Delivery: \_\_\_\_\_

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: \_\_\_\_\_

SECTION D

#### DETAILS OF CLAIM

a) Details of treatment expenses claimed

i. Pre Hospitalization Expenses ₹ \_\_\_\_\_ ii. Pre hospitalization period: \_\_\_\_\_ days \_\_\_\_\_

i. Room, boarding, nursing expenses \_\_\_\_\_ days @ ₹ \_\_\_\_\_ per day [Limit of 1% of SI per day, max ₹5,000] Maximum limit of 25% of SI for any one illness

ii. ICU, boarding, nursing expenses \_\_\_\_\_ days @ ₹ \_\_\_\_\_ per day [Limit of 2% of SI per day, max ₹10,000]

i. Medical practitioner's fees ₹ \_\_\_\_\_ Maximum limit of 25% of SI for any one illness

i. Anaesthesia, blood, oxygen, OT ₹ \_\_\_\_\_

ii. Surgical appliances ₹ \_\_\_\_\_

iii. Medicines, drugs ₹ \_\_\_\_\_

iv. Diagnostic test ₹ \_\_\_\_\_

v. Pacemaker, artificial limbs, stent and imr ₹ \_\_\_\_\_ Maximum limit of 50% of SI for any one illness

vi. Dialysis ₹ \_\_\_\_\_

vii. Chemotherapy ₹ \_\_\_\_\_

viii. Radiotherapy ₹ \_\_\_\_\_

ix. Expense for organ donor's treatment ₹ \_\_\_\_\_

x. Ambulance Charges ₹ \_\_\_\_\_ [Limit of 1% of SI per day, max ₹2,000]

i. Ayurveda and Homeopathy ₹ \_\_\_\_\_ Maximum limit of 20% of SI for any one illness

ii. Post Hospitalization Expenses ₹ \_\_\_\_\_

i. Health Check up Cost ₹ \_\_\_\_\_

Total claimed amount ₹ \_\_\_\_\_

Claim Documents Submitted- Check List:

Claim Form/Duly 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 /

Doctor's Prescription

Others

SECTION E

#### DETAILS OF BILLS ENCLOSED

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

SECTION F

#### DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

a) PAN: \_\_\_\_\_ b) Account Number: \_\_\_\_\_

c) Bank Name and Branch: \_\_\_\_\_

d) Cheque/ DD Payable details: \_\_\_\_\_ e) IFSC Code: \_\_\_\_\_

SECTION G

#### 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 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
<b>SECTION A - DETAILS OF PRIMARY INSURED</b>		
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 IRDA 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
<b>SECTION B - DETAILS OF INSURANCE HISTORY</b>		
a) Currently covered by any other Mediciam / Health Insurance?	Indicate whether currently covered by another Mediciam / 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 Mediciam/ Health Insurance?	Indicate whether previously covered by another Mediciam / Health Insurance	Tick Yes or No
f) Company Name	Enter the full name of the insurance company	Name of the organization in full
<b>SECTION C - DETAILS OF INSURED PERSON HOSPITALIZED</b>		
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
<b>SECTION D - DETAILS OF HOSPITALIZATION</b>		
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/ 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 cause	Indicate cause of injury	Tick the right option
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
<b>SECTION E - DETAILS OF CLAIM</b>		
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 lump sum/ 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
<b>SECTION F - DETAILS OF BILLS ENCLOSED</b>		
Indicate which bills are enclosed with the amounts in rupees		
<b>SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT</b>		
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
<b>SECTION H - DECLARATION BY THE INSURED</b>		
Read declaration carefully and mention date (in dd.mm.yy format), place (open text) and sign.		



National Medclaim Policy
CLAIM FORM - PART B
TO BE FILLED IN BY THE HOSPITAL

The issue of this 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)

DETAILS OF HOSPITAL

Form fields for hospital details including Name of Hospital, Hospital ID, Type of Hospital (Network/Non Network), Name of treating doctor, Qualification, Registration No., and Phone No.

DETAILS OF PATIENT ADMITTED

Form fields for patient details including Name of Patient, IP Registration No., Gender, Age, Date of Birth, Date of Admission, Time, Date of Discharge, Type of Admission (Emergency/Planned/Day Care/Maternity), Date of Delivery, Gravidity Status, Status at time of discharge, and Total claimed amount.

DETAILS OF ALLMENT DIAGNOSED (PRIMARY)

Form fields for diagnosis and procedure details including ICD 10 Codes, Description, ICD 10 PCS, Procedure 1-3, Details of Procedure, Pre-authorization status, and injury details.

CLAIM DOCUMENTS SUBMITTED - CHECKLIST

Checklist of submitted documents including Claim Form, Pre-authorization request, Approval letter, Photo ID card, Discharge summary, Theatre Notes, Main bill, Break-up bill, Investigation reports, CT/MRI/USG/HPEI reports, Doctor's reference slip, ECG, Pharmacy bills, MLC report & Police FIR, and Original death summary.

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

Form fields for non-network hospital details including Address, City, State, Pin Code, Phone No., Registration No., and Facilities available (OT, ICU).

DECLARATION BY THE HOSPITAL

(Please read very carefully)

Declaration text and signature fields for the hospital and the insured.

SECTION A

SECTION B

SECTION C

SECTION D

SECTION E

SECTION F



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GUIDANCE FOR FILLING CLAIM FORM – PART B (To be filled in by the hospital)		
DATA ELEMENT	DESCRIPTION	FORMAT
<b>SECTION A - DETAILS OF HOSPITAL</b>		
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 the treating doctor	Name of doctor in full
e) Qualification	Enter the qualifications of the 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 the Medical Council of India
g) Phone No.	Enter the phone number of doctor	Include STD code with telephone number
<b>SECTION B – DETAILS OF THE PATIENT ADMITTED</b>		
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 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 Date of Delivery if maternity	Use dd-mm-yy format
Gravida Status	Enter Gravida status if maternity	Use standard format
k) Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
<b>SECTION C – DETAILS OF AILMENT DIAGNOSED (PRIMARY)</b>		
a) ICD 10 Code		
Primary Diagnosis	Enter the ICD 10 Code and description of the primary diagnosis	Standard Format and Open text
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 co-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
<b>SECTION D – CLAIM DOCUMENTS SUBMITTED-CHECK LIST</b>		
Indicate which supporting documents are submitted		
<b>SECTION E – DETAILS IN CASE OF NON NETWORK HOSPITAL</b>		
a) Address	Enter the full postal address	Include Street, City and Pin Code
b) Phone No.	Enter the phone number of hospital	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
<b>SECTION F - DECLARATION BY THE INSURED</b>		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.		