BAJAJ | Allianz

Bajaj Allianz General Insurance Company Limited.
Regd. & Head Office : GE Plaza, Airport Road, Yerawada, Pune 411 006

Health Administration Team : *A - Wing 2nd Floor, Bajaj Finserv Building, Behind Weikfield IT Park, Off Nagar Road, Viman Nagar | Pune - 411 014
Phone No.: 020-30305858/ 1800-103-2529 Fax: 020-30512224/ 6/ 7
Email: preauth@bajajallianz.co.in

(To be filled in block letters)

CASHLESS FORM

PLEASE FAX/SCAN PAGE 1 AND 2 ONLY
REQUEST FOR CASHLESS HOSPITALISATION FOR MEDICAL INSURANCE POLICY

DETAILS OF THE PROVIDER

SECTION A

Hospital Name/nursing Home Name:____________________

City Name:____________________ Pin Code: [| | | | | | | | | | | | |]

State Name:____________________ Hosp Id: [| | | | | | | | | | | | |]

Landmark:____________________

Hospital Contact No: __________ Fax No: __________ TPA desk No __________ Email id: __________

TO BE FILLED BY THE INSURED/PATIENT

SECTION B

a) Name of the Patient: ____________________

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) Name of the Attendant:____________________ f) Contact number, if any: [| | | | | | | | |]

g) Contact number: [| | | | | | | | |] h) Insured card ID number: [| | | | | | | | | | | | | | |]

I) Policy number I Name of corporate:____________________

j) Employee ID: [| | | | | | | | | | | | | | |]

k) Currently do you have any other Mediclaim / Health insurance: [ ] Yes [ ] No

Company Name:____________________

Give details:____________________

l) Do you have a family physician: [ ] Yes [ ] No m) Name of the family physician:____________________

n)Contact number, if any: [| | | | | | | | |]

o) Insured E-mail id____________________ **(PLEASE COMPLETE DECLARATION ON THE REVERSE SIDE OF THIS FORM)**

TO BE FILLED BY THE TREATING DOCTOR / HOSPITAL

SECTION C

a) Name of the treating doctor: ____________________ b) Contact number: [| | | | | | | | |]

c) Nature of ILLNESS / Disease with presenting complaints____________________

d) Relevant clinical findings:____________________

e) Duration of the present ailment: [| |] Days i. Date of first consultation: [D|D] [M|M] [Y|Y|Y|Y]

i. 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 [ ] Non allopathic treatment

h) If Investigation & I 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 injury occur:____________________

I) In case of accident: i. Is it RTA: [ ] Yes [ ] No ii. Date of injury: [D|D] [M|M] [Y|Y|Y|Y]

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 establish this : [ ] Yes [ ] No (If Yes attach reports)

I) In case of Maternity: G [ ] P [ ] L [ ] A [ ] Date of Delivery: [D|D] [M|M] [Y|Y|Y|Y] LMP: [D|D] [M|M] [Y|Y|Y|Y]

Details of the patient admitted

a) Date of admission: D D M M Y Y   b) Time: H H : M M

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

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

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

g) Expected cost for investigation + diagnostics.: Rs. ____

h) ICU Charges: Rs. ____

i) OT Charges: Rs. ____

j) Professional fees Surgeon + Anesthetist Fees + consultation Charges Rs. ____

k) Medicines + Consumables + Cost of Implants specify). Other hospital expenses if any: Rs. ____

l) All inclusive package charges if any applicable Rs. ____

m) Sum Total expected cost of hospitalization Rs. ____

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: ____________

(PLEASE READ VERY CAREFULLY)

DECLARATION

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

a) Name of the treating doctor:____________

b) Qualification:____________ c) Registration No. with State Code: ____

Hospital Seal (Must include Hospital ID)

Patient Insured Name & Signature

SECTION D

DECLARATION BY THE PATIENT / REPRESENTATIVE

1. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Bajaj Allianz General Insurance Company Limited 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 Bajaj Allianz General Insurance Company Limited 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 Bajaj Allianz General Insurance Company Limited not governed by the terms and conditions of the policy will be paid by me.
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 Bajaj Allianz General Insurance Company Limited
5. I agree and understand that Bajaj Allianz General Insurance Company Limited is in no way warranting the service of the hospital & that the Bajaj Allianz General Insurance Company Limited 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 with respect to the claim, my right to claim reimbursement of the said expenses shall be absolutely forfeited.
7. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Bajaj Allianz General Insurance Company Limited
8. I Agree to be abide by the AML guidelines issued by IRDA*

a) Patient's / insured's Name: ______________________________

b) Contact number: | | | | | | | | | | |

c) Patient's / Insured's Signature:

HOSPITAL DECLARATION

1. We have no objection to any authorized Bajaj Allianz General Insurance Company Limited official verifying documents pertaining to hospitalization.
2. All valid original documents duty countersigned by the insured I patient as per the checklist below will be sent to Bajaj Allianz General Insurance Company Limited 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 Bajaj Allianz General Insurance Company Limited, OR arising out of incorrect information in the pre-authorisation form will be collected from the patient.
4. WE AGREE THAT BAJAJ ALLIANZ GENERAL INSURANCE COMPANY LIMITED 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 I 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.

*As per IRDA circular Ref: IRDA/SDD/GDL/CIR/020/02/2013 Anti-Money Laundering /Counter Financing of Terrorism (AML/CFT)-Guidelines for General Insurers All general insurance companies are required to carry out KYC norms at the settlement stage where claim payout crosses a threshold of ` One lakh per claim. In cases where payments are made to third party service providers such as hospitals, the KYC norms shall apply on the customers on whose behalf service providers act.

HEALTH CLAIM MANDATORY DOCUMENTS CHECKLIST FOR HOSPITALIZATION CLAIMS

Sr. No	Name of Documents
1	Duly filled and signed Bajaj Allianz Health Insurance Claim Form.
2	Original Discharge Summary stating the date of admission, date of discharge, presenting complaints with duration ,clinical condition, detailed line of treatment, final diagnosis and past medical and surgical history with duration.
3	Original Hospital Bill giving detailed break up of all expense heads mentioned in the bill. Clear break ups have to be mentioned for OT Charges, Doctor's Consultation and Visit Charges, OT Consumables, medicines, Transfusions, Room Rent, etc.
4	Original Paid Receipt with revenue stamp, hospital seal and signature towards the final hospital bill of Hospital for hospitalization period.
5	All Laboratory and Diagnostic Test Reports. E.g. X-Ray, E.C.G, USG, MRI Scan, Haemogram etc.
6	Completely filled NEFT Details stating Branch MICR Code, IFSC Code & Account type, Complete Account Number duly signed by Policy Holder/proposer with Preprinted canceled cheque (Note ;First page of Bank pass book or statement would be mandatory if account number is ink stamped and name of the account holder is not printed. All Fields in the form are mandatory to process).
*7	In case of Surgeries where Implant and Stent has been used copy of invoice /stickers/Barcode of Implant used will have to be enclosed.
*8	First Consultation letter from the Doctor
*9	For Retail Claims:- In case claim amount is INR 1 lac and above then KYC(Know your customer) form will require with photo dully completed filled and signed by insured along with AML documents: Pan card/passport/Voter identity card (For identity proof), Bank account statement/electricity bill/Telephone bill (For the residential proof).

* 1) Waiver of condition (7) and (8) may be considered from case to case basis
2) Health Administration Team reserves right to raise deficiencies for any other document depending upon case to case basis to ascertain admissibility of claim.
3) If beneficiary is corporate, NEFT details of employee/nominee are not required.

Mandate Form for Electronic Transfer of Claim Payments

To **Bajaj Allianz General Insurance Company Ltd**	**Office Code & Name :** **i-track Number :**

Partner ID *(To be filled by Office)*: | | | | | | | | | |

Full Name: Shri / Smt / Kum / M/s ____
(As appears in your bank account)

Full Address: ____

_______________________________________PIN Code: _________________

Contact / Mobile No: ___________ ___Email ID:____

Bank Name:																
Branch Name & Address:																
Branch Tel No & Contact No:																
Branch IFSC Code for NEFT																
Branch MICR Code																
Name of the Account Holder : (As per Bank Account)																
Account Type		Savings		Current		Cash Credit										
Account No. (as appearing in the cheque book)																

I/we have read the declarations / conditions mentioned overleaf.

Place: ____________________Date: _____________ (Beneficiary's Signature)_______________________________

MANDATORY REQUIREMENT

PLEASE ATTACH HERE

Cancelled blank Cheque of your bank for ensuring accuracy of name of the bank, branch name, Account number and IFSC code. If NAME OR IFSC code of the payee is not printed on the cheque leaf, please attach copy of the first page of the bank passbook also.

I have verified the documents attached with the mandate and confirm that these documents correctly belong to the Partner ID & Partner Name mentioned in the mandate. (To be verified by superior)

Employee Code_______ Employee Name:_________________________ Designation_________________

Place ___________________ Date___________ Signature ___________________________________

DECLARATION

- I / We hereby declare that the particulars given above are correct and complete and no blanks have been left. If the transaction is delayed or not effected at all for reason of incomplete or incorrect information I / we would not hold Bajaj Allianz General Insurance Company Limited responsible.

- I / We undertake to revoke the instruction for NEFT in the event of the business relationship expiring and or being 'terminated' and further hereby specifically authorize Bajaj Allianz General Insurance Company Limited, to do so, for me and on my behalf, in case the revocation communication is not received from me within seven days of expiry and or being termination of relationship.

- I / We further undertake to refund, at any time, any excess amount whether demanded by Bajaj Allianz General Insurance Company Limited or not, which has been credited to my account [due to any reason] by Bajaj Allianz General Insurance Company Limited, in excess of (i) the amount due to me, or (ii) in excess of amount for which I gave mandate, and or (iii) agreed rent/license fees/compensation/refundable security deposit/Commission/Claim/Refund/ Any other payment.

- I / We agree that the payment will be endeavoured to be credited starting from the date of next payment cycle and unless the Mandate is revoked by me/us issuance of relevant credit instruction for electronic payment from Bajaj Allianz General Insurance Company Limited into the aforesaid account will be valid discharge to Bajaj Allianz General Insurance Company Limited for having paid (i) the amount due to me, or (ii) in excess of amount for which I gave mandate, and or (iii) agreed rent/license fees/compensation/refundable security deposit/ Commission/Claim/Refund/ Any other payment.

- I / We further confirm that we understand this mode as a method of payment introduced by Reserve Bank of India, which provides us an option to receive the amount and or to collect our payments by electronic payment mode directly through my/our bank accounts.

- I / We further confirm that I/we understand, Bajaj Allianz General Insurance Company Limited, shall make electronic payment to my account by issuing the Payment instruction electronically through its banker to the Clearing Authority and the Clearing Authority would ensure credit to my/our specified bank account provided hereinabove.

- I / We further undertake to inform Bajaj Allianz General Insurance Company Limited with an advance notice of 6 weeks, to withdraw from this mode of electronic payment.

- I / We further confirm that Bajaj Allianz General Insurance Company Limited will have, at its sole discretion, the right to return back to the option of paying to me/us by way of cheque if there are more than 2 consecutive failures in remittances for no fault on the side of Bajaj Allianz General Insurance Company Limited.

- After Bajaj Allianz General Insurance Company Limited issuing the Payment instruction electronically through its banker, for whatever reasons, if I/we do not get the credit to my/our account, then same shall neither constitute the default in (i) Payment of amount requested by me, or (ii) Payment of amount due to me/us, or (iii) Payment of agreed rent/license fees/compensation/refundable security deposit/ commission/claim/ Refund/Any other payment by Bajaj Allianz General Insurance Company Limited nor constitute default of any terms and conditions of any agreement/MOU/ Claim/Refund/Other contract and or Lease agreement/Leave and license agreement with me/us.

BAJAJ Allianz

Bajaj Allianz General Insurance Company Limited.
Regd. & Head Office : GE Plaza, Airport Road, Yerawada, Pune 411 006
Email id:-customercare@bajajallianz.co.in
Toll free no:1800-209-5858
020-30305858

(To be filled in block letters)

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

TO BE FILLED IN BY THE INSURED
The issue of this form is not to be taken as an admission of liability

SECTION A

DETAILS OF PRIMARY INSURED

a) Policy No: b) Sl. No/Certificate No:
c) Company TPA ID No: d) Customer ID:
e) Company Name:__________ f) Employee No:__________
g) Name:
h) 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 (Rs.):
d) Have you been hospitalized in the last four years since inception of the contract? Yes No Date: D D M M Y Y Y Y
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 of the Patient:__________
b) Health ID card no of the Patient:__________
c) Gender: Male Female d) Age: years months e) Date of Birth D D M M Y Y Y Y
f) Relationship of 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:
I) Phone No: J) Email ID:__________

SECTION D

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) Hospitalisation due to: Injury Illness Maternity
d) Date of Injury/Date 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) Name of treating doctor__________ Diagnosis__________
j) 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 and Police FIR attached: Yes No j) System of Medicine

DETAILS OF CLAIM

a) Details of the treatment expenses claimed

I. Pre-Hospitalisation Expenses: Rs. | | | | | | |

ii. Hospitalisation Expenses Rs. | | | | | | |

iii. Post-Hospitalisation Expenses: Rs. | | | | | | |

iv. Health checkup cost Rs. | | | | | | |

v. Ambulance Charges: Rs. | | | | | | |

vi. Others (code) Rs. | | | | | | |

Total Rs. | | | | | | |

vii. Pre-Hospitalisation period: days | | |

viii. Post Hospitalisation period: days | | |

b) Claim for Domiciliary Hospitalisation: Yes [ ] No [ ] (If yes, provide details in annexure)

c) Details of Lump sum / cash benefit claimed:

i. Hospital Daily Cash Rs. | | | | | | |

ii. Surgical Cash Rs. | | | | | | |

iii. Critical illness Benefit Rs. | | | | | | |

iv. Convalescence Rs. | | | | | | |

v. Pre/Post hospitalisation lump sum benefit Rs. | | | | | | |

vi. Others Rs. | | | | | | |

Total Rs. | | | | | | |

Claim Documents Submitted – Check List

- [ ] Claim Form Duly Signed
- [ ] Copy of claim intimation if any
- [ ] Original Hospital Main Bill
- [ ] Original Hospital Breakup Bill
- [ ] Original Hospital Bill Payment Receipt
- [ ] Original Hospital Discharge SummaryPharmacy Bill
- [ ] Operation Theater Notes
- [ ] ECG
- [ ] Original Doctor's Prescriptions
- [ ] Original Doctors request for investigation reports (including CT/MRI/USG/HPE)
- [ ] Others
- [ ] Cancelled blank cheque leaf with payee name printed. If name of the payee is not printed on the cheque leaf please attach copy of the first page of the bank passbook.

DETAILS OF BILLS ENCLOSED

Sr.No	Bill No	Date						Issued by	Towards	Amount (Rs)						
1		D	D	M	M	Y	Y		Hospitalisation Main Bill							
2		D	D	M	M	Y	Y		Pre-Hospitalisation Bills:__Nos							
3		D	D	M	M	Y	Y		Post-Hospitalisation Bills:__Nos							
4		D	D	M	M	Y	Y		Pharmacy Bills							
5		D	D	M	M	Y	Y									
6		D	D	M	M	Y	Y									
7		D	D	M	M	Y	Y									
8		D	D	M	M	Y	Y									
9		D	D	M	M	Y	Y									
10		D	D	M	M	Y	Y									

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

a) Name of the Account Holder (As per Bank Account):______________________

b) Account no (As appearing in the cheque book): | | | | | | | | | | | | | | | | | |

c) Bank Name :______________________

d) Branch Name & Address:______________________:

e) Account Type : Saving [ ] Current [ ] Cash Credit [ ]

f) MICR No. | | | | | | | | | | | | |

g)IFSC Code: | | | | | | | | | | | | |

h) PAN: | | | | | | | | | | | | |

i) Cheque / DD Payable Details: [ ]

DECLARATION

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 Bajaj Allianz General Insurance Company Limited, to seek necessary medical information / documents from any hospital / Medical Practitioner who ha s 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 the Insured

SECTION E

SECTION F

SECTION G

SECTION H

GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled in by the insured)		
DATA ELEMENT	DESCRIPTION	FORMAT
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 a s allotted by IRDA and printed in TPA documents.
g) Name	Enter the full name of the policyholder	Surname, First name, Middle name
h) 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 Policy No. Sum Insured	Enter the full name of the insurance company Enter the policy number Enter the total sum insured a s per the policy	Name of the organization in full As allotted by the insurance company In rupees
d) Have you been Hospitalized in the last four years since inception of the contract? Date Diagnosis	Indicate whether hospitalized in the last four years Enter the date of hospitalization Enter the diagnosis details	Tick Yes or No Use dd-mm-yy format 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 of the Patient	Enter the full name of the patient	Surname, First name, Middle name
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 Birth	Enter Date of Birth of patient	Use dd-mm-yy format
f) Relationship to primary Insured	Indicate relationship of patient with policyholder	Tick the right option. If others, please specify.
g) Occupation	Indicate occupation of patient	Tick the right option. If others, please specify.
h) Address	Enter the full postal address	Include Street, City and Pin Code
i) Phone No	Enter the phone number of patient	Include STD code with telephon number
j) 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/ 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 i) If Injury give cause If Medico legal Reported to Police MLC Report & Police FIR attached	Enter time of discharge indicate cause of injury indicate whether injury is medico legal indicate whether police report was filed indicate whether MLC report and Police FIR attached	Use hh:mm format Tick the right option Tick Yes or No Tick Yes or No 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 a s 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
Indicate which bills are enclosed with the amounts in rupees		
SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT		
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
i) 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
g) IFSC Code	Enter the IFSC code of the bank branch	FSC code of the bank branch in full
h) PAN	Enter the permanent account number	As allotted by the Income Tax department
SECTION H - DECLARATION BY THE INSURED		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.		

BAJAJ Allianz

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Regd. & Head Office : GE Plaza, Airport Road, Yerawada, Pune 411 006
Email id: customercare@bajajallianz.co.in, **Toll free no.** 1800-209-5858, 020-30305858

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

SECTION A

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

SECTION B

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 time of discharge: Discharge to home ☐ Discharge to another hospital ☐ Deceased: ☐ m) Total claimed Amount: | | | | | | | |

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

SECTION C

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:		

d) Pre-Authorization Obtained: Yes ☐ No ☐ e) Pre-Authorization Number: | | | | | | | | | | | | |

f) If authorization by network hospital no 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 reports) iii)Medico Legal: Yes ☐ No ☐

iv)Reported to Police: Yes ☐ No ☐ v) FIR no: ______ vi) if not reported to police give reason: ______

CLAIM DOCUMENTS -CHECK LIST

SECTION D

- ☐ Claim form duly signed
- ☐ Original Pre-Authorization request
- ☐ Copy of Pre-Authorization letter
- ☐ Copy of photo ID card of patient verified by hospital
- ☐ Hospital discharge summary
- ☐ Operation theatre notes
- ☐ Hospital main bill
- ☐ Hospital break up bill
- ☐ Ingestion reports
- ☐ CT/MR/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, please specify

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

SECTION E

a) Address of hospital______

City:______ State: ______ Pin Code: ______ Phone No: ______ c) Registration no with State Code: ______

d) Hospital PAN:______ e) Number of Inpatient beds: | | | Facilities available in hospital: i) OT: Yes ☐ No ☐ ii) ICU: Yes ☐ No ☐

iii) Others: ______

DECLARATION BY THE HOSPITAL: (PLEASE READ VERY CAREFULLY)

SECTION F

We hereby declare that the information furnished in the Claim Form is true and correct to the best of our knowledge and belief. If we have made any false and untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited.

Date : D D M M Y Y

Place : ______

Signature and Seal of the Hospital Authority

GUIDANCE FOR FILLING CLAIM FORM - PART B (To be filled in by the hospital)		
DATA ELEMENT	**DESCRIPTION**	**FORMAT**
	SECTION A - DETAILS OF HOSPITAL	
a) Name of Hospital	Enter the name of hospital	Name of hospital in full
b) Hospital ID	Enter ID number of the hospital	As allocated by 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 no of treating doctor along with state code	As allocated by the medical council of India
g) Phone No	Enter the phone no of doctor	Include STD code with telephone number
SECTION B - DETAILS OF THE PATIENT ADMITTED		
a) Name of the patient	Enter the name of hospital	Name of hospital in full
b) IP Registration number	Enter the insurance provide registration number	As allocated by the insurance provide
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 Birth	Enter date of admission	Use dd-mm-yy format
f) Date of Admission	Enter date of admission	Use dd-mm-yy format
g) Time	Enter date of admission	Use hh:mm format
h) Date of Discharge	Enter date of discharge	Use dd-mm-yy format
i) Time	Enter time of discharge	Use hh:mm format
j) Type of Admission	Indicate type of admission of patient	Tick the right option
k) 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
l) Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
m)Total claimed amount	Indicate the total claimed amount	In rupees (Do not enter paise values)

SECTION C - DETAILS OF AILMENT DIAGNOSED (PRIMARY)		
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 tex
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
SECTION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST		
Indicate which supporting documents are submitted		
SECTION E - DETAILS IN CASE OF NON NETWORK HOSPITAL		
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
SECTION F - DECLARATION BY THE HOSPITAL		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign and stamp		

BAJAJ | Allianz

Affix Passport Size Recent
Photograph
And
Sign Across

Company / Firms
Representative

Self Declaration of **KYC Document** Submission

For Institute/Company Partner

To,

Bajaj Allianz General Insurance Co. Ltd

G.E. Plaza, Airport Road,
Yerawada, Pune - 411006

Company Representative / Officer Name ....

Designation ....

Name of Payment Receiver Company / Firms ....

Address..

City...State.. Pin Code..

Telephone No... Mobile No..

(Please tick the relevant document in the list below)

Proof of Identity (any one)	Proof of Residential Address (any one)
☐ Memorandum & Articles of Association	☐ Land Line Telephone Bill
☐ Resolution of the Board for Accounts	☐ Co / Firms Electricity Bill
☐ Power of Attorney / Letter to Transact business	☐ Co / Firms Registration Certificate
☐ Copy of PAN Card , allotment letter	
☐ Co / firms Registration Certificate	
☐ Partnership Deed	
☐ Memorandum & Articles of Association	

The documents provided as proof of identity and proofs of address have been self-attested. I have also attached my recent photograph above.

Date.....................................Place...

....
Signature of the Representative / Officer