IndusInd Nippon Life

Reimbursement Claim form

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

Please include the original pre- authorization request form in the lieu of the Part A

(To be filled in BLOCK LETTERS)

DETAILS OF THE HOSPITAL

Name of the hospital

Hospital ID Type of hospital Network Non-network (if non- network, fill section E)

Name of the treating Doctor

Qualification Registration number. with state code

Phone No.

DETAILS OF PATIENT ADMITTED

Name of the patient (FIRST MIDDLE LAST)

IP registration No. Gender Male Female Age Years Months

Date of birth (DDMMYEAR) Date of admission (DDMMYEAR) Time (MMHH)

Date of discharge (DDMMYEAR) Time (MMHH) Type of admission Emergency Planned Day care

Maternity If Maternity, date of delivery (DDMMYEAR) Gravida Status

Status at the time of discharge Discharge to home Discharge to another hospital Deceased

DETAILS OF THE AILMENT DIAGNOSED (PRIMARY)

ICD 10 quotes	Description	CD 10 PCS	Description
i. Primary diagnosis		I Procedure 1	
ii. Additional diagnosis		ii. Procedure 2	
iii. Co-morbidities		iii. Procedure 3	
iv. Morbidities		iv. Details of procedure	

Present Ailment is a complication of PED? Yes No (If Yes, specify details)

Pre- authorization obtained Yes No Pre-authorization No.

If authorization by network hospital not obtained, give reasons

Hospitalization due to injury Yes No If yes, give reason Self-inflicted Road traffic accident Substance abuse/ alcohol consumption

If injury due to substance abuse/alcohol consumption. Test conducted to establish this Yes No (if Yes, attach reports)

If Medico legal Yes No Reported to police Yes No FIR No.

If not reported to police, give reasons

CLAIM DOCUMENT 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 bills
- Investigation Reports
- CT/MR/USH/HPE Investigation reports
- Doctors reference slip for investigation
- ECG
- Pharmacy bills
- MLC report and 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)

Address of the hospital BUILDING

ROAD NAME/NO. LANDMARK 1

DISTRICT/TALUKA LANDMARK 2

CITY/VILLAGE STATE Pin Code

Registration No. PAN Card No.

No. of inpatient beds Facilities available at the hospital OT Yes No ICU Yes No Others

DECLARATION BY THE INSURED (PLEASE READ VERY CAREFULLY)

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 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 DDMMYEAR Place

Signature of the Insured

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 my 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. This signature of the insured is taken on this form after claim form B is fully filled up by us.

Date DDMMYEAR Place

Signature of Hospital Authority (with Hospital stamp)

GUIDANCE FOR FILLING THE CLAIM FORM PART B (to be filled in by the Hospital)		
DATA ELEMENT	**DESCRIPTION**	**FORMAT**
SECTION A DETAILS OF THE HOSPITAL		
a) Name of the hospital	Enter the name of the hospital	Name of the hospital
b) Hospital ID	Enter ID number of the hospital	As allocated by the TPA
c) Type of the hospital	Indicate whether in network or non-network hospital	Tick the right option
d) Name of the treating doctor	Enter the name of the treating doctor	Name of the doctor in full
e) Qualification	Enter the qualification of the treating doctor	Abbreviation of education qualification
f) Registration No. with the 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 the doctor	Include STD code with telephone number
SECTION B DETAILS OF THE PATIENT ADMITTED		
a) Name of the patient	Enter the name of the patient	Name of the patient in full
b) IP Registration	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 year sand months
e) Date of admission	Enter the date of admission	Use dd-mm-yy format
f) Time	Enter the time of admission	Use the hh-mm format
g) Date of discharge	Enter the date of discharge	Use dd-mm-yy format
h) Time	Enter the time of discharge	Use the hh-mm format
i) Type of admission	Indicate the type of admission of the patient	Tick the right format
j) If Maternity		
Date of delivery	Enter the date of delivery,If maternity	Use the dd-mm-yy format
Gravida Status	Enter the Gravida Status,If maternity	Use the standard format
k) Status at the time of discharge	Indicate the status of the patient at the time of discharge	Tick the right option

GUIDANCE FOR FILLING THE CLAIM FORM PART B (to be filled in by the Hospital)		
DATA ELEMENT	**DESCRIPTION**	**FORMAT**
DECLARATION BY THE HOSPITAL (PLEASE READ VERY CAREFULLY)		
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 primary diagnosis	Standard format and open text
Co- morbidities	Enter the ICD 10 Code and description of the co-morbidities diagnosis	Standard format and open text
b) ICD 10 Code		
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 the procedure	Enter the details of the procedure	Open text
c) Present aliment is a complication of PED	Indicate whether present ailment is a complication of some pre- existing disease	Tick Yes or No
d) Pre- authorization obtained	Indicate whether pre-authorization is obtained	Tick Yes or No
e) Pre-authorization number	Enter pre-authorization number	As allotted by TPA
f) If authorization by network hospital not obtained, give reasons	Enter reason for not obtained pre-authorization number	Open text
g) Hospitalization due to injury	Indicate whether test conducted	Tick Yes or No
Cause	Indicate whether test conducted	Tick Yes or No
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 was Medico legal	Tick Yes or No
Reported to police	Indicate whether police report was filed	Tick Yes or No
FIR No.	Enter the first information report number	As issued by the police authorities
If not reported police, give reason	Enter the reason for not reporting it 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, & Pin Code
b) Phone No.	Enter the phone number of the hospital	Include STD code with telephone number
c) Registration No.	Enter registration number of the patient	As allotted by the hospital
d) PAN Card No.	Enter the permanent account number	As allotted by the income tax department
e) Number of In-patient beds	Enter the number of In-patient beds	Digits
f) Facilities available at the hospital	Indicate facilities available at the hospital	Tick the right option. If others, please specify
SECTION F DECLARATION BY THE INSURED		
Read Declaration carefully and mention date in (dd-mm-yy format), place (open text) & sign.		
SECTION G DECLARATION BY THE HOSPITAL		
Read declaration carefully and mention date in (dd-mm-yy format), place (open text), sign& stamp		

IndusInd Nippon Life Insurance Company Limited (Formerly Reliance Nippon Life Insurance Company Limited). IRDAI Registration No. 121. Registered & Corporate Office: Unit Nos. 401B, 402, 403 & 404, 4th Floor, Inspire-BKC, G Block, BKC Main Road, Bandra Kurla Complex, Bandra East, Mumbai-400051, India. T +91 22 6896 5000. For more information or any grievance, 1. Call us between 8 am to 8 pm, Monday to Saturday (except public holidays) on our Toll-Free Number - 1800 102 1010 or 2. Visit us at www.indusindnipponlife.com 3. Email us at customerservice@indusindnipponlife.com. 4. Chat with us on our WhatsApp number (+91) 7208852700. The trade logo displayed above belongs to IndusInd International Holdings Limited & Nippon Life Insurance Company and is used by IndusInd Nippon Life Insurance Company Limited under license.

BEWARE OF SPURIOUS PHONE CALLS AND FICTITIOUS/FRAUDULENT OFFERS: IRDAI or its officials do not involve in activities like selling insurance policies, announcing bonus or investment of premiums. Public receiving such phone calls are requested to lodge a police complaint.

CIN: U66010MH2001PLC167089