

ଓଡ଼ିଶା औडिशा ODISHA

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# MEMORANDUM OF UNDERSTANDING

The Memorandum of understanding executed at Rourkela on this 31<sup>st</sup> day of July, 2017, between Biju Patnaik University of Technology, Odisha having its headquarters at Rourkela-769015 (hereinafter called 'University') and referred to as the First Party and The New India Asturance Company Ltd. having its Branch Office at Kachery Road, Uditnagar, Rourkela-769012 (hereinafter called 'Company') and referred to as the Second Party.

### Whereas :-

- By virtue of this MOU, the Company agrees to issue a Students' Package Insurance Policy as per Table-I, in respect of all the students such as
  - a) Students admitted during 2013-14 to 2017-18 under 5 yr UG Program,
  - b) Students admitted during 2014-15 to 2017-18 under 4 yr UG Program,
  - c) Students admitted during 2015-16 to 2017-18 under 3 yr UG(LE) Program and
  - d) Students admitted during 2015-16 to 2017-18 under 3 yr PG Program
  - e) Students admitted during 2016-17 to 2017-18 under 2 yr PG Program,

And continuing studies in different colleges/ institutions affiliated to Biju Patnaik University of technology, Odisha, Rourkela.

Period of Insurance: The Students' Package Insurance Policy as per Table-I is valid for a period of twelve months from the commencement of the policy i.e. from 01.08.2017.

<u>Premium:</u> Premium (including service tax) has been received from the University vide Cheque No.312341 dated 31.07.2017 drawn on State Bank of India, Uditnagar Branch, Rourkela for Rs.71,00,000/- (Rupees seventy one lakhs only) by the Company. It is understood that the insurance cover shall attach only in respect of those students for whom premium has been paid in advance and also to the subsequent inclusion of students for whom the premium will be paid by the University accordingly. The balance amount, if any, after final calculation, will be returned to the University.

<u>Details of Insured Persons:</u> The University shall provide the details of the students to be covered under the policy. The personal details to be provided would include name, address & registration number along with the names of earning parent/guardian of each student. The admitting college/institution will be the nominee. The disbursement of the settled claim amount will be paid through the college to the students/students' parents/guardians as the case may be. The discharge of the payment given by the admitting college/institution will be final.

The coverage of the scheme and sum insured is as per Table -I mentioned as below:

Table -I

SI	Towns of the same		
31	Type of Insurance Cover	Sum insured	Beneficiary
		per Student	
A	Death of the student continuing in BPUT	Rs. 2,00,000/-	Parent of the student
	due to accident		concerned
В	If the accident results in irrecoverable loss	Rs. 1,00,000/-	Student himself
	of sight of one eye or loss of use of one limb		(through college)
	of the student insured		
C	If the accident results in grievous injury to	Rs. 1,00,000/-	Student himself
	any limbs of the student insured		(through college)
D	Accident results in total irrecoverable loss	Rs. 2,00,000/-	Student himself
	of sight of both eyes or loss of use of two		(through college)
1	limbs or loss of sight of one eye and loss of	80	
	use of one limb of the student insured		
E	Death of earning parents / guardian (as per	Rs. 2,00,000/-	Student himself
	University records) resulting from injury		(through college)
	caused by an accident		, , ,
F	The student or earning parent / guardian	Rs. 2,00,000/-	Student himself
ļ	(as per University record) becoming	xe xe	(through college)
	permanent total disabled because of an		,
	accident		
G.	Reimbursement of the cost of	Upto Rs.	Student himself
	hospitalization to the student as an	50,000/-	(through college)
	inpatient due to illness/disease/injury. Such	200 500	
}	cost will include the cost of room rent/		B
	boarding expenses provided by hospital/		Į
]	nursing home expenses, fees of surgeon,		Ì
	Doctor and specialist fee. It will also include		
<u></u>	OT charges, cost of blood, anesthesia,	<b>x</b>	



Biju Patnaik University of Technology, Odisco

	oxygen, surgical appliance, medicines, x-ray, any testing fees, the cost of chemotherapy, dialysis, pacemaker, artificial limbs, artificial organs etc, and all related expenses as per Standard Group Mediclaim Policy		
Н	A Buffer sum insured to be kept as reserve for the students to meet the expenses arising out of extreme Medical cases only as per decision of the competent authority of BPUT	Rs. 10,00,000/- (Overall cap for all the insured student)	Student himself (through college)
! 	Theft of laptop/ study materials of the student insured	Upto Rs. 30,000/-	Student himself (through college)

(ii) This MOU also covers mid-term inclusion of students in the Students' Package Insurance Policy as per Table-I. The university shall pay the premium as per pro-rata rate for the period i.e. from the date of inclusion of the student till the expiry of the policy.

# Insurance Cover: Comprehensive Student Insurance Scheme 2017-18

### Personal Accident Insurance - Students

It is agreed that the Company shall pay to the Insured Person or the nominee if any of the Insured Person sustains any bodily resulting solely and directly from accident caused by external, violent and visible means, the sum hereinafter set forth in respect of any of the insured persons:-

- If such injury shall, within twelve calendar months of its occurrence be the sole and direct cause of the death or permanent disablement of the insured student, the capital sum insured of Rs.2,00,000/- (two lakhs only).
- If the accident results in irrecoverable loss of sight of one eye or loss of use of one limb
  of the student, the capital sum insured of Rs.1,00,000/- (one lakh only).
- 3. If the accident results in grievous injury to any limbs of the student insured, the capital sum insured of Rs.1,00,000/- (one lakh only)
- 4. If the accident resulting in injury shall within twelve calendar months of its occurrence be the sole and direct cause of loss of sight of both eyes or loss of use of two limbs or loss of sight of one eye and loss of use of one limb of the student, then a sum of Rs.2,00,000 (two lakhs only).

# Personal Accident Insurance - Parents

It is agreed that the Company shall pay a sum of Rs.2,00,000/- (two lakhs only) to the insured student, if the named earning Parent/Guardian of the insured student (as per University records) shall sustain any bodily injury resulting solely and directly from an accident caused by



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external, violent and visible means, and if such injury shall be the sole and direct cause of the death or permanent disablement of the named earning parent/guardian.

It is understood that the exception, i.e. the situations/contingencies under which the Company shall not be liable under the policy, are as per the Student's Package Insurance Policy.

# Hospitalization Benefits - Students

The Policy covers reimbursement of Hospitalization expenses incurred by the student as an inpatient due to disease/illness/injury sustained by him/her. This being tailor made policy, exclusion clause 4.1, 4.2 & 4.3 of standard GMC stands deleted. In the event of any claim becoming admissible under this policy, the Company will pay to the insured student through the college/institution the amount of such expenses as would fall under different heads mentioned below, and as are reasonably and necessarily incurred thereof by or on behalf of such insured students, but not exceeding the sum insured of Rs.50,000/- (fifty thousand) during the policy period.

- Room, Boarding and Nursing Expenses as provided by the Hosp[ital/Nursing home.
- 2. I.C. Unit expenses.
- Surgeon, Anesthetists, Medical Practitioner, Consultants, Specialists fees.
- Anesthesia, Blood, Oxygen, Operation Theater charges, Surgical Appliances, Medicines and Drugs, Diagnostic Materials, and X-ray, Dialysis, Chemotherapy, Cost of Pace maker, Artificial limbs and Cost of Organs and similar expenses.
- Ambulance expenses.

Company's Liability in respect of all claims admitted during the period of insurance shall not exceed Rs.50,000/- per student.

It is understood that, the terms conditions definitions exclusions etc. of the Students' Package Insurance Policy shall apply in the settlement of the claims.

### **Buffer Sum Insured**

It is agreed that, in case of an admissible claim if the medical expenses of the insured student exceeds the covered amount of Rs.50,000/- as per Section-G of Table-I then the excess amount is to be paid by the Company to the student out of the Buffer Sum Insured of Rs.10,00,000/- as per the decision of the competent authority of BPUT on case to case basis.

# Insurance Cover for Laptops/Study Materials

It is agreed that the company shall pay to the insured student a maximum up to Rs.30,000/- in case of loss of Laptop/Study materials due to theft.

It is understood that, the terms conditions definitions exclusions etc. of the Student's Package Insurance Policy shall apply in the settlement of the claims

Claim Procedure: Upon the happening of any event which may give rise to claim under the policy, written claim intimation with full particulars to be given to the Company immediately by either the insured student or by the college. All supporting claim documents (as detailed below) will be submitted to the company within 60 days of discharge from the hospital/nursing



Registrar
Biju Patnaik University
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home, in case of hospitalization claims. As regards to personal accident claims, the supporting claim documents must be submitted to the company at the earliest. The Company shall not be liable to make any payment in respect of any claim if such claim be in any manner fraudulent or supported by any fraudulent statement or device for intimation and submission of the claim documents, the contact Authority of the Company and his/her address is as under:-

Authority	Postalddress	Telephone (Office	E-mail
Sr. Branch Manager	City Branch, Kachery Road, Rourkela- 769012	_	sakti.maity@newindia.co.in nia.550501@newindia.co.in

# Students' Package Insurance Policy

The following documents would be submitted to the company in support of the claim (as per Table –I).

# 1. (Sl. A to F as per Table I)

### Death claims:

- 1. Claim form duly completed
- Death certificate from the competent authority.
- 3. Police Report wherever applicable
- 4. Post-mortem Report and Viscera Report wherever applicable
- Statement of the official of the College.
- 6. Copy of BPUT Regd. Card.
- Copy of College/Institution ID Card

### **Injury Claims:**

- 1. Claim form duly completed
- 2. Police reports wherever applicable
- 3. Report of the attending doctor.
- 4. Investigation Report like laboratory tests, X-ray and reports essential for confirmation of the injury.
- 5. Copy of BPUT Regn.Card
- Copy of College/Institution ID Card.
- Statement of the officials of the college.
- 8. Voter ID Card or any other Identification of earning parent (incase of accidental death of parent)

### 2. (Section G as per Table-I)

- Claim form duly completed.
- Doctor's advice for hospitalization.
- Bills, from chemist(s) supported by proper prescription.
- Bills, receipts and discharge certificate from the hospital.
- 5. Receipts and Pathological test reports from Pathologists
- 6. Nature of operation performed and surgeon's bill and receipt
- 7. Copy of BPUT Regn. Card
- Copy of College/Institution ID Card.

# 3. (Section I as per Table I)



Pagistrar
Pagistrar
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- 1. Claim form duly completed
- 2. Proof of purchase/purchase bill
- 3. Police reports
- 4. Letter of subrogation & undertaking
- 5. Copy of BPUT Regn. Card
- Copy of College/Institution ID Card.

# **Time Limit for Settlement of Claims:**

The disposal of the claims will be done within 15 working days from the <u>date of receipt of the Relevant documents as stated above.</u> In cases where a claim would require an investigation, the same will be done with promptitude, and in any case their disposal will not be delayed beyond 15 working days from the receipt of <u>Investigation report</u>. Only in extreme cases where the genuineness (or otherwise) of a claim cannot be established within the aforesaid time frame for reasons beyond the control of the Company, the matter shall be brought to the notice of the University/College, and further action as deemed fit would be taken after mutual consent and to be disposed off within 15 days.

It is also agreed that the company shall communicate the status of claims reported, processed, and settled to the University on every quarterly basis during the period of insurance.

FOR AND ON BEHALF OF THE NEW INDIA ASSURANCE CO.LTD

FOR AND ON BEHALF OF BIJU PATNAIK UNIVERSITY OF TECHNOLOGY, ODISHA, ROURKELA

Sr. Branch Manager Rourkela Branch

Registrar, B.P.U. Todosha Rourkela

Biju Patnaik University

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#### CLAIM FORM FOR HEALTH INSURANCE POLICIES FOR INJURY/ILLNESS- (PART-A)

### TO BE FILLED IN BYTHE INSURED- STUDENT SAFETY ILLNESS & EMPLOYEE MEDICLAIM POLICY

The issue of this Form is not to be taken as an admission of liability  DETAILS OF PRIMARYINSURED (To be filled in block letters) (STRIKE OUT WHICH EVER IS NOT APPLICABLE)
a) Policy No:
b) Company/TPAID No:
c) SI. No/ Certificate No:
d) Name: SURNAME FIRST NAME MIDDLE NAME
e) Address
City:
State: Pin Code: Pin Code:
Phone No:
DETAILS OF INSURANCE HISTORY:
a) Currently covered by any other Mediclaim / Health Insurance:Yes /No
b) Date of commencement of first Insurance:
c) If yes, company name:  Policy No:  Sum Insured s. s. s. R. Rs. Rs. Rs. Rs. Rs. Rs. Rs.
Policy No: Sum Insured s. s. F. R. Rs. Rs. Rs. Rs. Rs. Rs. Rs. Rs. Rs.
d) Have you been hospitalized in the last four years since inception of the contract?  Yes //No Date: // Y
Diagnosis:
e) Previously covered by any other Mediclaim / Health Yes //No // insurance:
c) If yes, company name:
DETAILS OF INSURED PERSONHOSPITALIZED:
a) Name SURNAME FIRST NAME MIDDLE NAME
b) Gender Male Female C) Age:years months b) Date of Birth:
e) Relationship to Primary Self Spouse Child Father Mother Other
insured: (Please Specify)
f) Occupation: Service Self Employed Homemaker Student Retired Other
f) Occupation: Service Self Employed Homemaker Student Retired Other (Please Specify)
g) Address (if different from above):
city:
State: Pin Code: Pin Code:
Phone No: Phone No: Email ID:
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 Occupied:
c) Hospitalization due to: d) Date of Injury / Date Disease first detected /Date of Delivery:
d) Date of Injury / Date Disease first detected /Date of Delivery: DDD MM M YY Y  e) Date of Admission: DDD MM M YY Y h)Time: HH H: MM  g) Date of Discharge: DDD MM M YY Y h)Time: HH H: MM M
D  D   M  M   Y  Y  h) Ime:  H  H  :  M  M

h) If Injury give cause & Details:				
DETAILS OF CLAIM:				
a) Details of the treatment expens	ses claimed:			
i) Pre-hospitalization Expenses:				Claim Form Duly signed
ii) Hospitalization Expenses:				Copy of the claim intimation, if any
iii) Post-hospitalization Expenses:				Hospital Main Bill
iv) Health-Check up Cost:				Heavital Davids on Dill
v) Ambulance Charges:			$  \; \sqcup \;$	Hospital Break-up Bill
vi) Others (code):				Hospital Bill Payment Receipt
Total				
				Hospital Discharge Summary
vii) Pre-hospitalization period:	Days			Pharmacy Bill
viii) Post-hospitalization	Days		╽╙	гнаннасу biii
period: b) Claim for Domiciliary Hospital	ization:	Yes /No (If yes, provide details in annexure)		OperationTheatre Notes
c) Details of Lump sum / cash be	enefit			ECG

Doctor's request for investigation

Investigation Reports (Including

CT/ MRI / USG / HPE)

Doctor's Prescriptions

Others

claimed:

ii) Surgical Cash:

iv) Convalescence:

vi) Others:

Total

i) Hospital Daily Cash:

iii) Critical Illness Benefit:

v) Pre/Post hospitalization Lump sum benefit:

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DETAIL	3 OF BILLS ENGLOSED.																
SI. No	Bill No	Date Issued by Towards				Towards	Amount(Rs)							7			
1.		D	D	M	M	Υ	Υ		Hospital Main Bill								
2.		D	D	M	M	Υ	Υ		Pre-hospitalization Bills: Nos		Ш						
3.		D	D	M	M	Υ	Υ		Post-hospitalization Bills: Nos		Ш			_	_	$\perp$	_
4.		D	D	M	M	Y	Y		Pharmacy Bills		Ш				_	$\perp$	بر إ
5. 6.		D	D	IVI	IVI	Y	Y				Н			-	+	+	SEE930N 3
7.		D	D	IVI	IVI	Y	I V				Н			-	+	+	
8.		D	D	M	IVI	Y	Y				$\vdash\vdash$					+	- 4
9.		D	D	M	M	Y	Y				$\vdash$				-	+	┨╻
10.		D	D	M	M	Υ	Υ				Н					$\top$	┪┃
DETAILS	S OF PRIMARYINSURED	'S BAI	NKA	CCC	<u>DUN</u>	Т:											- $ $
a) Pa	an No.:		7		$\neg$	Г	1										
b)	count No.:	- -	] ]	; ;	$\exists$	$\vdash$	] 				$\Box$		1	7	٦г	76	┑╹
b) Ac	count No	ᆜ	] 	ا لــــــــــــــــــــــــــــــــــــ	_	느					ᆜ		]  -	JL 	ᆜᆫ	<b>」</b> ∟	~
c) Ba	ank Name and Brancl	h:	JL				JL						JL	JL	IJL	IJL	\$\$e530%
d) Cł	neque/ DD Payable d	letail	s:[														JC.
o) IE		¬—	┐┌		$\overline{}$	Г	1										40
e) ir	SC Code:		JL	_		L	JL										
untrue reimb anyho	e statement, suppressursement shall be for ospital / Medical Prac	sion rfeite tition	or o d. I er v	con als who	ceal so co ha	lme ons s at	nt o ent tend will	of any material fact with re & authorizeTPA/ insurand ded on the person agains	correct to the best of my knowledge and espect to questions asked in relation to the company, to seek necessary medical at whom this claim is made. I hereby decementary claim except the pre/post-hosp	nis claim, r informatior lare that I I	my r n / d have	ight locu e ind	to d imei clud	clain nts f ed a	rom		
																	_
				UID	AN	CE	FO		M – PARTA(To be filled in by the insur	ed)							_
	DATA ELEM	IENT						DE	SCRIPTION		F	FOR	MA	T			
								SECTIONA- DETA	ILS OF PRIMARYINSURED								
a) Pol	icy No.					E	nte	r the policy number		As allotted	yd b	the	insu	ranc	e con	npan	у
b) SI.	No/ Certificate No.								er or the certificate number of social health	As allotted	d by	the	orga	niza	tion		1
c) Cor	mpanyTPAID No.					$\neg \neg$		rance scheme rrtheTPAID No		License n	umb	er a	s all	otted	l by I	RDA	$\dashv$
d) Nai					—	_		r the full name of the policyh	polder	and printe Surname,						me	$\dashv$
<u> </u>						+			loidei								-
e)Add	iress						nte	r the full postal address		Include St	reet	, Cit	y an	a Pir	1 COC	ie	$\perp$
						, ,		SECTION B - DETA	ILS OF INSURANCE HISTORY	ı							$\perp$
He	rrently covered by any calth Insurance?					ا [	ndic	cate whether currently covere	ed by another Mediclaim / Health Insurance	TickYes or	r No						
b) Dat	te of Commencement o hout break	f first	Insi	urar	се	E	nte	r the date of commencemen	t of first insurance	Use dd-m	m-y	y for	mat				7
	mpany Name					E	nte	r the full name of the insurar	nce company	Name of t	he o	rgar	nizat	ion ii	n full		$\neg$
Poli	icy No.					1	nte	r the policy number		As allotted	d by	the	insu	ranc	e con	npan	y
Sur	n Insured					+	nte	r the total sum insured as pe	er the policy	In rupees							$\dashv$

d) Have you been Hospitalized in the last four years since inception of the contract?	Indicate whether hospitalized in the last four years	TickYes or No
Date	Enter the date of hospitalization	Use mm-yy format
Diagnosis	Enter the diagnosis details	OpenText
e) Previously Covered by any other Mediclaim/ Health Insurance?	Indicate whether previously covered by another Mediclaim / Health Insurance	TickYes 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, pleasespecify.
f) Occupation	Indicate occupation of patient	Tickthe right option. If others, pleasespecify.
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 C - DETAILS OF INSURED PERSON HOSPITALIZED	
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

i) If Injury give cause	Indicate cause of injury	Tick the right option				
If Medico legal	Indicate whether injury is medico legal	TickYes or No				
Reported to Police	Indicate whether police report was filed	TickYes or No				
MLC Report & Police FIR attached	Indicate whether MLC report and Police FIR attached	TickYes or No				
j) System of Medicine	Enter the system of medicine followed in treating the patient	OpenText				
SECTION E - DETAILS OF CLAIM						
a) Details ofTreatment 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	TickYes 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				
	SECTION F - DETAILS OF BILLS ENCLOSED					
Indicate which bills are enclosed with the amounts in rupees						
SEC	CTION G - DETAILS OF PRIMARYINSURED'S BANKACCOUNT					
a) PAN	Enter the permanent account number	As allotted by the IncomeTaxdepartment				
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				
SEC	CTION G - DETAILS OF PRIMARYINSURED'S BANKACCOUNT					
Read declaration carefully and mention date (ir	n dd:mm:yy format), place (open text) and sign.					
	CLAIM FORM - PART B					
	TO BE FILLED IN BYTHE HOSPITAL					
	The issue of this Form is not to be taken as an admission of liability					

Please include the original preauthorization request from in lieu of  $\ensuremath{\mathbf{PARTA}}$ 

DETAILS OF HOSPITAL(To be filled in block letters)
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.:
DETAILS OF THE PATIENTADMITTED
a) Name of the Patient: SURNAME FIRSTNAMEMIDDLENAME
b) IPRegistration Number:
c) Gender Male Female d) Age:years M months M Me) Date of Birth: DD M M YY
f) Date of Admission:
h) Date of Discharge: Louis Lo
j) Type ofAdmission: Emergency: Planned: Day Care: Maternity: Maternity:
k) If Maternity: i) Date of Delivery:
I) Status at time of Discharge to home : Discharge to another hospital: Deceased:
m) Total claimed amount:

a) Codes    Primary Diagnosis:	DETAILS OFAILMENT DIAGNO	OSED (PRIMARY)				
ii) Additional Diagnosis:	a)		Description			ı
iii) Co-morbidities:  iv) Co-morbidities:  b) ICD 10 Description PCS  Description j) Procedure 1:  ii) Procedure 2:  iii) Procedure 3:  iv) Details of Procedure:  c) Pre-authorization yes No d) Pre-authorization Number: obtained:  o) If authorization by network hospital not obtained, give reason:  l) Hospitalization due to injury: Yes No i)  Substance abuse / alcohol consumption  iii) If injury due to substance abuse / alcohol consumption, Test conducted to establish this: Yes No (If Yes, attach reports)  iv) If Medico Yes No iv) Reported to Police: Yes No v)FIR No.  Claim Form duly signed  Original Pre-authorization request  Copy of Photo ID Card of patient Verified by hospital  Hospital Discharge summary  Pharmacy bills  MLC reports & Police FIR  MLC reports & Police FIR  Original Planary from hospital where applicable	i) Primary Diagnosis:					ı
iv) Co-morbidities:  b) ICD 10 Description PCS  ii) Procedure 1:  iii) Procedure 2:  iii) Procedure 3:  iv) Details of Procedure:  of Pre-authorization yets work hospital not obtained, give reason:  f) Hospitalization due to injury:  yes No  ii) Procedure 2:  iii) Procedure 3:  iv) Details of Procedure:  of Pre-authorization yetswork hospital not obtained, give reason:  f) Hospitalization due to injury:  yes No  ii) If westing about 2 index of procedure injury:  yes No  iii) If yes, give cause: Self-inflicted Road Traffic Accident Substance abuse / alcohol consumption. Test conducted to establish this:  yes No  (If Yes, attach reports)  iv) If not reported to police give reason:  yi) If not reported to police give reason:  Claim Form duly signed  Original Pre-authorization request  Original Pre-authorization request  Hospital Discharge summary  Pharmacy bills  MLC reports & Police FIR  OperationTheatre Notes  MLC reports & Police FIR  Original death summary from hospital where applicable	ii) Additional Diagnosis:					
b) ICD 10 Description PCS Description procedure 1:  ii) Procedure 2:  iii) Procedure 3:  iv) Details of Procedure:  iii) Procedure 3:  iv) Details of Procedure:  iv) Procedure 3:  iv) Details of Procedure:  iv) Procedu	iii) Co-morbidities:					
ii) Procedure 2:  iii) Procedure 3:  iii) Procedure 3:  iii) Procedure 3:  iv) Details of Procedure:  c) Pre-authorization obtained:  iii) Hospital Discharge summary    Operation Theatre Notes	iv) Co-morbidities:					Ş
ii) Procedure 2:  iii) Procedure 3:  iii) Procedure 3:  iii) Procedure 3:  iv) Details of Procedure:	b)		Description	n		ЕСГЯСМ
iii) Procedure 3:  iv) Details of Procedure:  c) Pre-authorization obtained: e) If authorization by network hospital not obtained, give reason: f) Hospitalization due to injury:  yes No i) iii) If yes, give cause: Self-inflicted Road Traffic Accident  Substance abuse / alcohol consumption  iii) If injury due to substance abuse / alcohol consumption, Test conducted to establish this: yes No (If Yes, attach reports)  iv) If Medico Yes No iv) Reported to Police: yes No v) FIR No.:  CLAIM DOCUMENTS SUBMITTED - CHECK LIST  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 Pharmacy bills Original death summary from hospital where applicable	i) Procedure 1:					و د
iv) Details of Procedure:    C) Pre-authorization	ii) Procedure 2:					
c) Pre-authorization obtained:  e) If authorization by network hospital not obtained, give reason:  (hospitalization due to injury: Yes No i)    iii) If yes, give cause: Self-inflicted Road Traffic Accident     Substance abuse / alcohol consumption     iii) If injury due to substance abuse / alcohol consumption, Test conducted to establish this: Yes No (IfYes, attach reports)     iv) If Medico Yes No iv) Reported to Police: Yes No v)FIR No.:     legal:     vi) If not reported to police give reason:	iii) Procedure 3:					
obtained:  e) If authorization by network hospital not obtained, give reason:  f) Hospitalization due to injury:  yes  No  ii) If yes, give cause:  Self-inflicted  Road Traffic Accident  Substance abuse / alcohol consumption  iii) If injury due to substance abuse / alcohol consumption, Test conducted to establish this:  yes  No  (If yes, attach reports)  iv) If Medico  legal:  vi) If not reported to police give reason:  CLAIM DOCUMENTS SUBMITTED - CHECK LIST  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  OperationTheatre Notes  MLC reports & Police FIR  Original death summary from hospital where applicable	iv) Details of Procedure	ж				ı
f) Hospitalization due to injury:		Yes No	d) Pre-authoriz	ation Number:		
ii) If Yes, give cause: Self-inflicted	e) If authorization by ne	etwork hospital not obtained	, give reason:	Γ		۱[
iii) If injury due to substance abuse / alcohol consumption, Test conducted to establish this:    Yes	f) Hospitalization due to	o injury: Yes No	,	use: Self-inflicte	d Road Traffic Accident	
iv) If Medico	Substance abuse / alco	ohol consumption				1
legal: vi) If not reported to police give reason:  CLAIM DOCUMENTS SUBMITTED - CHECK LIST  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  OperationTheatre Notes  MLC reports & Police FIR  Original death summary from hospital where applicable	iii)If injury due to substa	ance abuse / alcohol consur	nption,Test conducted to	establish this:	Yes No (IfYes, attach reports)	
CLAIM DOCUMENTS SUBMITTED - CHECK LIST  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  OperationTheatre Notes  Hospital main bill  Claim Form duly signed  Investigation reports CT/MR/USG/HPE  Investigation reports  Doctor's reference slip for investigation  ECG  Pharmacy bills  MLC reports & Police FIR  Original death summary from hospital where applicable		Yes No iv) Repo	orted to Police: Ye	es No v	FIR No.:	
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  OperationTheatre Notes  Hospital main bill  Investigation reports  Doctor's reference slip for investigation  ECG  Pharmacy bills  MLC reports & Police FIR  Original death summary from hospital where applicable	vi) If not reported to pol	ice give reason:				<u>ا</u> ا
Original Pre-authorization request  Copy of the Pre-authorization approval letter  Doctor's reference slip for investigation  ECG  Hospital Discharge summary  Pharmacy bills  OperationTheatre Notes  Hospital main bill  Original death summary from hospital where applicable	CLAIM DOCUMENTS SUBMIT	TED - CHECK LIST				_ "
Copy of the Pre-authorization approval letter  Copy of Photo ID Card of patient Verified by hospital  Hospital Discharge summary  OperationTheatre Notes  Hospital main bill  Original death summary from hospital where applicable	Claim Form duly s	signed			Investigation reports CT/MR/USG/HPE	
Hospital Discharge summary  OperationTheatre Notes  Hospital main bill  Original death summary from hospital where applicable	Original Pre-autho	orization request			Investigation reports	۲.
Hospital Discharge summary  OperationTheatre Notes  Hospital main bill  Original death summary from hospital where applicable	Copy of the Pre-a	uthorization approval letter			Doctor's reference slip for investigation	SECT
Hospital Discharge summary  OperationTheatre Notes  Hospital main bill  Original death summary from hospital where applicable	Copy of Photo ID	Card of patient Verified by h	ospital		ECG	70N :
Hospital main bill Original death summary from hospital where applicable	Hospital Discharg	e summary			Pharmacy bills	9
	OperationTheatre	Notes		$\Box$	MLC reports & Police FIR	
Hospital break-up bill Any other, please specify	Hospital main bill				Original death summary from hospital where applicab	le
	Hospital break-up	bill			Any other, please specify	

DETAILS IN CASE OF NON NETWORK HOSPITAL(ONLY FILLIN CASE OF NON-NETWORK HOSPITAL)
a) Address:  City:  Diplome No:  Diplome No:
DECLARATION BYTHE HOSPITAL (PLEASE READ VERYCAREFULLY)
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 anyfalse or untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited.
anyfalse or untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited.  Date: DD MM MM YYY
Place: Signature and Seal of the HospitalAuthority:

GUIDANCE FOR FILLING CLAIM FORM - PART B (To be filled in by the hospital)			
DATA ELEMENT	DESCRIPTION	FORMAT	
	SECTIONA- DETAILS OF HOSPITAL	•	
a) Name of the hospital	Enter the name of hospital	Name of the hospital in full	
b) Hospital ID	Enter ID number of hospital	As allocated by theTPA	
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 qualification 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 o	
g) Phone No.	Enter the phone number of doctor	Include STD code with telephone number	
	SECTION B - DETAILS OF THE PATIENTADMITTED	,	
a) Name of Patient	Enter the name of patient	Name of patient in full	
b) IPregistration 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 Birth	Enter date of birth	Use dd-mm-yy format	
f)Date ofAdmission	Enter date of admission	Use dd-mm-yy format	
g)Time	EnterTime 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 ofAdmission	Indicate type of admission of patient	Tick the right option	
k)If Maternity			
i) Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format	
ii) Gravida Status	Enter Gravida status if maternity	Use standard format	
I) 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)	

DATA ELEMENT	DESCRIPTION	FORMAT
	SECTION C - DETAILS OFAILMENT 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 Code and description of the first procedure	Standard Format and Open text
Procedure 2	Enter the ICD 10 Code and description of the second procedure	Standard Format and Open text
Procedure 3	Enter the ICD 10 Code 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	TickYes or No
d) Pre-authorization Number	Enter pre-authorization number	As allotted byTPA
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	TickYes 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	TickYes or No
Medico Legal	Indicate whether injury is medico legal	TickYes or No
Reported to Police	Indicate whether police report was filed	TickYes or No
FIR No.	Enter first information report number	As issued by police authrities
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 sub	omitted	
	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 Hospital obtained from local body like City Corporation / Municipality	As allocated by the City Corporation Municipality
d) Hospital PAN	Enter the permanent account number	As allocated by the IncomeTaxDepartment
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, pleasespecify
	SECTION F - DECLARATION BYTHE HOSPITAL	