BIRLA INSTITUTE OF TECHNOLOGY, MESRA : RANCHI

Form No MCLM - 4

MEDICLAIM BILL SUBMISSION FORM

BILL SUBMISSION BY

Employee code: _____ Name of the Employee: _____

Designation: _____Department : _____Centre: _____

Mobile Number / E Mail: _____

BILL SUBMITTED IN RESPECT OF HOSPITALISATION OF

Dr/Prof/Mr/Ms/Mrs/_____ Card ID No. _____

Relationship with Employee: _____ for treatment of Disease: _____

_____

Name of the Hospital / Nursing Home: _____

Address of the Hospital / Nursing Home: _____

Registration Number of the Hospital / Nursing Home: _____

DURATION OF HOSPITALISATION & DETAILS OF HOSPITAL BILL

From Date : ……..Time: ……..To Date : ……Time: ……..Days: ……..

Hospital Bill Reference No: …….. Date: …….. Bill Amount Rs: ……..

Receipt Number of the Final Settlement of the Bill: …….. Date of Receipt: ……..

BREAKUP OF THE MEDI-CLAIM EXPENSES

Bill Amount …….. Duration of Expenses Bills (From Date …… To Date ……..)

Before Hospitalisation Rs: ……..

During Hospitalisation Rs: ……

Post Hospitalisation Rs: ……..

Total Amount Claimed Rs: …….. (Please Submit Date Bills Details in Separate Sheet)

ENCLOSURE

01. Number of Cash Memos & Receipts Nos: ……..

02. Number of Pathological Reports Nos: ……

03. Number of Prescriptions Nos: ……..

04. Other Documents Like Discharge Summary Nos: …….. Total: …….. Nos: ……

Signature of the Employee (Claimant)

Forwarded by Head of the Department / Centre
(Signature with Date) Date of Submission ……..

……

FOR OFFICE USE ONLY

Claim Papers Received on (Date) Checked By

Claim Forwarding SRL No. BIT/ADRF/Mediclaim/ / Dated:-

Courier / Speed Post Consignment Number:-

Medi Assist®

REIMBURSEMENT CLAIM FORM

TO BE FILLED BY THE INSURED

The issue of this Form is not to be taken as an admission of liablity

(To be Filled in block letters)

SECTION A

DETAILS OF PRIMARY INSURED:

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

c) Company / TPA ID (MA ID)No:

d) Name: SURNAME FIRST NAME MIDDLE NAME

e)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: D D M M Y Y Y Y

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: M M 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: SURNAME FIRST NAME MIDDLE NAME

b) Gender Male Female c) Age years Y Y Months M M d) Date of Birth D D M M Y Y Y Y

e) Relationship to Primary insured: Self Spouse Child Father Mother Other (Please Specify)

f) Occupation Service Self Employed Home Maker Student Retired Other (Please Specify)

g) Address (if diffrent from above) :

City: State:

Pin Code Phone No: Email ID:

SECTION D

DETAILS OF HOSPITALIZATION:

a) Name of Hospital where Admited:

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: D D M M Y Y Y Y

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

I) If injury give cause: Self inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption I) If Medico legal Yes No

ii) Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine:

SECTION E

DETAILS OF CLAIM:

a) Details of the Treatment expenses claimed

I. Pre -hospitalization expenses Rs. ii. Hospitalization expenses Rs.

iii. Post-hospitalization expenses Rs. iv. Health-Check up cost: Rs.

v. Ambulance Charges: Rs. vi. Others (code): Rs.

Total Rs.

vii. Pre -hospitalization period: days viii. Post -hospitalization period: days

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

c) Details of 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 hospitalization Lump sum benefit: Rs. vi. Others: Rs.

Total Rs.

Claim Documents Submitted - Check List:

- Claim form duly signed
- Copy of the claim intimation, if any
- Hospital Main Bill
- Hospital Break-up Bill
- Hospital Bill Payment Receipt
- Hospital Discharge Summary
- Pharmacy Bill
- OperationTheater Notes
- ECG
- Doctors request for investigation
- Investigation Reports (Including CT / MRI / USG / HPE)
- Doctors Prescriptions
- Others

SECTION F

DETAILS OF BILLS ENCLOSED:

Sl. No.	Bill No.	Date	Issued by	Towards	Amount (Rs)
1.		D D M M Y Y		Hospital main Bill	
2.		D D M M Y Y		Pre-hospitalization Bills: Nos	
3.		D D M M Y Y		Post-hospitalization 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			

SECTION G

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 H

DECLARATION BY THE INSURED:

I hereby declare that the information furnished in the claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealent of any material fact with respect to questions asked in relation to this claim, my right to claim reimbrusement shall be forfeited, I also consent & authorize TPA / insurance Company, to seek necessary medical information / documents from any hospital / Medical Practitioner who has attended on the person against whom this claim is made. I hereby declare that I have included all the bills / receipts for the purpose of this claim & that I will not be making any supplementary claim except the pre/post-hospitalization claim, if any.

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

(IMPORTANT: PLEASE TURN OVER)

CLAIM FORM - PART B

TO BE FILLED IN BY THE HOSPITAL

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

Please include the original preauthorization request form in lieu of PART A

(To be Filled in block letters)

SECTION A

DETAILS OF HOSPITAL

a) Name of the hospital:

a) Hospital ID: c) Type of Hospital: Network : ☐ Non Network : ☐ (if non network fill section E)

c) Name of the treating doctor: SURNAME FIRST NAME MIDDLE NAME

e) Qualification: f) Registration No. with State Code: g) Phone No.

SECTION B

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient: SURNAME FIRST NAME MIDDLE NAME

b) IP Registration Number: c) Gender: Male ☐ Female ☐ d) Age: Years YY Months MM e) Date of birth: DD MM YY

f) Date of Admission: DD MM YY g) Time: HH MM h) Date of Discharge: DD MM YY i) Time: HH MM

j) Type of Admission: Emergency ☐ Planned ☐ Day Care ☐ Maternity ☐ k) If Maternity i) Date of Delivery: DD MM YY ii) Gravida Status: :

l) Status at time of discharge: Discharge to home ☐ Discharge to another hospital ☐ Deceased ☐ m) Total claimed amount

SECTION C

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

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:		

c) Pre-authorization obtained: ☐ Yes ☐ No d) Pre-authorization Number:

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

f) 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. If Medico legal: ☐ Yes ☐ No iv. Reported to Police ☐ Yes ☐ No

v. FIR No. vi. If not reported to police give reason:

SECTION D

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
- ☐ Operation Theatre Notes
- ☐ Hospital main bill
- ☐ Hospital break-up bill
- ☐ 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
- ☐ Any other, please specify

SECTION E

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

a) Address of the Hospital

City: State:

Pin Code: b) Phone No. c) Registration No. with State Code:

d) Hospital PAN: e) Number of inpatient beds f) Facilities available in the hospital i. OT ☐ Yes ☐ No ii. ICU ☐ Yes ☐ No

iii. Others:

SECTION F

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 our knowledge and belief. If we have made any false or untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited.

Date: DD MM YY

Place:

Signature and Seal of the Hospital Authority: