KWA-JB/8497/2025-E11 1/187915/2025

Website: www.kwa.kerala.gov.in Mobile/ Whatsapp: +919495998258 Tel. 0471-2738300 Consumer Helpline Number 1916 [24X7] [Toll Free] 1916cckwa@gmail.com



Jalabhavan Thiruvananthapuram – 695033 Kerala - India

Dated: 25-10-2025

File No. KWA-JB/8497/2025-E11

കേരള വാട്ടർ അതോറിറ്റിയിലെ മെഡിക്കൽ ഇൻഷുറൻസിൽ ചേർന്നിട്ടുള്ള പെൻഷൻകാർക്ക് സമഗ്ര ആരോഗ്യ ഇൻഷുറൻസിന്റെ ഭാഗമായുള്ള കോർപ്പറേറ്റ് ബഫർ ഫണ്ട് അനുവദിയ്ക്കുന്നതിനുള്ള മാനദണ്ഡങ്ങൾ .

1)ഇൻഷുറൻസ് കവറേജ് പരിധിയായ 2 ലക്ഷം രൂപ പൂർണമായും വിനിയോഗിച്ച് കഴിയുന്ന സാഹചര്യത്തിലാണ് ബഫർ ഫണ്ടിന് വേണ്ടിയുള്ള അപേക്ഷ പരിഗണിയ്ക്കുന്നത്.

2)ബഫർ ഫണ്ട് അനുവദിയ്ക്കുന്നതിന് മാനേജിംഗ് ഡയറക്ടർക്ക് നേരിട്ട് അപേക്ഷ kwa.tvm.e11@gmail.com എന്ന ഇമെയിൽ വിലാസത്തിൽ അയയ്ക്കേണ്ടതാണ്.

3)ബഫർ ഫണ്ടിനുള്ള അപേക്ഷയോടൊപ്പം സമർപ്പിക്കേണ്ട രേഖകൾ :

എ) ആശുപത്രിയിൽ അഡ്മിഷനിൽ തുടരുന്ന കേസുകളിൽ, ബഫർ ഫണ്ട് ക്യാഷ്-ലെസ്സ് ആയി അനുവദിക്കേണ്ട സാഹചര്യത്തിൽ വിശദമായ രോഗവിവരങ്ങളും Anticipated Treatment expenditure-ഉം ഉൾപ്പെടുത്തിയ ഡോക്ലറുടെ സാക്ഷ്യപത്രത്തിന്റെ അടിസ്ഥാനത്തിൽ ഇൻഷുറൻസ് കമ്പനിയുടെ റിപ്പോർട്ട് കൂടി ലഭ്യമാക്കി ബഫർ ഫണ്ടിന് പരിഗണിക്കുന്നതാണ്

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ബി) ക്യാഷ്-ലെസ്സ് ആയി തുടർ ചികിത്സകൾക്ക് മുൻകൂർ അനുമതി ആവശ്യപ്പെടുന്ന സാഹചര്യങ്ങളിൽ വിശദമായ ഡോക്ടർ സർട്ടിഫിക്കറ്റിനൊപ്പം Anticipated Treatment expenditure/Monthly expenditre ഡീറ്റെയിൽസ് എന്നീ വിവരങ്ങൾ കൂടി ഉൾപ്പെടുത്തിയ ഡോക്ടറുടെ സാക്ഷ്യപത്രത്തിന്റെ അടിസ്ഥാനത്തിൽ ഇൻഷുറൻസ് കമ്പനി /FHPL ന്റെ റിപ്പോർട്ട് കൂടി ലഭ്യമാക്കിയ ശേഷം പോളിസി പീരീഡിനുള്ളിലുള്ള ചികിത്സ കണക്കാക്കി ബഫർ ഫണ്ടിന് പരിഗണിക്കുന്നതാണ് .

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ക്ലെയിമിൽ ഉൾപ്പെടുത്തി അനുവദിയ്ക്കുന്ന reimbursement ക്ലെയിമുകൾക്ക് സി) ബഫർ ഡിസ് ചാർജ്ജ് സമ്മറി/ ഫൈനൽ ബില്ലിന്റെ പകർപ്പ് എന്നിവ സഹിതം സമർപ്പിക്കേണ്ടതാണ്. ദിവസത്തിനുള്ളിൽ അപേക്ഷ കൂടാതെ അതിനാസ്പദമായ ഇൻഷുറൻസ് ക്ലെയിം അപേക്ഷ ഇൻഷുറൻസ് കമ്പനിക്ക് TPA (Third Party Administrator) മുഖേന സാധാരണ reimbursement ക്ലെയിമുകൾ സമർപ്പിക്കുന്ന രീതിയിൽ (അനുബന്ധം-1) നിർബന്ധമായും സമർപ്പിക്കേണ്ടതാണ്. ഇത്തരത്തിൽ reimbursement-നായി സമർപ്പിക്കുന്ന ക്യാഷ്-ലെസ്സ് അനുവദിച്ച ശേഷമുള്ള തുക കമ്പനി റിപ്പോർട്ടിന്റെ അടിസ്ഥാനത്തിൽ ബഫർ ഫണ്ടിന് പരിഗണിക്കുന്നതാണ് .

ഡി) ഇൻഷുറൻസ് കമ്പനി / FHPL ന്റെ റിപ്പോർട്ട് ലഭ്യമാകുന്നതിൽ പ്രസ്തുത രോഗം Critical illness Category യിൽ ഉൾപ്പെടുന്നവയ്ക്ക് പരമാവധി 50,000/- രൂപവരെയും, Non-critical കാറ്റഗറിയിൽ ഉൾപ്പെടുന്ന രോഗങ്ങൾക്ക് പരമാവധി 25,000/- രൂപ വരെയും ബഫർ ഫണ്ടിന് അനുവദിയ്ക്കുന്നതാണ്.

5) 2025 ഡിസംബർ 31-വരെയുള്ള ഫണ്ട് വിനിയോഗം പരിശോധിച്ച് ബാലൻസ് തുക ഉള്ള പക്ഷം ബഫർ ഫണ്ട് അനുവദിക്കുന്നതിൽ കൂടുതൽ നിയന്ത്രണമോ ഇളവുകളോ ആവശ്യമുണ്ടെങ്കിൽ നൽകുന്നതാണ് .

ഉള്ളടക്കാം: അനുബന്ധാ TPA യ്ക്ക് റീ-ഇമ്പേഴ്സ്മെന്റിനുള്ള ക്ലെയിമുകൾ സമർപ്പിക്കേണ്ട അപേക്ഷാഫോമും നിർദ്ദേശങ്ങളും

Binu Signed by

MBinu Francis

Date: 25-10-2025 19:24:04

To

- 1. Publish in the Website for the information of all pensioeners
- 2. All Pensioners organizations for information
- 3. File / Stock File

PROCEDURE FOR REIMBURSEMENT OF MEDICAL CLAIMS FOR KWA EMPLOYEES

- 1. Duly filled in Claim Form of respective insurance company (Form A and B needed with contact number)
- 2. Copy of Member Insurance ID Card.
- 3. Copy of Govt. ID Proof of the patient.
- 4. Cancelled Cheque of Main Member **OR** Front page copy of employee's bank pass book with IFSC.
- 5. Original detailed Discharge Summary with Doctor seal and signature. Need Date and time of Hospital Admission and Discharge.
- 6. Original investigation reports including Lab reports, X- ray films, ECG, Scan reports etc. with hospital seal and signature.
- 7. Original Hospital Bills consolidated with detailed breakup with the seal and sign of the hospital with cash paid seal. (in case of any advance paid to hospital, its receipt to be attached.) Mandatory
- 8. In case of surgical packages detail breakup of the package.
- 9. Pharmacy bills and breakup with seal and sign of hospital.
- Pre and Post bill for claim settlement Prescriptions and doctor consultation paper (Mandatory)
- 11. In case of hospitalization due to accident, copy of MLC / FIR. There is no MLC/FIR kindly submit Self declaration Letter of patient. First consult treating doctor certificate for non alcoholic(Mandatory)
- 12. Medical Reimbursement Claim has to be submitted within **30 days from the**Date of Discharge. If exceeds **30 days, attach a Delay in Submission**Note stating the reason along with the Claim Documents. (Submission letter should be write in English or Malayalam)
- 13. In case of cataract surgery, IOL sticker(original) and A scan report (original) to be attached. Break up bills also needed. Copy IOL Invoice is Mandatory
- 14. In case of cardiac surgery, **invoice copy** of **stent and sticker (original)** also **Mandatory.**
- **15.** In case of orthopedics surgery, **invoice copy** of **implant and sticker (original)** also **Mandatory.**
- 16. In case of Pregnancy claim kindly mention the **GPLA Status** in the Discharge Summary.

Please note that claims pertaining to investigation purposes alone are not eligible for reimbursement/cashless purpose

Contact Address:

Family Health Plan Insurance TPA Ltd-FHPL, TC 83/840, 2nd Floor,

"ELEEZA" Luke's Cottage, Seeveli

Nagar, Kaithamukku, Trivandrum – 695024

Ph: 0471-2578940



CLAIM FORM - PART A

TO BE FILLED IN BY THE INSURED

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

(To be filled in block letters)

DETAILS OF PRIMARY INSURED		
a) Policy no:	b) Sl. No/ Certificate No:	
c) Company/ TPA ID No:		
d) Name:		
e) Address:		SECT SECT
		SECTION A
City:	State:	
Pin Code: Phone No:	Email ID:	
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:	<u> </u>
Sum Insured (`): d) Have you been hospitalized	d in the last four years since inception of the contract? Yes No Date:	SECTION B
Diagnosis:	e) Previously covered by any other Mediclaim/ Hea	Ith Insurance : Yes No
f) If yes, Company Name :		
DETAILS OF INSURED PERSON HOSPITALIZED		
a) Name :		
b) Gender: Male Female c) Age: years months	d) Date of Birth:	
e) Relatuionship to Primary Insured: Self Spouse Child Father	Mother Other (Please specify)	
f) Occupation: Service Self Employed Homemaker Student	Retired Other (Please specify)	SE SE
g) Address (if different from above):		SECTION C
City:	State: State:	
Pin Code: 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	
c) Hospitalization due to: Injury Illness Maternity	d) Date of injury/ Date Disease first detected/ Date of Delivery:	
e) Date of Admission:	g) Date of Discharge:	h) Time: : : : SEC
i) If injury, give cause: Self inflicted Road Traffic Accident	Substance abuse / Alcohol Consumption i. If Medico Legal:	Yes No
ii. Reported to police: Yes No iii. MLC Report & Police FIR attached:	Yes No j) System of medicine:	
	Yes No j) System of medicine:	
DETAILS OF CLAIM		n Documents Submitted- Check List:
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DETAILS OF CLAIM a) Details of treatment expenses claimed i. Pre Hospitalization Expenses iii. Post Hospitalization Expenses v. Ambulance Charges vi. Pre hospitalization period: b) Claim for Domiciliary Hospitalization: c) Details of Lump sum / cash benefit claimed: i. Hospital Daily Cash: iii. Critical Illness Benefit: v. Pre/Post hosp. Lump sum benefit: DETAILS OF BILLS ENCLOSED Si. No. Bill No. Date Issued By Total Si. No. Bill No. Date Issued By 1 2 3 4 5 6 6 7	Clain spitalization Expenses alth Check up Cost uers (code): uers (cod	Claim FormDuly signed Copy of the claim intimation, if any Hospital Main bill Hospital Break-up bill Hospital Discharge Summary Pharmacy Bill Operation Theatre Notes ECG Doctor's request for investigation Investigation Reports (including CT / MRI / USG / HPE) Doctor's Prescription Others Amount (')
DETAILS OF CLAIM a) Details of treatment expenses claimed i. Pre Hospitalization Expenses iii. Post Hospitalization Expenses v. Ambulance Charges vi. Pre hospitalization period: b) Claim for Domiciliary Hospitalization: c) Details of Lump sum / cash benefit claimed: i. Hospital Daily Cash: iii. Critical Illness Benefit: v. Pre/Post hosp. Lump sum benefit: SI. No. Bill No. Date Issued By Total SI. No. Bill No. Date Issued By 1 2 3 4 5 6 7 8	Clain spitalization Expenses alth Check up Cost uers (code): uers (cod	Claim FormDuly signed Copy of the claim intimation, if any Hospital Main bill Hospital Break-up bill Hospital Discharge Summary Pharmacy Bill Operation Theatre Notes ECG Doctor's request for investigation Investigation Reports (including CT / MRI / USG / HPE) Doctor's Prescription Others Amount (')
DETAILS OF CLAIM a) Details of treatment expenses claimed i. Pre Hospitalization Expenses iii. Post Hospitalization Expenses v. Ambulance Charges vi. Pre hospitalization period: b) Claim for Domiciliary Hospitalization: c) Details of Lump sum / cash benefit claimed: i. Hospital Daily Cash: iii. Critical Illness Benefit: v. Pre/Post hosp. Lump sum benefit: SI. No. Bill No. Date Issued By 1 2 3 4 5 6 7 8 9 9	Clain spitalization Expenses alth Check up Cost uers (code): uers (cod	Claim FormDuly signed Copy of the claim intimation, if any Hospital Main bill Hospital Break-up bill Hospital Discharge Summary Pharmacy Bill Operation Theatre Notes ECG Doctor's request for investigation Investigation Reports (including CT / MRI / USG / HPE) Doctor's Prescription Others Amount (')
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d) Cheque/ DD Payable details:						e) IFSC Co	de:											G
DECLARATION BY THE INSURED																		
I hereby declare that the information fu	umished in this claim form	is true & correct to the best o	of my knowledge and	belief. If I have made any	v false or untru	ue statement, suppr	ession o	r concealr	nent of ar	nv mat	terial fact w	ith respe	ect to c	uestion:	s asked in	relation to the	his	_
claim, my right to claim reimbursement	it shall be forfeited. I also o	onsent & authorize TPA / ins	surance company, to	seek necessary medical i	information / d	documents from any	hospita	I / Medical	Practition	ner wh	no has atter	ded on t	he pe	rson aga	ainst whom	this claim is	S	
made. I hereby declare that I have	included all the bills / rei	ceipis for the purpose of tr	nis ciaim & maci w	iii not be making any su	ppiementary	y ciaim except the	pre/po:	st-nospita	iization	ciaim,	ii ariy.							SECT
																		Q
																		I
Date:		Place:				Signature	of the i	nsured:										
	DATA ELEMENT		GUIDANCE FOR	FILLING CLAIM FORM			the ins	ured)										
	DATA LLLINLIN			SECTION A - DETAILS	DESCRI										RMAT			
a) Policy No.				olicy number	OF PRIMA	KT INSURED				Δe	allotted b	v the in	neura	nce cc	mnany			
-				ocial insurance numb	per or the c	ertificate numbe	er of so	cial heal	th									
b) SI. No/ Certificate No.			insurance							As	allotted b	y the o	rganı	zation				
c) Company TPA ID No.			Enter the 1	TPA ID No							ense num cuments.	ber as	allott	ed by I	RDA and	d printed ir	n TPA	
d) Name			Enter the fi	ull name of the policy	holder					_	rname, Fi	irst nam	ne M	liddle r	ame			
e) Address				ull postal address	Holder						lude Stre							
				ECTION B - DETAILS O	OF INSURAN	NCE HISTORY				1		,,						
a) Currently covered by any other Medi	iclaim / Health Incurance	.2	Indicate wh	nether currently cover	ed by anoth	her Mediclaim / I	Health	Incuranc	-	Tic	k Yes or	No						
		**					lealin	insuranc		-								
b) Date of Commencement of first Insu	irance without break			late of commenceme							e dd-mm-							
c) Company Name Policy No.				ull name of the insura	ance compa	any					me of the							
Sum Insured				olicy number	41 1:						allotted b	y the ir	isura	nce co	mpany			
d) Have you been Hospitalized in the la	act 4 years since incentic	on of the contract?		otal sum insured as p nether hospitalized in						_	upees k Yes or	No	—					
Date	ast 4 years since inception	on or the contract:		late of hospitalization		yours				_	e mm-yy							
Diagnosis				liagnosis details						_	en Text	ionnat						
a) Draviavah Covered by any other Ma	dialaim/ Haalth Jacurana			nether previously cove	arad by and	other Mediclaim	/ Hoalt	h Incurar	.00		k Yes or	No						
e) Previously Covered by any other Me	edicialiii/ Healtii Insurand	;e :	iliulcate wi	lettlet previously cove	ered by and	other wediciality	/ Healt	IIISUIAI	ice	TIC	K 162 UI	INU						
f) Company Name				ull name of the insura						Na	me of the	organi	zatio	n in ful	1			
a) Name				N C - DETAILS OF INS		SON HOSPITALIZ	ZED			1								
b) Gender				ull name of the patier	nt						rname, Fi			iddle n	ame			
c) Age				ender of the patient of the patient							k Male or			ontho				
d) Date of Birth				of Birth of patient						_	mber of y e dd-mm-			Jillio				
e) Relationship to primary Insured				lationship of patient v	vith policyh	nolder				_				thers.	please sp	pecify.		
f) Occupation				cupation of patient						_					please sp			
g) Address			Enter the fo	ull postal address						Inc	lude Stre	et, City	and	Pin Cc	de			
h) Phone No			Enter the p	hone number of patie	ent					Inc	lude STD	code v	with to	elepho	ne numb	er		
i) E-mail ID			Enter e-ma	ail address of patient						Co	mplete e-	mail ac	dres	s				
			ı	SECTION D - DETAILS	OF HOSPIT	TALIZATION												
a) Name of Hospital where admitted				ame of hospital						_	me of ho							
b) Room category occupied c) Hospitalization due to			Indicate the	e room category occu	upied						k the righ	-						
d) Date of Injury/Date Disease first dete	ected/ Date of Delivery			ason of hospitalizatio	on						k the righ	-						
e) Date of admission	ected/ Date of Delivery			elevant date							e dd-mm-	•						
f) Time				of admission of admission							e dd-mm- e hh:mm		nat					
g) Date of discharge				of discharge						_	e dd-mm-		nat					
h) Time				of discharge						_	e hh:mm							
i) If Injury give cause				use of injury						_	k the righ							
If Medico legal				nether injury is medic	o legal						k Yes or							
Reported to Police				hether police report w						Tic	k Yes or	No						
MLC Report & Police FIR attached			Indicate wh	Indicate whether MLC report and Police FIR attached														
j) System of Medicine			Enter the s	ystem of medicine fo	llowed in tr	reating the patie	ent			Op	en Text							
				SECTION E - DE	TAILS OF C	CLAIM												
a) Details of Treatment Expenses			Enter the a	mount claimed as tre	eatment exp	penses				ln r	upees (D	o not e	nter p	oaise v	alues)			
 b) Claim for Domiciliary Hospitalization c) Details of Lump sum/ cash benefit cl 				nether claim is for dor						_	k Yes or							
d) Claim Documents Submitted-Check				mount claimed as lur							upees (D			oaise v	alues)			
a, c.a.m bocuments Submitted-Check	. 2.01		Indicate wh	nich supporting docum						Гic	k the righ	t optior	1					
Indicate which bills are enclosed with the	he amounts in rupees			SECTION F - DETAILS	OF BILLS	FUCTOSED							—					
			SECTION	G - DETAILS OF PRIMA	ARY INSTIRE	ED'S RANK ACC	DUNT											
a) PAN			-	ermanent account nu			111			Αs	allotted h	v the Ir	ncom	e Tax	departme	ent		
b) Account Number				ank account number							allotted b	•			- Sparaile			
c) Bank Name and Branch				ank name along with		h				_	me of the	•						
d) Cheque/ DD payable details				ame of the beneficiar			e mad	e out to		_					zation in f	full		
e) IFSC Code				FSC code of the bank							C code c			-				
				SECTION H - DECLAR	ATION BY T	HE INSURED												
Read declaration carefully and mention	n date (in dd:mm:yy form	at), place (open text) and s	sign.															



CLAIM FORM - PART B

TO BE FILLED IN BY THE HOSPITAL

The issue of theis form is not to be taken as admission of liability Please include the original preauthorization request form in lieu of PART A

DETAILS OF HOSPITAL																														letters)
a) Name of the Hospital:					T	$\overline{}$	П	$\overline{1}$	T																		T			
c) Hospital ID:	П			廿	Ħ	士		c) Typ	oe of Ho	spital:			Netwo	ork	Non I	letwork	T					(if nor	netwo	ork, fill	Sectio	n E)				
d) Name of the treating doctor	г			Ħ	Ŧ	Ŧ		T	\top								Ť	1				Ī		Т		Ī	\neg			
e) Qualification:						i	f)	Registratio	n No. w	ith state	code:								g) Phon	e No.			i	Ħ			Ħ	İ		İ
DETAILS OF PATIENT ADM	ITTED																													
a) Name of Patient:	П			$\overline{1}$	T			$\overline{1}$	T															T			\exists	T		
b) IP Registration No.:				\top	T		c) Gender	r: Ma	ale	F	emale			d) Age: y	ears		mont	hs		e) Dat	e of Bir	th:	Ī	\exists			\exists			
f) Date of Admission:					op	Ī	g) Time:						h)	Date of Di	scharge:					[- i	i) Time	. [\equiv		: 🗆	
j) Type of Admission: Eme	rgency		Planne	d 🔲	D;	ay Care	Ma	aternity	Ī		k) If N	1atemit	ty:	i. Date	of Delivery									j	ii. Grav	ida Sta	atus:			
I) Status at time of discharge:		Dischar	ged to hon	пе		Discha	rged to an	other hospi	ital _		Decea	ased								n	n) Total	claim	ed am	ount [\Box			
DETAILS OF AILMENT DIAG	NOSED	PRIMAR	Y)																											
a)		IC	0 10 Code	3				Descrip	tion			b)				-	CD 10	PCS							De	scriptic	on		
i. Primary Diagnosis :													i. Pro	cedure 1 :								[
					_	\vdash			_													ļ		_			_			
ii. Additional Diagnosis :						-							ii. Pro	ocedure 2								ŀ								
iii. Co-morbidities :				$\overline{}$	\neg	\vdash					=		iii De	ocedure 3			1	1	1		$\overline{}$	I I		_			_			
iii. Co-morbidiles :													iii. Pf	occuure 3				1	1			ŀ		_						
iv. Co-morbidities :			ШΤ						_				iv. De	etails of Pr	ocedure :									_						
																								_			_			
c) Pre authorization obtained:							Yes	No		d) f	re-autho	rization	numbe	er:																
e) If authorization by network	hospital n	ot obtaine	d, give rea	son:		L					_													_						
f) Hospitalization due to injury	: L	Yes	No	1	i. If y	yes, give	cause		Self	inflicted	닏		Road T	raffic Acci	dent	_			Sul	stance	abuse	/ alco	hol co		_		_		_	_
ii. If injurydue to Substance abo	use / alcoh	nol consu	mption, Te	st Conducte	d to esta	ablish this	S:		L	Yes	1	No _	(if ye	es, attach	eports)	iii. If N	ledico L	.egal:		Yes	l	No		iv. Re	eported	l to Po	lice:	Y	es	No
v. FIR No.							٧	i. If not rep	orted to	police,	give reas	on:																		
CLAIM DOCUMENTS SUBM			ST		—	—	—					_	_														—			
Claim Form d												F	4		ion reports															
Original Pre-a												Ļ	4		USG/ HPE		ition rep	orts												
Copy of the P												Ļ	4		eferance s	lip														
Copy of photo			verified by	nospital								Ļ	_	ECG																
Hospital disch												F	=	Pharmac																
Oparation The		S										F	=		ort & Police															
Hospital main												F	=		leath sumr		nospital	where	applica	ble										
Hospital break	c-up bill											L		Any othe	r, please s	pecity														
DETAILS IN CASE OF NON I	NETWOR	K HOSPI	TAL (ONL)	/ FILL IN C/	ASE OF	NON NE	TWORK F	HOSPITAL)	i				_																	
a) Address of the hospital:	П		ΤÌΤ	$\overline{\top}$	\top	$\overline{\Box}$		$\overline{\top}$	\top		T							_	_					=	Т		=	_	_	
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City	:H					1 1	1 [Т	$\frac{1}{1}$	\pm	1			$\frac{1}{1}$	+	$\frac{1}{1}$	<u> </u>		T	i		+	<u> </u>	1	\dashv	<u> </u> 	$\frac{\perp}{\perp}$	
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Pin (Code:			Ħ	Ŧ	<u>+</u>	Phone No		<u> </u>					State:			<u> </u>	c) R	egistrat	on No.	with S	tate C	ode:	<u> </u>			<u> </u>			
	Code:				I I	b) Phone No		Ther of	inpatien	t beds			State:	f) Facilitie	available	in the h		egistrati	- 1		Г	—i	1			CU:		es	I I
d) Hospital PAN	Code:					b) Phone No		mber of	inpatien	t beds			State:	f) Facilitie	available	in the h			on No.		tate C	—i	I		ii.	ICU:		es	No
d) Hospital PAN iii. Others:						b) Phone No		nber of	inpatien	t beds			State:	f) Facilitie	s available	in the h			- 1		Г	—i	I I I No						
d) Hospital PAN iii. Others: DECLARATION BY THE HOS	SPITAL							e) Nun										ospital		i. OT:	,	Yes [(Pl	ease re	ead ve	y caref	
d) Hospital PAN iii. Others:	SPITAL	on furnish	ed in this C	laim Form is	; true & c			e) Nun				l l	de any f					ospital		i. OT:	,	Yes [aim un	(Pl	ease re	ead ve	y caref	
d) Hospital PAN iii. Others: DECLARATION BY THE HO: We hereby declare that the forfeited.	SPITAL	on furnish	ed in this C	laim Form is	true & c			e) Nun				l l	de any t					ospital		i. OT:	,	Yes [aim un	(Pl	ease re	ead ve	y caref	
d) Hospital PAN iii. Others: DECLARATION BY THE HOS We hereby declare that the	SPITAL	on furnish	ed in this C	laim Form is	s true & c			e) Nun				l l	de any t					ospital		i. OT:	,	Yes [in un	(Pl	ease re	ead ve	y caref	
d) Hospital PAN iii. Others: DECLARATION BY THE HO: We hereby declare that the forfeited.	SPITAL	on furnish	ed in this C	laim Form is	s true & c			e) Nun				l l	de any t		true stater		ress or	concea		i. OT:	,	Yes [I I	(Pl	ease re	ead ve	y caref	
d) Hospital PAN iii. Others: DECLARATION BY THE HO: We hereby declare that the forfeited. Date:	SPITAL	on furnish	ed in this C	laim Form is	true & c			e) Nun				l l	de any t		true stater	nent, supp	ress or	concea		i. OT:	,	Yes [aim un	(Pl	ease re	ead ve	y caref	
d) Hospital PAN iii. Others: DECLARATION BY THE HO: We hereby declare that the forfeited. Date:	SPITAL	on furnish	ed in this C	laim Form is	s true & c		the best of	e) Nur	edge ar	nd belief	. If we ha			false or un	true stater	nent, supp	ress or	concea		i. OT:	,	Yes [alim un	(Pl	ease re	ead ve	y caref	
d) Hospital PAN iii. Others: DECLARATION BY THE HO: We hereby declare that the forfeited. Date:	SPITAL		ed in this C		s true & c		the best of	e) Nun	edge ar	nd belief	. If we ha		– PAR	false or ur	true stater Signa e filled in	nent, supp	ress or	concea		i. OT:	,	Yes [(Please of the second s	ease re	ead ve	y caref	
d) Hospital PAN iii. Others: DECLARATION BY THE HO: We hereby declare that the forfeited. Date:	SPITAL				as true & c		the best of	e) Nur	edge ar	nd belief	. If we ha	FORM :	– PAR	false or un	true stater Signa e filled in	nent, supp	ress or	concea		i. OT:	,	Yes [(Pl	ease re	ead ve	y caref	
d) Hospital PAN iii. Others: DECLARATION BY THE HO: We hereby declare that the forfeited. Date: Place:	SPITAL				s true & c		the best of	e) Nun of our knowle	edge ar	LLING SEC	CLAIM F	FORM :	– PAR	T B (To b	true stater Signa e filled in	nent, supp	ress or	concea		OT:	of hos	Yes [ur righ			(Please of the second s	ease re	ead ve	y caref	
d) Hospital PAN iii. Others: DECLARATION BY THE HO: We hereby declare that the forfeited. Date: Place: a) Name of Hospital b) Hospital ID	SPITAL				s true & c		the best of	e) Nun of our knowle	edge ar	SEC of hosp	CLAIM F TION A ital pital	FORM -	– PAR [*] DES AILS O	T B (To b	true stater Signa e filled in	nent, supp	ress or	concea		OT:	of hos	Yes [ur righ			(Please of the second s	ease re	ead ve	y caref	
d) Hospital PAN iii. Others: DECLARATION BY THE HO: We hereby declare that the forfeited. Date: Place:	SPITAL				s true & c		the best of	e) Nur	e name	SEC of hosp	CLAIM P TION A ital pital	- DET/	– PAR [*] DES AILS O	T B (To b	true stater Signa e filled in	nent, supp	ress or	concea		Name As allo	of hose	Yes [u full			(Please of the second s	ease re	ead ve	y caref	
d) Hospital PAN iii. Others: DECLARATION BY THE HO: We hereby declare that the forfeited. Date: Place: a) Name of Hospital b) Hospital ID c) Type of Hospital	SPITAL				s true & c		the best of	e) Nur of our knowle JIDANCE F Enter the Enter ID Indicate Enter the	edge ar	SEC of hosp	CLAIM F TION A ital pital	- DET/	– PAR* DES AILS O	T B (To b	true stater Signa e filled in	nent, supp	ress or	concea		Name As allo Tick th	of hos	Yes [I full TPA	it to cla	FOI	(PI	ease re	ead ve	y caref	
d) Hospital PAN iii. Others: DECLARATION BY THE HO: We hereby declare that the forfeited. Date: Place: a) Name of Hospital b) Hospital ID c) Type of Hospital d) Name of treating doct e) Qualification f) Registration No. with 3	SPITAL	DATA			s true & c		the best of	e) Nur	e name e name o numbe e name e qualifi	SEC of hosp or of hos r In network of the treatment of th	CLAIM F TION A TION A pital pital of the tre umber of	- DET/	– PAR DES AILS O	T B (To b	Signa Signa N N	ture of the	ress or	concea		Name As allo Name As allo As allo	of hos ocated he right of doc viations	Yes fact, c	I full TPA Thull Iucation Medica	nal qua	FOI	(Plader this	ease re	ead ve	y caref	
d) Hospital PAN iii. Others: DECLARATION BY THE HO: We hereby declare that the forfeited. Date: Place: a) Name of Hospital b) Hospital ID c) Type of Hospital d) Name of treating doct e) Qualification	SPITAL	DATA			s true & c		the best of	e) Nur	FOR FI	SEC of hosp of the transfer of	CLAIM F TION A ital pital vork or not reating d of the tre umber of doct	- DET/	– PAR DES AILS O	T B (To b	Signa Signa Filled in N TAL	by the h	ress or	concea		Name As allo Name As allo As allo	of hospocated he right of doc	Yes fact, c	I full TPA Thull Iucation Medica	nal qua	FOI	(Plader this	ease re	ead ve	y caref	

b) IP Registration Number	Enter insurance provider registration number	As allotted by the insurance provider
c) Gender	Indicate Gender of the patient	Tick Male or Female
d) Age	Enter age of the patient	Number of years and months
e) Date of Admission	Enter date of admission	Use dd-mm-yy format
f) Time	Enter time of admission	Use hh:mm format
g) Date of Discharge	Enter date of discharge	Use dd-mm-yy format
h) Time	Enter time of discharge	Use hh:mm format
i) Type of Admission	Indicate type of admission of patient	Tick the right option
j) If Maternity		
Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format
Gravida Status	Enter Gravida status if maternity	Use standard format
k) Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
	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 text
Procedure 3	Enter the ICD 10 PCS and description of the third procedure	Standard Format and Open text
Details of Procedure	Enter the details of the procedure	Open text
c) Pre-authorization obtained	Indicate whether pre-authorization obtained	Tick Yes or No
d) Pre-authorization Number	Enter pre-authorization number	As allotted by TPA
e) If authorization by network hospital not obtained, give reason	Enter reason for not obtaining pre-authorization number	Open text
f) Hospitalization due to injury	Indicate if hospitalization is due to injury	Tick Yes or No
Cause	Indicate cause of injury	Tick the right option
If injury due to substance abuse/alcohol consumption, test conducted to establish this	Indicate whether test conducted	Tick Yes or No
Medico Legal	Indicate whether injury is medico legal	Tick Yes or No
Reported To Police	Indicate whether police report was filed	Tick Yes or No
FIR No.	Enter first information report number	As issued by police authorities
If not reported to police, give reason	Enter reason for not reporting to police	Open Text
	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 INSURED	
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign	ŋn.	