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KERALA WATER AUTHORITY

Jalabhavan
Thiruvananthapuram – 695033
Kerala - India

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

Dated: 25-10-2025

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

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

2) ബഫർ ഫണ്ട് അനുവദിക്കുന്നതിന് മാനേജിംഗ് ഡയറക്ടർക്ക് നേരിട്ട് അപേക്ഷ kwa.tvn.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 ഡോക്ടറുടെ സാക്ഷ്യപത്രത്തിന്റെ അടിസ്ഥാനത്തിൽ ഇൻഷുറൻസ് കമ്പനിയുടെ റിപ്പോർട്ട് കൂടി ലഭ്യമാക്കി ബഫർ ഫണ്ടിന് പരിഗണിക്കുന്നതാണ് .

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

സി) ബഹർ ക്ലെയിമിൽ ഉൾപ്പെടുത്തി അനുവദിക്കുന്ന **reimbursement** ക്ലെയിമുകൾക്ക് ഡിസ്ചാർജ്ജ് സമ്മതി/ ഫൈനൽ ബില്ലിന്റെ പകർപ്പ് എന്നിവ സഹിതം 30 ദിവസത്തിനുള്ളിൽ അപേക്ഷ സമർപ്പിക്കേണ്ടതാണ്. കൂടാതെ അതിനാസ്വദമായ ഇൻഷുറൻസ് ക്ലെയിം അപേക്ഷ ഇൻഷുറൻസ് കമ്പനിക്ക് TPA (Third Party Administrator) മുഖേന സാധാരണ **reimbursement** ക്ലെയിമുകൾ സമർപ്പിക്കുന്ന രീതിയിൽ (അനുബന്ധം-1) നിർബന്ധമായും സമർപ്പിക്കേണ്ടതാണ്. ഇത്തരത്തിൽ **reimbursement**-നായി സമർപ്പിക്കുന്ന അപേക്ഷകളിൽ ക്യാഷ്-ലെസ്സ് അനുവദിച്ച ശേഷമുള്ള തുക കമ്പനി റിപ്പോർട്ടിന്റെ അടിസ്ഥാനത്തിൽ ബഹർ 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 ബഹർ ഫണ്ടിന് അനുവദിക്കുന്നതാണ്.

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

ഉള്ളടക്കം: അനുബന്ധം1: TPA യ്ക്ക് റീ-ഇമ്പേഴ്സ്മെന്റിനുള്ള ക്ലെയിമുകൾ സമർപ്പിക്കേണ്ട അപേക്ഷാഫോമും നിർദ്ദേശങ്ങളും

Binu Signed by

M Binu 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.
10. 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



UNITED INDIA INSURANCE COMPANY LIMITED
REGISTERED & HEAD OFFICE: 24, WHITES ROAD, CHENNAI-600014

CLAIM FORM - PART A
TO BE FILLED IN BY THE INSURED

The issue of this 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:			
City:		State:	
Pin Code:		Phone No:	
		Email ID:	

DETAILS OF INSURANCE HISTORY

a) Currently covered by any other Medica/ Health Insurance:	<input type="checkbox"/> Yes <input type="checkbox"/> No	b) Date of commencement of first insurance without break:	
c) If yes, company name:		Policy No:	
Sum Insured (₹):		d) Have you been hospitalized in the last four years since inception of the contract?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diagnosis:		Date:	
f) If yes, Company Name :		e) Previously covered by any other Medica/ Health Insurance :	<input type="checkbox"/> Yes <input type="checkbox"/> No

DETAILS OF INSURED PERSON HOSPITALIZED

a) Name :			
b) Gender :	Male <input type="checkbox"/> Female <input type="checkbox"/>	c) Age: years	
		months	
		d) Date of Birth:	
e) Relationship to Primary Insured:	Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Other <input type="checkbox"/>	(Please specify)	
f) Occupation:	Service <input type="checkbox"/> Self Employed <input type="checkbox"/> Homemaker <input type="checkbox"/> Student <input type="checkbox"/> Retired <input type="checkbox"/> Other <input type="checkbox"/>	(Please specify)	
g) Address (if different from above):			
City:		State:	
Pin Code:		Phone No:	
		Email ID:	

DETAILS OF HOSPITALIZATION

a) Name of Hospital where Admitted:			
b) Room category occupied:	Day Care <input type="checkbox"/> Single occupancy <input type="checkbox"/> Twin sharing <input type="checkbox"/> 3 or more beds per room <input type="checkbox"/>		
c) Hospitalization due to:	Injury <input type="checkbox"/> Illness <input type="checkbox"/> Maternity <input type="checkbox"/>	d) Date of injury/ Date Disease first detected/ Date of Delivery:	
e) Date of Admission:		f) Time:	
		g) Date of Discharge:	
		h) Time:	
i) If injury, give cause:	Self inflicted <input type="checkbox"/> Road Traffic Accident <input type="checkbox"/> Substance abuse / Alcohol Consumption <input type="checkbox"/>	i. If Medico Legal: <input type="checkbox"/> Yes <input type="checkbox"/> No	
ii. Reported to police:	<input type="checkbox"/> Yes <input type="checkbox"/> No	iii. MLC Report & Police FIR attached:	<input type="checkbox"/> Yes <input type="checkbox"/> No
		j) System of medicine:	

DETAILS OF CLAIM

a) Details of treatment expenses claimed	Claim Documents Submitted- Check List:	
i. Pre Hospitalization Expenses		Claim FormDuly signed
iii. Post Hospitalization Expenses		Copy of the claim intimation, if any
v. Ambulance Charges		Hospital Main bill
		Hospital Break-up bill
vi. Pre hospitalization period: days		Hospital Discharge Summary
b) Claim for Domiciliary Hospitalization: <input type="checkbox"/> Yes <input type="checkbox"/> No	(if yes, provide details in annexure)	Pharmacy Bill
c) Details of Lump sum / cash benefit claimed:		Operation Theatre Notes
i. Hospital Daily Cash:		ECG
iii. Critical Illness Benefit:		Doctor's request for investigation
v. Pre/Post hosp. Lump sum benefit:		Investigation Reports (including CT / MRI / USG / HPE)
		Doctor's Prescription
		Others

DETAILS OF BILLS ENCLOSED

Sl. No.	Bill No.	Date	Issued By	Towards	Amount (₹)
1				Hospital Main Bill	
2				Pre hospitalisation Bills: ___Nos	
3				Post hospitalisation Bills: ___Nos	
4				Pharmacy Bills:	
5					
6					
7					
8					
9					
10					

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:

DECLARATION BY THE INSURED

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 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: Place:

Signature of the insured:

GUIDANCE FOR FILLING CLAIM FORM – PART A (To be filled in by the insured)		
DATA ELEMENT	DESCRIPTION	FORMAT
SECTION A - DETAILS OF PRIMARY INSURED		
a) Policy No.	Enter the policy number	As allotted by the insurance company
b) Sl. 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 as allotted by IRDA and printed in TPA documents.
d) Name	Enter the full name of the policyholder	Surname, First name, Middle name
e) Address	Enter the full postal address	Include Street, City and Pin Code
SECTION B - DETAILS OF INSURANCE HISTORY		
a) Currently covered by any other Medicaclaim / Health Insurance?	Indicate whether currently covered by another Medicaclaim / 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	Enter the full name of the insurance company	Name of the organization in full
Policy No.	Enter the policy number	As allotted by the insurance company
Sum Insured	Enter the total sum insured as per the policy	In rupees
d) Have you been Hospitalized in the last 4 years since inception of the contract?	Indicate whether hospitalized in the last 4 years	Tick Yes or No
Date	Enter the date of hospitalization	Use mm-yy format
Diagnosis	Enter the diagnosis details	Open Text
e) Previously Covered by any other Medicaclaim/ Health Insurance?	Indicate whether previously covered by another Medicaclaim / 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	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, please specify.
f) Occupation	Indicate occupation of patient	Tick the right option. If others, please specify.
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 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	Enter time of discharge	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	Tick Yes or No
Reported to Police	Indicate whether police report was filed	Tick Yes or No
MLC Report & Police FIR attached	Indicate whether MLC report and Police FIR attached	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 as 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
SECTION F - DETAILS OF BILLS ENCLOSED		
Indicate which bills are enclosed with the amounts in rupees		
SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT		
a) PAN	Enter the permanent account number	As allotted by the Income Tax department
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
SECTION H - DECLARATION BY THE INSURED		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.		



UNITED INDIA INSURANCE COMPANY LIMITED
REGISTERED & HEAD OFFICE: 24, WHITES ROAD, CHENNAI-600014

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

a) Name of the Hospital:																																
c) Hospital ID:											c) Type of Hospital:	Network	<input type="checkbox"/>	Non Network	<input type="checkbox"/>	(if non network, fill Section E)																
d) Name of the treating doctor:																																
e) Qualification:											f) Registration No. with state code:											g) Phone No.:										

SECTION A

DETAILS OF PATIENT ADMITTED

a) Name of Patient:																																			
b) IP Registration No.:											c) Gender :	Male	<input type="checkbox"/>	Female	<input type="checkbox"/>	d) Age: years			months			e) Date of Birth:													
f) Date of Admission:							g) Time:			:			h) Date of Discharge:							i) Time:			:												
j) Type of Admission:	Emergency	<input type="checkbox"/>	Planned	<input type="checkbox"/>	Day Care	<input type="checkbox"/>	Maternity	<input type="checkbox"/>	k) If Maternity:			i. Date of Delivery:							ii. Gravida Status:																
l) Status at time of discharge:	Discharged to home		<input type="checkbox"/>		Discharged to another hospital		<input type="checkbox"/>		Deceased		<input type="checkbox"/>																				m) Total claimed amount				

SECTION B

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:	<input type="checkbox"/> Yes <input type="checkbox"/> No		d) Pre-authorization number:		
e) If authorization by network hospital not obtained, give reason:					
f) Hospitalization due to injury:	<input type="checkbox"/> Yes <input type="checkbox"/> No		i. If yes, give cause	Self inflicted <input type="checkbox"/> Road Traffic Accident <input type="checkbox"/> Substance abuse / alcohol consumption <input type="checkbox"/>	
ii. If injury due to Substance abuse / alcohol consumption, Test Conducted to establish this:	<input type="checkbox"/> Yes <input type="checkbox"/> No		(if yes, attach reports)	iii. If Medico Legal:	<input type="checkbox"/> Yes <input type="checkbox"/> No
iv. Reported to Police:	<input type="checkbox"/> Yes <input type="checkbox"/> No				
v. FIR No.			vi. If not reported to police, give reason:		

SECTION C

CLAIM DOCUMENTS SUBMITTED - CHECKLIST

<input type="checkbox"/> Claim Form duly signed	<input type="checkbox"/> Investigation reports
<input type="checkbox"/> Original Pre-authorization request	<input type="checkbox"/> CT/ MRI/ USG/ HPE/ Investigation reports
<input type="checkbox"/> Copy of the Pre-authorization approval letter	<input type="checkbox"/> Doctor's reference slip
<input type="checkbox"/> Copy of photo ID card of patient verified by hospital	<input type="checkbox"/> ECG
<input type="checkbox"/> Hospital discharge summary	<input type="checkbox"/> Pharmacy bills
<input type="checkbox"/> Operation Theatre Notes	<input type="checkbox"/> MLC report & Police FIR
<input type="checkbox"/> Hospital main bill	<input type="checkbox"/> Original death summary from hospital, where applicable
<input type="checkbox"/> Hospital break-up bill	<input type="checkbox"/> Any other, please specify

SECTION D

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:	<input type="checkbox"/> Yes <input type="checkbox"/> No	ii. ICU:	<input type="checkbox"/> Yes <input type="checkbox"/> No						
iii. Others:																																

SECTION E

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, suppress or concealment of any material fact, our right to claim under this claim shall be forfeited.

Date:

Place:

Signature of the insured:

SECTION F

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 hospital	As allocated by the 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 the treating doctor	Name of doctor in full
e) Qualification	Enter the qualifications 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 of India
g) Phone No.	Enter the phone number of doctor	Include STD code with telephone number
SECTION B - DETAILS OF THE PATIENT ADMITTED		
a) Name of Patient	Enter the name of hospital	Name of hospital in full

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.		