Health Insurance

Aditya Birla Health Insurance Co. Limited



Activ Care - Claim Form - Part A (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)

a.	Name of the hospital:					
b.	Hospital ID:					
C.	Type of Hospital:	Network Non Ne	etwork (if non netwo	ork fill section E)		
d.	Name of the treating	doctor:				
e.	Qualification:					
f.	Registration No. with	State Code:				
g.	Phone No:					
2.	DETAILS OF THE PA	TIENT ADMITTED				
a.	Name of the Patient:					
b.	IP Registration Number	er:				
C.	Gender: Male	Female		d. Age: Y Y Years M	M Months	
e.	Date of Birth:	M M Y Y Y Y	f. Date of Admis	sion: DDMMYYY	Y Y g. Tim	ne:
h.	Date of Discharge:	D D M M Y Y Y	i. Time:			
j.	Type of Admission:	Emergency	Planned Day Care	Maternity		
k.	If Maternity i) Date of	Delivery: DDMM	Y Y Y Y	ii) Gravida Status:		
l.	Status at time of disc	harge: Discharge t	to home D	scharge to another hospital	Deceased	
m.	Total claimed amount:	Rs.				
m.	Total claimed amount:	Rs.				
m.		Rs. IT DIAGNOSED (PRIMAR	RY)			
			RY) Description	a)	ICD 10 PCS	Description
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4.	CLAIM DOCUMENTS SUBMITTED - CHECK LIST:				
	a. Claim Form duly signed		b. O	riginal Pre-aut	thorization request
	c. Copy of the Pre-authorization approval letter		d. Co	opy of photo I	D Card of patient verified by hospital
	e. Hospital Discharge summary		f. Op	eration Theat	tre Notes
	g. Hospital main bill		h. H	ospital break-	up bill
	i. Investigation reports		j. CT	/MR/USG/HI	PE investigation reports
	k. Doctor's reference slip for investigation		l. EC	G	
	m. Pharmacy bills		n. M	LC reports & I	Police FIR
	o. Original death summary from hospital where applicable				
	p. Any other P L E A S E S P E C I F Y				
5.	ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL	(ON	ILY F	ILL IN CASE	OF NON-NETWORK HOSPITAL)
a.	Address of the Hospital:				
	City: State:				Pin Code:
b.	Phone No. c. Registration No. w	vith S	State	Code:	
d.	Hospital PAN: e. Numbe	r of I	Inpati	ent beds:	
f.	Facilities available in the hospital: OT: Yes No	ICU	:	Yes	No
g.	Others:				
6.	DECLARATION BY THE HOSPITAL (PLEASE READ VERY CAREF	ULL	Y)		
We	hereby declare that the information furnished in this Claim Forr	n is	true	& correct to	the best of our knowledge and belief. If we have
mac	de any false or untrue statement, suppression or concealment o	f an	y ma	terial fact, ou	ur right to claim under this claim shall be
forf	eited.				
	Date: D D M M Y Y Y Y				
	Place:				Signature and Seal of the Hospital Authority:

DATA ELEMENT DESCRIPTION PORMAT	GUIDANCE FOR F	ILLING CLAIM FORM - PART B (To be filled in	by the hospital)
Discontinuity Discontinuit	DATA ELEMENT	DESCRIPTION	FORMAT
Disposability Comment		SECTION A - DETAILS OF HOSPITAL	
indicate whether in network or non network or non network or non network in paytor of Name of treating doctor or Enter the name of the treating doctor or All more of doctor in full or the payment of the treating doctor or All more of doctor in full or the payment of the treating doctor or All more of doctor in full or the payment of the treating doctor or All more of doctor in full or the payment of the payment of the doctor of the treating doctor or As allocated by the Medical Council or India of payment or the doctor of the payment or the doctor of the payment or the doctor of the payment or the payment or the doctor of the payment or pa	a) Name of Hospital	Enter the name of hospital	Name of hospital in full
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d) Name of treating doctor Counting treating doctor Counting treating doctor Counting treating doctor Counting treating doctor Counting treating doctor Counting treating doctor Counting treating doctor Counting treating doctor Counting treating doctor Counting treating doctor Counting treating doctor Counting treating	c) Type of Hospital	Indicate whether In network or non network	Tick the right option
Disagnification of the treating doctor Disagnification with State Code Enter the registration of the doctor along with the state code git Phone No. Enter the phone number of doctor section is - DETAILS OF THE PATIENT ADMITTED a) Name of Patient b) IP Registration Number Enter the phone number of doctor include STD code with religious runtber SECTION 8 - DETAILS OF THE PATIENT ADMITTED a) Name of Patient b) IP Registration Number Enter the manner of hospital b) IP Registration Number C) Gunder Indicate Gender of the patient D) Page of the patient D) Date of Birth Enter date of admission Enter date of admission Enter date of admission Enter date of admission D) Use of Admission Enter date of admission D) Use of Discharge Enter date of discharge Use of Use Admission D) Use of Discharge Enter date of discharge Enter date of discharge Use of Discharge Enter date of discharge Use of Discharge Enter date of Discharge Enter date of Discharge Enter date of Discharge Use of Discharge Enter date of Discharge Use of Discharge Enter date of Discharge Enter date of Discharge Use dischar		hospital	
Pregistration No. with State Code Enter the registration number of the doctor Adellocated by the Medical Council of India along with the state code Adellocated by the Medical Council of India along with the state code Adellocated STD code with telephone number	d) Name of treating doctor	Enter the name of the treating doctor	Name of doctor in full
pi Pharun No. Enter the pharun number of dector SECTION B - DETAILS OF THE PATIENT ADMITTED a) Name of Patuent Enter the pharun number of dector Beginstation Number Enter the rame of finespital Name of Negitial in full	e) Qualification	Enter the qualification of the treating doctor	Abbreviations of educational qualifications
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SECTION B - DETAILS OF THE PATIENT ADMITTED a) Name of Patient Enter the name of hospital Name of hospital in full b) PRegistration Number Enter insurance provider registration number c) Gender Indicate Gender of the patient Tick Maile or Fernale d) Age Enter age of the patient Number of years and months e) Date of Birth Enter date of admission Use di-mm-yy format e) Date of Admission Enter date of admission Use di-mm-yy format e) Date of Discharge Enter time of discharge Use di-mm-yy format e) Time Enter time of discharge Use himm format e) Date of Discharge Enter time of discharge Use himm format e) Time Enter time of discharge Use himm format e) Time Enter time of discharge Use himm format e) Time Enter time of discharge Use himm format e) Time Enter time of discharge Use himm format e) Time Enter time of discharge Use himm format e) Time Enter time of discharge Use himm format e) Time Enter time of discharge Use di-mm-yy format e) Time Enter of Admission of patient Tick the right option e) Time Enter of Enter time of the Standard format e) Tick the right option e) Tick the right op		along with the state code	
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Medico Legal Indicate whether injury is medico legal Tick Yes or No			
		Indicate whether injury is medico legal	Tick Yes or No
	_	Indicate whether police report was filed	Tick Yes or No

FIR No.	Enter first information report number	As issued by police authorities Open Text	
If not reported to police, give reason	Enter reason for not reporting to police		
s	SECTION D - CLAIM DOCUMENTS SUBMITTED-CHE	CK LIST	
Indicate which supporting documents are	submitted		
SI	ECTION E - DETAILS IN CASE OF NON NETWORK H	OSPITAL	
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 allocated 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 HOSPITA	L	
Read declaration carefully and mention da	ate (in dd:mm:yy format), place (open text) and sign and	stamp	

