CHOLAMANDALAM MS GENERAL INSURANCE COMPANY LIMITED
Registered Office: 2nd Floor, "DARE House", 2, N.S.C. Bose Road, Chennai - 600 001.
Toll free: 1800 208 9100 | T: +91 (0) 44 4044 5400 | E: customercare@cholams.murugappa.com | website: www.cholainsurance.com
IRDA Regn. No.123 | PAN: AABCC6633K | CIN: U66030TN2001PLC047977
REACH US THROUGH WHATSAPP 7305234433

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

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

☐ IN-PATIENT HOSPITALIZATION CLAIM ☐ CRITICAL ILLNESS ☐ HOSPITAL DAILY CASH ☐ HEALTH CHECK UP
☐ PRE AND POST CLAIM ☐ OUT-PATIENT CLAIM ☐ OTHERS

SECTION A – DETAILS OF PRIMARY INSURED

a.	Policy No		Membership No
b.	Certificate No		
c.	Company / TPA ID No		
d.	ABHA ID No		
e.	Name (In Block Letters)		
f.	Address (In Block Letters)		
	Phone No	Email ID	
	WhatsApp No	☐ I hereby provide my consent for Chola MS to communicate through Whatsapp	

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	DD/MM/YYYY	
c.	If Yes, Company Name		
	Policy No.		
	Sum Insured		
d.	Have you been hospitalized in the last four years since inception of the contract	YES / NO	Date: MM/YYYY
	Diagnosis		
e.	Previously covered by any other Mediclaim/Health insurance	YES / NO	
f.	If yes, Company Name		

SECTION C – DETAILS OF INSURED PERSON HOSPITALISED

a.	Name			____	____
b.	Relationship (Self/spouse/Child/Father/Mother/Other)	c. Date of Birth		d. Age Yrs	months
e.	Address (If different than above)				
f.	Gender	Male / Female	g. Occupation	Service/Self-employed/ Homemaker/student/ Retired/ Others	
h.	Telephone No	i. Mobile No			
j.	E-mail ID, if any				

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SECTION D - DETAILS OF HOSPITALISATION

a. Name of the Hospital where admitted			
b. Room Category occupied		Daycare/Single Occupancy/Twin Sharing/3 or more beds per room	
c. Hospitalization due to		Illness/Injury/Maternity	
d. Date of Injury/Date of disease first detected/ Date of delivery		DD/MM/YYYY	
e. Date of admission		DD/MM/YYYY	
f. Time admission		HH/MM	
g. Date of discharge		DD/MM/YYYY	
h. Time discharge		HH/MM	
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	System of medicine	Allopathic/Other systems of medicine

SECTION E - DETAILS OF CLAIM

a) Claim under Hospitalization Cover			
i) In-Patient Hospitalization	YES / NO	ii) Pre-hospitalization Expenses	YES / NO
iii) Post-hospitalization Expenses	YES / NO	iv) Day Care Procedures	YES / NO
v) Domiciliary Hospitalization	YES / NO (if yes, please provide details in annexure)	vi) Road Ambulance Cover	YES / NO
vii) Critical illness	YES / NO	viii) Hospital Daily cash	YES / NO
b) Please tick the applicable Optional Cover claimed under Hospitalization Cover:			
i) Hospital Cash	YES / NO	<<Please provide details>>	
ii) Preventive Health Check Up	YES / NO	<<Please provide details>>	
iii) Restore Benefit	YES / NO	<<Please provide details>>	
iv) Alternative Treatment	YES / NO	<<Please provide details>>	
v) Second Medical Opinion	YES / NO	<<Please provide details>>	
vi) Double Restore Benefit	YES / NO	<<Please provide details>>	
vii) Maternity Expenses	YES / NO	<<Please provide details>>	
viii) Pre and Post Natal Expenses	YES / NO	<<Please provide details>>	
ix) Infertility Cover	YES / NO	<<Please provide details>>	
x) Accidental Death	YES / NO	<<Please provide details>>	
xi) Permanent Disablement	YES / NO	<<Please provide details>>	
xii) OPD Cover	YES / NO	<<Please provide details>>	

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Claim Documents Submitted Check List: Hospitalization Claim		**Check list of additional documents for Hospital Cash claims**
☐ Duly filled and signed Claim Form	☐ Copy of intimation letter, if any	☐ Copy of discharge summary/discharge certificate along with time of admission and discharge for hospital cash benefit
☐ Hospital main bill	☐ Hospital bill break up	☐ First consultation letter from treating medical practitioner
☐ Hospital bill payment receipt	☐ Hospital discharge summary	☐ Certificate from treating medical practitioner, specifying the duration and aetiology
☐ Pharmacy bill	☐ Operation theatre notes	☐ MLC/FIR copy/ certificate regarding abuse of alcohol/intoxicating agent if applicable
☐ Investigation/diagnostic Reports with bills and payment receipt	☐ Doctors request for investigations	☐ Cancelled cheque copy with primary insured name printed or bank pass book copy with clear name/account no./ bank details
☐ ECG	☐ Prescriptions	
☐ Copy of the network provider's registration certificate	☐ MLC/FIR copy of applicable	
☐ KYC documents	☐ Implant stickers for all implants used during surgeries	

SECTION F – DETAILS OF BILLS ENCLOSED

Sno	Bill No	Date						Issued By	Towards	Amount (Rs)					
		D	D	M	M	Y	Y		Hospitalization bills						
									Pre-Hospitalization						
									Post-Hospitalization						
									Total Amount						

SECTION G – DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

a) Name of the primary insured	
b) Account number	
c) PAN number of the primary insured	
d) Bank name/ Branch	
e) Payee Name	
f) IFSC Code	

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g) *Attach a cancelled cheque pertaining to the same name of the account holder must be printed on the cheque	
h) MICR No	
i) CKYC of the primary insured	

Note:
Enclose NEFT documents (Cancelled Cheque or Bank passbook clear copy)
Please send all original documents along with duly filled and signed Claim form to the address mentioned on the Top of the Claim form
Please mention as "Health Claim Documents" on the TOP of the envelop and mention the complete sender address along with mobile number without fail.

SECTION H – 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 Insured: _____

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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 pre-authorization request form in lieu of PART A

SECTION A – DETAILS OF HOSPITAL

a) Name of the Hospital where treated		b) Hospital Registration No	
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	

SECTION B – DETAILS OF PATIENT ADMITTED

a) Name of the patient		b) IP registration number	
c) Gender	Male/Female	d) Age	YY/MM
e) Date of birth	DD/MM/YYYY		
f) Date of admission	DD/MM/YYYY	g) Time of admission	HH/MM
h) Date of discharge	DD/MM/YYYY	i) Time of discharge	HH/MM
j) Type of admission	Emergency/Planned/Daycare/ Maternity	k) If Maternity	
i) Date of delivery	DD/MM/YYYY	ii) Gravida status	
l) Status at time of discharge	Discharged to Home Discharged to another Hospital Deceased	Total claimed amount	

SECTION C – DETAILS OF AILMENTS DIAGNOSED (PRIMARY)

a) ICD 10 Codes	Primary Diagnosis		Additional Diagnosis		Comorbidities	
Details of procedures done						
b) ICD 10 PCS	Procedure 1		Procedure 2		Procedure 3	
i) Pre-authorization obtained	Y/N		j) Pre-authorization No			
f) If authorization by network hospital not obtained, give reason						
g) Hospitalisation due to Injury	Y/N		i) If yes, give cause			
Self-inflicted?	Y/N	Road traffic accident	Y/N	Substance abuse / Alcohol consumption		Y/N
ii) If Injury due to substance abuse / alcohol consumption, Test Conducted to establish this:		Y/N (If yes, attach reports	iii) Medico legal	Y/N		
iv) Reported to Police			v) FIR No			
vi) If not reported to police give reasons						

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SECTION D – CLAIM DOCUMENTS SUBMITTED – CHECK-LIST

☐ Claim form duly filled and signed	☐ Investigation reports
☐ Pre authorization request	☐ CT/MRI/USG/HPE investigation report
☐ Copy of Pre-authorization approval letter	☐ Doctor's reference slip for investigation
☐ Copy of photo ID card of patient verified by Hospital	☐ ECG
☐ Hospital discharge summary	☐ Pharmacy bills
☐ Operation theatre notes	☐ MLC report & Police FIR
☐ Hospital main bill	☐ Death summary from hospital where applicable
☐ Hospital break up bill	☐ Any other, Pl specify

SECTION E – DETAILS IN CASE OF NON NETWORK HOSPITAL

a) Address of the Hospital		b) Phone no	
c) Registration no with State Code		d) Hospital PAN	
e) No of In-patient beds		f) Facilities available in Hospital	
i) OT	Y/N	ii) ICU	Y/N
iii) Others			

SECTION F – DECLARATION BY HOSPITAL

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: _____ Place: _____ Signature and seal of the Hospital Authority _____

CLAIM INTIMATION

Chola MS has arrangements with more than 11000 hospitals across India for availing of cashless facility. For availing benefit through reimbursement mode, advance intimation of at least 48 hours to Chola MS is required for planned hospitalisation and intimation within 24 hours for emergency hospitalisation. This would help us to pre-process your claim for a smooth experience. For more details call toll free number for Claim intimation at 1800-208-9100 or Mail: customercare@cholams.murugappa.com

EXCLUDED HOSPITALS

Expenses incurred towards the treatment in any hospital specifically excluded by Chola MS and disclosed in our website / notified to the policyholders are not admissible. However, in case of life-threatening situations or following an accident, expenses incurred for the treatment up to the stage of stabilization are payable but not the complete claim. Please refer our website www.cholainsurance.com for latest list of excluded hospitals and reach us at 1800-208-9100 or Mail: customercare@cholams.murugappa.com for any further clarification on this.

Please refer our website for latest list of Excluded Hospitals before Hospitalization, as we will not consider any claim from these hospitals. Please reach us at our tollfree number/mail ID given above for any further clarification on this.