RELIANCE GENERAL INSURANCE
A RELIANCE CAPITAL COMPANY

HEALTH INFINITY INSURANCE – CLAIM FORM - B
UIN: RELHLIP20089V021920

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

(To be filled in BLOCK letters)

SECTION A
DETAILS OF HOSPITAL

a) Name of Hospital:
b) Hospital ID:
c) Type of Hospital: Network ☐ Non Network ☐ (If non network, fill Section E)
d) Name of treating doctor:
e) Qualification/Specialization:
f) Registration No. with State Code:
g) Phone No.:

SECTION B
DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient:
b) IP Registration Number.: c) Gender: M ☐ F ☐ Others ☐ d) Age: Years YY Months MM
e) Date of Birth: DDMMYYYY f) Date of Admission: DDMMYYYY g) Time: HHMM
h) Date of Discharge: DDMMYYYY i) Time: HHMM
j) Type of Admission: Emergency ☐ Planned ☐ Day Care ☐ Maternity ☐ Transfer from other Hosp ☐
k) If Maternity, (i) Date of Delivery: DDMMYYYY (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) (i) Primary Diagnosis: ICD 10 Code: Description:
(ii) Additional Diagnosis: ICD 10 Code: Description:
(iii) Co-morbidities: ICD 10 Code: Description:
(iv) Co-morbidities: ICD 10 Code: Description:
b) (i) Procedure 1: ICD 10 PCS: Description:
(ii) Procedure 2: ICD 10 PCS: Description:
(iii) Procedure 3: ICD 10 PCS: Description:
(iv) Details of Procedure:
c) Pre-authorisation obtained: Yes ☐ No ☐ d) Pre-authorisation Number:
e) If this is a network hospital and cashless facility not availed, give reason:
f) Hospitalisation 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 – CHECKLIST

(i)	Claim Form duly signed	Yes No	(ix)	Investigation Report	Yes No
(ii)	Original Pre-authorisation request	Yes No	(x)	ECG/ CT / MRI / USG / HPE /Other investigation reports	Yes No
(iii)	Copy of Pre-authorisation approval letter	Yes No	(xi)	Doctor's reference slip for investigation	Yes No
(iv)	Copy of photo ID card of patient verified by hospital	Yes No	(xii)	Previous Consultation Papers	Yes No
(v)	Hospital Discharge Summary	Yes No	(xiii)	Pharmacy Bills	Yes No
(vi)	Operation Theatre /Anesthesia notes	Yes No	(xiv)	MLC Report & Police FIR	Yes No
(vii)	Hospital Main/Final Bill	Yes No	(xv)	Original death summary from hospital, where applicable	Yes No
(viii)	Hospital Break-up Bill	Yes No	(xvi)	Any other, please specify ____________________	Yes No

SECTION E

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

a) Address of the Hospital:

City

Pin Code

State

b) Contact person Name

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. We authorize officials from RGICL to verify the hospitalization records for the said patient.

Date: D D M M Y Y Y Y

Signature & Seal of the Hospital Authority: ____________________

Place:

GUIDANCE FOR FILING 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 qualification
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		
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 Birth	Enter Date of Birth of patient	Use dd-mm-yy format
f) Date of Admission	Enter date of admission	Use dd-mm-yy format
g) Time	Enter time of admission	Use hh : mm format
h) Date of Discharge	Enter date of discharge	Use dd-mm-yy format
i) Time	Enter time of discharge	Use hh : mm format
j) Type of Admission	Indicate type of admission of patient	Tick the right option
k) 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
l) Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
m) Total claimed amount	Indicate the total claimed amount	In rupees (do not enter paise values)
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

SECTION C – DETAILS OF AILMENT DIAGNOSED (PRIMARY) Continu........

	Field	Description	Instruction
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 : CHECKLIST

Indicate which supporting documents are submitted.

SECTION E – DETAILS IN CASE OF NON-NETWORK HOSPITAL

	Field	Description	Instruction
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 HOSPITAL

Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign and stamp