Bajaj Allianz General Insurance Co. Ltd.
Bajaj Allianz House, Airport Road, Yerwada, Pune – 411006. Reg.: 113 | CIN: U66010PN2000PLC015329
For more details, log on to : www.bajajallianz.com

Email id:- bagichelp@bajajallianz.co.in
Toll free no:1800-209-5858
020-30305858

Bajaj Allianz — Caringly yours

(To be filled in block letters)

CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT – PART A

TO BE FILLED IN BY THE INSURED
The issue of this form is not to be taken as an admission of liability

SECTION A

DETAILS OF PRIMARY INSURED

a) Policy No: b) Sl. No/Certificate No:
c) Company TPA ID No: d) Customer ID:
e) Company Name: f) Employee No:
g) Name:
h) Address:
City: State: Pin Code:
Phone No: Email ID:

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
c) If yes, company name: Policy No:
Sum Insured (Rs.):
d) Have you been hospitalized in the last four years since inception of the contract? ☐ Yes ☐ No Date: D D M M Y Y Y Y
Diagnosis
e) Previously covered by any other Mediclaim / Health Insurance: ☐ Yes ☐ No
f) If yes, Company Name

SECTION C

DETAILS OF INSURED PERSON HOSPITALIZED

a) Name of the Patient:
b) Health ID card no of the Patient:
c) Gender: Male ☐ Female ☐ d) Age: years months e) Date of Birth D D M M Y Y Y Y
f) Relationship of Primary insured: Self ☐ Spouse ☐ Child ☐ Father ☐ Mother ☐ Other ☐ (Please Specify)
g) Occupation: Service ☐ Self Employed ☐ Homemaker ☐ Student ☐ Retired ☐ Other ☐ (Please Specify)
h) Address (if different from above)
City: State: Pin Code:
I)Phone No: J) Email ID:

SECTION D

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) Hospitalisation due to: Injury ☐ Illness ☐ Maternity ☐
d) Date of Injury/Date Disease first detected/Date of Delivery: D D M M Y Y Y Y
e) Date of admission D D M M Y Y Y Y f) Time: H H M M g)Date of Discharge D D M M Y Y Y Y h)Time: H H M M
I) Name of treating doctor Diagnosis
j) 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 and Police FIR attached: Yes ☐ No ☐ j) System of Medicine

SUPPLEMENTARY FORMAT FOR COVID RELATED CLAIMS

1. RT–PCR/RAT report from authorised laboratories (Home testing kit results not acceptable)
2. X-ray of lung/HR CT report with severity score if done
3. D-dimer/CRP and other blood result

History of co-morbid conditions	Yes/No	If yes, duration
Heart ailments		
Stroke		
Paralysis		
Kidney failure		
Cancer		
Tuberculosis		
HIV		
COPD		
Asthma		
Diabetes (latest HbA1 c report)		
Other medical conditions if any		
Any major surgery in the last 4 years 1. 2 3.	Month/Year	Details of surgery

4. Details of on-going treatment, if any, other than COVID
5. Vaccination history for COVID
6. Vital charts including temperature chart, oxygen saturation chart at the time of hospitalisation
7. Previous history of COVID if any and treatment details relating to the same

DETAILS OF CLAIM

a) Details of the treatment expenses claimed

I. Pre-Hospitalisation Expenses:	Rs.	ii. Hospitalisation Expenses	Rs.
iii. Post-Hospitalisation Expenses:	Rs.	iv. Health checkup cost	Rs.
v. Ambulance Charges:	Rs.	vi. Others (code)	Rs.
		Total	Rs.
vii. Pre-Hospitalisation period:	days	viii. Post Hospitalisation period:	days

b) Claim for Domiciliary Hospitalisation: Yes ☐ No ☐ (If yes, provide details in annexure)

c) Details of Lump sum / cash benefit claimed:

i. Hospital Daily Cash	Rs.	ii. Surgical Cash	Rs.
iii. Critical illness Benefit	Rs.	iv. Convalescence	Rs.
v. Pre/Post hospitalisation lump sum benefit	Rs.	vi. Others	Rs.
		Total	Rs.

Claim Documents Submitted – Check List

- ☐ Claim Form Duly Signed
- ☐ Copy of claim intimation if any
- ☐ Original Hospital Main Bill
- ☐ Original Hospital Breakup Bill
- ☐ Original Hospital Bill Payment Receipt
- ☐ Original Hospital Discharge SummaryPharmacy Bill
- ☐ Operation Theater Notes
- ☐ ECG
- ☐ Original Doctor's Prescriptions
- ☐ Original Doctors request for investigation reports (including CT/MRI/USG/HPE)
- ☐ Others
- ☐ Cancelled blank cheque leaf with payee name printed. If name of the payee is not printed on the cheque leaf please attach copy of the first page of the bank passbook.

DETAILS OF BILLS ENCLOSED

Sr.No	Bill No	Date	Issued by	Towards	Amount (Rs)
1		D D M M Y Y		Hospitalisation Main Bill	
2		D D M M Y Y		Pre-Hospitalisation Bills:__Nos	
3		D D M M Y Y		Post-Hospitalisation Bills:__Nos	
4		D D M M Y Y		Pharmacy Bills	
5		D D M M Y Y			
6		D D M M Y Y			
7		D D M M Y Y			
8		D D M M Y Y			
9		D D M M Y Y			
10		D D M M Y Y			

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

a) Name of the Account Holder (As per Bank Account):_____

b) Account no (As appearing in the cheque book): ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

c) Bank Name :_____

d) Branch Name & Address:_____:

e) Account Type : Saving ☐ Current ☐ Cash Credit ☐

f) MICR No. ☐☐☐☐☐☐☐☐☐ g)IFSC Code: ☐☐☐☐☐☐☐☐☐☐☐

h) PAN: ☐☐☐☐☐☐☐☐☐☐ i) Cheque / DD Payable Details: ☐

j) CKYC No. ☐

DECLARATION

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 Bajaj Allianz General Insurance Company Limited, to seek necessary medical information / documents from any hospital / Medical Practitioner who ha s 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.

SECTION E

SECTION F

SECTION G

SECTION H

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

Bajaj Allianz General Insurance Co. Ltd.
Bajaj Allianz House, Airport Road, Yerwada, Pune – 411006. Reg.: 113 | CIN: U66010PN2000PLC015329
For more details, log on to : www.bajajallianz.com
Email id: bagichelp@bajajallianz.co.in, Toll free no. 1800-209-5858, 020-30305858

Bajaj Allianz Caringly yours

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)

SECTION A

DETAILS OF HOSPITAL

a) Name of the hospital : _____

b) Hospital ID : _____ c) Type of hospital : Network ☐ Non-Network ☐ (If non-network fill section E)

d) Name of treating doctor: _____

e) Qualification: _____ f) Registration No with State Code _____ g) Phone No: _____

h) Rohini Code _____ i) NABH CODE _____ j) State Level Certificate _____

k) Higher Level Certificate _____ l) National Quality Assurance Standards _____ m) National Health System Resource Center _____

SECTION B

DETAILS OF THE PATIENT ADMITTED

a) Name of the patient : _____

b) IP registration Number : _____ c) Gender: Male ☐ Female ☐ d) Age : Years ☐☐ Months: ☐☐ e) Date of birth: D D M M Y Y

f) Date of admission: D D M M Y Y g) Time : H H M M h) Date of discharge : D D M M Y Y i) Time: H H M M

j) Type of Admission : Emergency ☐ Planned ☐ Day Care ☐ Maternity ☐ k) If Maternity i) Date of delivery D D M M Y Y 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)	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:		

d) Pre-Authorization Obtained: Yes ☐ No ☐ e) Pre-Authorization Number: ☐☐☐☐☐☐☐☐☐☐

f) If authorization by network hospital no obtained, give reason: _____

g) Hospitalization 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)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 -CHECK LIST

- ☐ Claim form duly signed
- ☐ Original Pre-Authorization request
- ☐ Copy of Pre-Authorization letter
- ☐ Copy of photo ID card of patient verified by hospital
- ☐ Hospital discharge summary
- ☐ Operation theatre notes
- ☐ Hospital main bill
- ☐ Hospital break up bill
- ☐ Ingestion reports
- ☐ CT/MR/USG/HPE investigation report
- ☐ Doctor's reference slip for investigation
- ☐ ECG
- ☐ Pharmacy bills
- ☐ MLC report & Police FIR
- ☐ Original death summary from hospital where applicable
- ☐ Any other, please specify

SECTION E

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

a) Address of hospital _____

City: _____ State: _____ Pin Code: _____ Phone No: _____ c) Registration no with State Code: _____

d) Hospital PAN: _____ e) Number of Inpatient beds: ☐☐☐ Facilities available in 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 the Claim Form is true and correct to the best of our knowledge and belief. If we have made any false and untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited.

Date : D D M M Y Y
Place : _____

Signature and Seal of the Hospital Authority

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 the hospital	As allocated by 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 treating doctor	Name of doctor in full
e)Qualification	Enter the qualification of treating doctor	abbreviations of educational qualifications
f) Registration No with state code	Enter the registration no of treating doctor along with state code	As allocated by the medical council of India
g)Phone No	Enter the phone no of doctor	Include STD code with telephone number
SECTION B - DETAILS OF THE PATIENT ADMITTED		
a) Name of the patient	Enter the name of hospital	Name of hospital in full
b) IP Registration number	Enter the insurance provide registration number	As allocated by the insurance provide
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 admission	Use dd-mm-yy format
f) Date of Admission	Enter date of admission	Use dd-mm-yy format
g)Time	Enter date 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 tex
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 HOSPITAL		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign and stamp		

DECLARATIONS – CLAIM FORM

1. For retail policies/individual customers:

   Consent/Declaration to be added in proposal and claim for CKYC no.:

   I/we hereby give my/our consent to the Company to verify and obtain my/our identity/address proof through Central KYC Registry or National Securities Depository Limited Portal for the purpose of undertaking KYC verification.

2. For Juridical person/non-individual customer:

   Consent/Declaration to be added in proposal and claim for CKYC no.:

   I/we hereby give my/our consent to the Company to verify and obtain my/our identity/address proof through Central KYC Registry or Goods and Service Tax Portal or Ministry Of Corporate Affairs Portal or National Securities Depository Limited portal for the purpose of undertaking KYC.

3. For Group Policies:

   Consent/Declaration to be added in claim form CKYC no.:

   I/we hereby give my/our consent to the Company to verify and obtain my/our identity/address proof through Central KYC Registry for the purpose of undertaking KYC

4. For Juridical person/non-individual customer and Group Policies:

   Consent/Declaration to be added in claim form CKYC no.:

   I/we hereby give my/our consent to the Company to verify and obtain my/our identity/address proof through Central KYC Registry or UIDAI or through any other modes for the purpose of undertaking KYC

Date: D D M M Y Y Y Y Place:

Signature of the Insured