



New National Parivar Mediclaim Policy

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
For claims under Medical Second Opinion (MSO), no need to fill up Section C and Section D of the claim form

(To be filled in block letters)

DETAILS OF PRIMARY INSURED

Form fields for primary insured details: a) Policy no., b) Company/ TPA ID No., c) Name, d) Address, City, State, Pin Code, Phone No., Email ID.

DETAILS OF INSURANCE HISTORY

Form fields for insurance history: a) Currently covered by any other Mediclaim/ Health Insurance, 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?, e) Previously covered by any other Mediclaim/ Health Insurance.

DETAILS OF INSURED PERSON HOSPITALIZED

Form fields for insured person hospitalized: a) Name, b) Gender, c) Relationship to Primary Insured, d) Date of Birth, e) Sum insured, f) Occupation, g) Occupation, h) Address, City, State, Pin Code, Phone No., Email ID.

DETAILS OF HOSPITALIZATION (NOT REQUIRED FOR CLAIMS WITH RESPECT TO HEALTH CHECKUP EXPENSES, MSO)

Form fields for hospitalization details: a) Name of Hospital where Admitted, b) Room category occupied, c) Hospitalization due to, d) Date of Admission, e) Date of Discharge, f) Time, g) Date of injury/ Date Disease first detected, h) Time, i) If Medico Legal, j) Reported to police, k) MLC Report & Police FIR attached, l) System of medicine.

DETAILS OF CLAIM

Form fields for claim details: a) Details of expenses (Pre Hospitalization, Medical Practitioner's Fees, Post Hospitalization, Ambulance Charges, Room/ICU Charges, Others, Health Check Up, Post hospitalization period, Total), b) Details of Treatment (Claim for Day Care Procedure, HIV/AIDS Treatment, Claim under reinstated SI, Hemodialysis, Radiotherapy, Refractive Error, Modern Treatment, Organ Donor's Medical Expenses, Mental Illness Treatment, Cataract Treatment, Chemotherapy, Morbid Obesity, Hazardous Sport, Claim Documents Submitted- Check List).

DETAILS OF BILLS ENCLOSED

Table with columns: Sl. No., Bill No., Date, Issued By, Bill Towards, No. of bills, Amount (₹). Rows 1-10.

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

Form fields for bank account details: a) PAN, b) Account Number, c) Bank Name, d) Bank Branch, e) Cheque/ DD Payable details, f) 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: []



National Insurance Company Limited

Regd. Office 3, Middleton Street, Post Box 9229, Kolkata 700 071

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) Company TPA ID No.	Enter the TPA ID No	License number as allotted by IRDA and printed in TPA documents.
c) Name	Enter the full name of the policyholder	Surname, First name, Middle name
d) Address	Enter the full postal address	Include Street, City and Pin Code
SECTION B - DETAILS OF INSURANCE HISTORY		
a) Currently covered by any other Mediciam / Health Insurance?	Indicate whether currently covered by another Mediciam / 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 Mediciam/ Health Insurance?	Indicate whether previously covered by another Mediciam / 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	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 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	Enter the bank name	Name of the Bank in full
d) Bank Branch	Enter the bank branch name	Name of the Bank Branch in full
e) 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
f) 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.