

Health Insurance

Aditya Birla Health Insurance Co. Limited

(A subsidiary of Aditya Birla Capital Ltd.)



ADITYA BIRLA CAPITAL

PROTECTING INVESTING FINANCING ADVISING

Activ Health - 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 preauthorization request form in lieu of PART A (To be filled in BLOCK letters)

A. DETAILS OF HOSPITAL

a.	Name of the Hospital:	
b.	Hospital ID:	
c.	Type of Hospital:	<input type="checkbox"/> Network <input type="checkbox"/> 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.:	

B. DETAILS OF THE PATIENT ADMITTED

a.	Name of the Patient:	
b.	IP Registration Number:	
c.	Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
d.	Age:	<input type="text"/> Years <input type="text"/> Months
e.	Date of Birth:	<input type="text"/>
f.	Date of Admission:	<input type="text"/>
g.	Time:	<input type="text"/>
h.	Date of Discharge:	<input type="text"/>
i.	Time:	<input type="text"/>
j.	Type of Admission:	<input type="checkbox"/> Emergency <input type="checkbox"/> Planned Day Care <input type="checkbox"/> Maternity
k.	If Maternity: i) Date of Delivery:	<input type="text"/>
	ii) Gravida Status:	<input type="text"/>
l.	Status at Time of Discharge:	<input type="checkbox"/> Discharge to home <input type="checkbox"/> Discharge to another Hospital <input type="checkbox"/> Deceased
m.	Total Claimed Amount: Rs.	<input type="text"/>

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:		

c.	Pre-authorization obtained:	<input type="checkbox"/> Yes <input type="checkbox"/> No	d.	Pre-authorization Number:	
e.	If authorization by Network Hospital not obtained, give reason: _____				
f.	Hospitalization due to Injury: <input type="checkbox"/> Yes <input type="checkbox"/> No				
i.	If Yes, give cause <input type="checkbox"/> Self-inflicted <input type="checkbox"/> Road Traffic Accident <input type="checkbox"/> Substance Abuse / Alcohol Consumption				
ii.	If Injury due to Substance Abuse / Alcohol Consumption, Test Conducted to establish this: <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, attach reports)				
iii.	If Medico Legal: <input type="checkbox"/> Yes <input type="checkbox"/> No				
iv.	Reported to Police: <input type="checkbox"/> Yes <input type="checkbox"/> No				
v.	FIR No.: <input type="text"/>				
iv.	If not reported to Police give reason: _____				

D. CLAIM DOCUMENTS SUBMITTED - CHECK LIST:

- | | |
|---|---|
| <input type="checkbox"/> a. Claim Form duly signed | <input type="checkbox"/> b. Original Pre-authorization request |
| <input type="checkbox"/> c. Copy of the Pre-authorization approval letter | <input type="checkbox"/> d. Copy of photo ID Card of patient verified by hospital |
| <input type="checkbox"/> e. Hospital Discharge summary | <input type="checkbox"/> f. Operation Theatre Notes |
| <input type="checkbox"/> g. Hospital main bill | <input type="checkbox"/> h. Hospital break-up bill |
| <input type="checkbox"/> i. Investigation reports | <input type="checkbox"/> j. CT/MR/USG/HPE investigation reports |
| <input type="checkbox"/> k. Doctor's reference slip for investigation | <input type="checkbox"/> l. ECG |
| <input type="checkbox"/> m. Pharmacy bills | <input type="checkbox"/> n. MLC reports & Police FIR |
| <input type="checkbox"/> o. Original death summary from hospital where applicable | |
| <input type="checkbox"/> p. Any other | P L E A S E S P E C I F Y |

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

- a. Address of the Hospital:
- City: State: Pin Code:
- b. Phone No. c. Registration No. with State Code:
- d. Hospital PAN: e. Number of Inpatient beds:
- f. Facilities available in the Hospital: OT: ☐ Yes ☐ No ICU: ☐ Yes ☐ No
- g. Others:

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.

Date:

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 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 Qualification of the Treating Doctor	Abbreviations of Educational Qualifications
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 ADMITTED		
a) Name of Patient	Enter the full name of the Patient	Surname, First Name, Middle Name
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 or Other
d) Age	Enter Age of the Patient	Number of years and months
e) Date of Birth	Enter Date of Birth of the 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
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 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 HOSPITAL		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign and stamp		

