

STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED Regd. & Corporate Office: 1, New Tank Street, Valluvar Kottam High Road, Nungambakkam, Chennai - 600 034. Corporate Office - Claims Dept.: No.15, Balaji Complex, Whites Lane, 1st Floor, Royapettah, Chennai - 600 014. Toll free Phone No: 1800 425 2255 Toll free Fax No: 1800 425 5522

CIN: L66010TN2005PLC056649 Email:support@starhealth.in Website: www.starhealth.in IRDAI Regn. No: 129

CLAIM FORM - PART - A

DETAILS OF PRIMARY INSURED:							im No		d in block letters)
a) Policy No:					b) Sl. No/ Certificate No:			(10 00 111100	a iii biook iettere)
c) Company/ TPA ID No:									
d) Name :									
e) Address :									
City:					State:				
		-							
DETAILS OF INSURANCE HISTORY:				b) Date of commencement of first Insurance v				(Ossiss of Polisi	
a) Currently covered by any other Mediclaim / He		es	No _		vithout break: D D M	M Y	Υ	(Copies of Polici	ies to be attached)
c) If yes, company name:				Policy No					
Sum Insured (Rs.)		Have you	been ho	spitalized in the last 4 years? Yes No	Date:/ Diagnos	sis:			
e) Previously covered by any other Mediclaim / H	lealth insurance:	es	No	f) If yes, Company Name					
DETAILS OF INSURED PERSON HOSPITALIZE	ED:								
a) Name:									
b) Gender: Male Female	c) Age: year	s Y	Υ	months M M d) Date of Birth:	//				
e) Relationship to Primary insured: Self	Spouse		Child	Father Mother	Other (Please Specify)				
f) Occupation: Service	Self Employed	Hom	nemaker	Student Retired	Other (Please Specify)				
			. s. nanci	Tituli Cu	(i loade opeolity)				
g) Address (if different from above):									
Cite					Obstan				
City:									
Pin Code:	P	none No:			Email ID :				
DETAILS OF HOSPITALIZATION:									
a) Name of Hospital where Admitted:			_				No. of	IP Beds:	
b) Room Category occupied: Day care	Single o	ccupancy	Ш.	Twin sharing 3 or more beds per	room c) Hospitalization due to:	Injury	III	ness	Maternity
d) Date of Injury / Date Disease first detected /Da	ate of Delivery:	_/_	_ /_	e) Date of Admissi	on: /	f) Ti	me:	-:	
g) Date of Discharge: /	h	Time:		: i) If Injury give cause: Self inflict	ed Road Traffic Accident Sub	stance Abuse / A	dcohol Co	nsumption	
i. If Medico legal: Yes No	ii. Reported to poli	ce:	Yes	No iii. MLC Report & Police FIR attached:	Yes No j) System of M	fedicine:			
i. If Medico legal: Yes No DETAILS OF CLAIM:	ii. Reported to poli	be:	Yes	No iii. MLC Report & Police FIR attached:	Yes No j) System of M	ledicine:			
	ii. Reported to poli	ce:	Yes	No iii. MLC Report & Police FIR attached: b) Claim for Domiciliary Hospitaliza					nitted- Check List:
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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, 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: D D M M Y Y	Place:	Signature of the Insured

	DATA ELEMENT	DESCRIPTION	FORMAT
		SECTION A - DETAILS OF PRIMARY INSURED	
1)	Policy No.	Enter the policy number	As allotted by the insurance company
)	SI. No/ Certificate No.	Enter the social insurance number or the certificate number of social health insurance scheme	As allotted by the organization
:)	Company TPA ID No.	Enter the TPA ID No	License number as allotted by IRDA and printed in TPA documents.
1)	Name	Enter the full name of the policyholder	Surname, First name, Middle name
;)	Address	Enter the full postal address	Include Street, City and Pin Code
		SECTION B - DETAILS OF INSURANCE HISTORY	
1)	Currently covered by any other Mediclaim / Health Insurance?	Indicate whether currently covered by another Mediclaim / Health Insurance	Tick Yes or No
)	Date of Commencement of first Insurance without break	Enter the date of commencement of first insurance	Use dd-mm-yy format
;)	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
1)	Have you been Hospitalized in the last 4 years	Indicate whether hospitalized in the last 4 years	Tick Yes or No
1)	Date	Enter the date of hospitalization	
			Use mm-yy format
)	Diagnosis Previously Covered by any other Mediclaim/ Health	Enter the diagnosis details Indicate whether previously covered by another Mediclaim /	Open Text Tick Yes or No
-)	Insurance? Company Name	Health Insurance Enter the full name of the insurance company	Name of the organization in full
,		ON C - DETAILS OF INSURED PERSON HOSPITALIZED	Name of the organization in full
a)	Name	Enter the full name of the patient	Surname, First name, Middle name
))	Gender	Indicate Gender of the patient	Tick Male or Female
_		· · · · · · · · · · · · · · · · · · ·	Number of years and months
a)	Age	Enter age of the patient	· · · · · · · · · · · · · · · · · · ·
d)	Date of Birth	Enter Date of Birth of patient	Use dd-mm-yy format
.) =)	Relationship to primary Insured	Indicate relationship of patient with policyholder	Tick the right option. If others, please speci
)	Occupation	Indicate occupation of patient	Tick the right option. If others, please speci
3)	Address	Enter the full postal address	Include Street, City and Pin Code
1)	Phone No	Enter the phone number of patient	Include STD code with telephone number
)	E-mail ID	Enter e-mail address of patient	Complete e-mail address
		SECTION D - DETAILS OF HOSPITALIZATION	1
a)	Name of Hospital where admitted	Enter the name of hospital	Name of hospital in full
0)	Room category occupied	Indicate the room category occupied	Tick the right option
2)	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
-)	Time	Enter time of admission	Use hh:mm format
g)	Date of discharge	Enter date of discharge	Use dd-mm-yy format
า)	Time	Enter time of discharge	Use hh:mm format
)	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
)	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)
o)	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
_		SECTION F - DETAILS OF BILLS ENCLOSED	
ndic	ate which bills are enclosed with the amounts in rupees		
	SECTION	G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT	
а)	PAN	Enter the permanent account number	As allotted by the Income Tax department
0)	Account Number	Enter the bank account number	As allotted by the bank
	Bank Name and Branch	Enter the bank name along with the branch	Name of the Bank in full
c)		Enter the name of the beneficiary the cheque/ DD should be	
d)	Cheque/ DD payable details	made out to	Name of the individual/ organization in full



STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED

Regd. & Corporate Office: 1, New Tank Street, Valluvar Kottam High Road, Nungambakkam, Chennai - 600 034.

Corporate Office - Claims Dept.: No.15, Balaji Complex, Whites Lane, 1st Floor, Royapettah, Chennai - 600 014.

Toll free Phone No: 1800 425 2255 Toll free Fax No: 1800 425 5522

CIN: L66010TN2005PLC056649 Email:support@starhealth.in Website: www.starhealth.in IRDAI Regn. No: 129

CI	LAIM No :
PATIENT ADMISSION NO / IP NO /	/ MRD NO:
To: (Name of the Hospital & Addr	ress)
Dear Sirs,	
Re: AUTHORISATIO	ON TO STAR HEALTH AND ALLIED INSURANCE CO. LTD.,
I have undergone treatment for _	
from/ to	/in your Hospital.
I hereby authorize M/s. Star He	ealth and Allied Insurance Company Ltd. and its representatives,
who is my Health Insurer to see	ek any medical information/records from you or from the Medical
	on me in connection with the above ailment and the treatment given.
In case they seek any such inform	ation/records/indoor case papers, kindly oblige.
Thanking you,	
Yours faithfully,	
(Signature of the Claimant)	
Address of the Insured:	DATE:
	PLACE:



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CLAIM FORM - PART - B

	N BY THE HOSPITAL Please include the original preauthorization request form in lieu of PART A (To be filled in block letters)
a) Name of the hospital:	(10 be filled iff block fetters)
b) Hospital ID: Star's Hospital ID:	c) Type of Hospital: Network Non Network (If non network fill section E)
	<u> </u>
d) Name of the treating doctor:	a) Qualification.
f) Registration No. with State Code:	n) Email IU:
a) Name of the Patient:	
	d) Age: Years Y Y Months M M e) Date of birth:
f) Date of Admission: :	h) Date of Discharge: i) Time: H H : M M M
j) Type of Admission: Emergency Planned Day Care Maternity k) If Maternity	i. Date of Delivery:
I) Status at time of discharge: Discharge to home Discharge to another hospital Deceased	
DETAILS OF AILMENT DIAGNOSED (PRIMARY)	100 40 000
a) ICD 10 Codes Description	b) ICD 10 PCS Description
i. Primary Diagnosis:	I. Procedule 1.
	ii. Procedure 2:
iii. Co-morbidities:	
iv. Co-morbidities:	iii. Procedure 3:
v. Duration of Illness:	iv. Details of Procedure:
vi. Past Medical History:	
c) Present ailment is a complication of PED? Yes No (If Yes, specify details)	Ω
d) Pre-authorization obtained: Yes No e) Pre-authorization Number:	
f) If authorization by network hospital not 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 (II	f 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:	
CLAIM DOCUMENTS SUBMITTED - CHECK LIST	
Claim Form duly signed	Investigation reports
Original Pre-authorization request	CT/MRI/USG/HPE investigation reports
Copy of the Pre-authorization approval letter Copy of photo ID card of patient verified by hospital	Doctor's reference slip for investigation ECG Pharmacy bills
Hospital Discharge summary	
Operation Theatre notes Hospital main bill	MLC report & Police FIR Original death summary from hospital where applicable
Hospital break-up bill	Any other, please specify
ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)	·
a) Address of the Hospital:	
	S
	SECTION
	-
City:	State:
Pin Code: b)Phone No	c) Registration No.:
d) PAN: e) Number of Inpatient beds	f) Facilities available in the hospital: i, OT: Yes No ii, ICU: Yes No
	,
iii. Others :	
DECLARATION BY THE HOSPITAL	
We hereby declare that the information furnished in this Claim Form is true & correct to the best of our knowledge our right to claim under this claim shall be forfeited. The signature of the insured is taken on this form after Claim Formation.	orm R is fully filled up by us
Date: D D M M Y Y	SECTION T
Place	O _N
Place: Signature	e and Seal of the Hospital Authority:



Not to be Faxed / Scanned

	DATA ELEMENT	DESCRIPTION	FORMAT
	DATA ELEMENT	SECTION A - DETAILS OF HOSPITAL	TOMBAT
	Name of Hospital	Enter the name of hospital	Name of hospital in full
	Hospital ID		As allocated by the TPA
	'	Enter ID number of hospital Indicate whether In network or non network nospital	,
	Type of Hospital	'	Tick the right option
	Name of treating doctor	Enter the name of the treating doctor	Name of doctor in full
	Qualification	Enter the qualifications of the treating doctor Enter the registration number of the doctor along with the state	Abbreviations of educational qualifications
	Registration No. with State Code	code	As allocated by the Medical Council of Indi
	Phone No.	Enter the phone number of doctor	Include STD code with telephone number
	S	ECTION B - DETAILS OF THE PATIENT ADMITTED	
	Name of Patient	Enter the name of hospital	Name of hospital in full
	IP Registration Number	Enter insurance provider registration number	As allotted by the insurance provider
	Gender	Indicate Gender of the patient	Tick Male or Female
	Age	Enter age of the patient	Number of years and months
	Date of Admission	Enter date of admission	Use dd-mm-yy format
	Time	Enter time of admission	Use hh:mm format
	Date of Discharge	Enter date of discharge	Use dd-mm-yy format
	Time	Enter time of discharge	Use hh:mm format
	Type of Admission	Indicate type of admission of patient	Tick the right option
	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
	Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
		ON C - DETAILS OF AILMENT DIAGNOSED (PRIMARY)	
	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
	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
	Present Ailment is a Complication of PED	Indicate whether present ailment is a complication of some pre- existing disease	Tick Yes or No
	Pre-authorization obtained	Indicate whether pre-authorization obtained	Tick Yes or No
	Pre-authorization Number	Enter pre-authorization number	As allotted by TPA
	If authorization by network hospital not obtained, give reason	Enter reason for not obtaining pre-authorization number	Open text
	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
_	SECT	ION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST	
c	ate which supporting documents are submitted		
_	SECTIO	ON E - DETAILS IN CASE OF NON NETWORK HOSPITAL	
	Address	Enter the full postal address	Include Street, City and Pin Code
	Phone No.	Enter the phone number of hospital	Include STD code with telephone number
	Registration No.	Enter the registration number of patient	As allocated by the Hospital
	PAN	Enter the permanent account number	As allotted by the Income Tax department
	Number of Inpatient Beds	Enter the number of inpatient beds	Digits
	Facilities available in the hospital	Indicate facilities available in the hospital	Tick the right option. If others, please spec
_			The state of the s
		SECTION F-DECLARATION BY THE HOSPITAL	

