Zuno Health Insurance

Claim form - B

Instructions:
1. To be filled in BLOCK letters by the Insured.
2. The issue of this form is not to be taken as an admission of liability.

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: _____

f) Registration No. with state code: ☐☐☐☐☐☐ g) Phone No.: ☐☐☐☐☐☐☐☐☐☐

Section B – details of the patient admitted

a) Name of the patient: _____ b) IP registration No.: ☐☐☐☐☐☐☐☐☐☐☐☐

c) Gender: Male ☐ Female ☐ Third Gender ☐ d) Age: Y Y M M e) Date of birth: D D M M Y Y Y Y

f) Date of admission: D D M M Y Y Y Y g) Time: H H M M h) Date of discharge: D D M M Y Y 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 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
(i) Primary diagnosis:		
(ii) Additional diagnosis:		
(iii) Co-morbidities:		
(iv) Co-morbidities:		
b)	**ICD 10 codes**	**Description**
(i) Procedure 1:		
(ii) Procedure 2:		
(iii) Procedure 3:		
(iv) Details of procedure:		

c) Pre-authorization obtained: Yes ☐ No ☐ d) Pre-authorization No.: ☐☐☐☐☐☐☐☐☐☐☐☐

e) If authorization by network hospital not obtained, give reason: _____

f) 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) If medico legal: Yes ☐ No ☐ iv) Reported to police: Yes ☐ No ☐

(v) FIR No.: ☐☐☐☐☐☐☐☐☐☐☐☐ (vi) If not reported, give reason: _____

Section D – claim documents submitted – checklist

- ☐ Claim form duly signed
- ☐ Original pre-authorization request
- ☐ Copy of the Pre-authorization approval letter
- ☐ Copy of photo ID card of patient verified by hospital
- ☐ Hospital discharge summary
- ☐ Operation theatre notes
- ☐ Hospital main bill
- ☐ Hospital break-up bill
- ☐ Investigation reports
- ☐ CT/MR/USG/HPE investigation reports
- ☐ 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: ☐☐☐☐☐☐

b) 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 ☐

Other: _____

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.

Date: ☐D☐D☐M☐M☐Y☐Y☐Y☐Y

Place: _____

Signature & Seal of the Hospital Authority

Guidance for filling claim form – part B

(to be filled by the insured)

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 enter the TPA ID No	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 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 name of hospital	Name of hospital in full
b) IP Registration No.	Enter insurance provider registration number	As allotted by the insurance provider
c) Gender	Indicate gender of the patient	Tick male or female or third gender
d) Age	Enter age of the patient	Number of years and months
e) Date of birth	Enter date of birth	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) Baby's date of admission	Enter date of admission	Use dd-mm-yy format
m) Baby's date of discharge	Enter date of discharge	Use dd-mm-yy format
n) Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
o) 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 No.	Enter pre-authorization number	As allotted by TPA
e) If authorization by network hospital not obtained, 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
If reported, 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		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.		

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POLICY DECLARATION FORM

Date:……

Name of the Hospital :……

Address:……

PATIENT NAME (BLOCK LETTERS):…… AGE/SEX :……

Mobile No of Patient:……

Date of Admission:…… Date of Discharge:……

Undertaking by the Patient regarding Heath Insurance Policy
(स्वास्थ्य बीमा पॉलिसी के संबंध में रोगी द्वारा शपथ-पत्र))

☐ I have not declared about any health insurance policy, at the time of Hospital admission.
(मैं सुचित करता हूं कि अस्पताल में उपचार के दौरान मेरे पास कोई भी स्वास्थ्य बीमा पॉलिसी नहीं है ।

Signature: …… (हस्ताक्षर)
Name of the Patient/Patient's attendant (मरीज का नाम)

☐ I have declared about the health insurance policy, at the time of Hospital admission.
(मैं सुचित करता हूं कि अस्पताल में उपचार के दौरान मेरे पास स्वास्थ्य बीमा पॉलिसी है,

Signature: …… (हस्ताक्षर)
Name of the Patient/Patient's attendant (मरीज का नाम)

Undertaking by the Hospital

Based on patient undertaking hospital declare that patient: (रोगी के उपक्रम के आधार पर हम उस रोगी की घोषणा करते हैं)

- Patient did not declare any health insurance coverage, at the time of hospital admission. Hence we will bill the patient as per our rack rates. We may or may not consider discount for all such undertakings. (स्वास्थ्य बीमा कवरेज नहीं है, अस्पताल में भर्ती के समय । इसलिए हम मरीज को अपनी रैक दरों के अनुसार बिल देंगे। हम ऐसे सभी उपक्रमों के लिए छूट पर विचार कर भी सकते हैं और नहीं भी।)

- Patient declared health insurance coverage, at the time of hospital admission. But out of own free will is opting for reimbursement/ cash paying mode. . As insured is already covered under TPA servicing for which we are network provider, hence we agree to bill this patient as per PHS or insurer agreed rate list (whichever is less). The benefit of discount as per MOU will also be given to this patient. (रोगी के पास स्वास्थ्य बीमा कवरेज है, अस्पताल में भर्ती के समय । लेकिन वह अपनी मर्जी से रीइंबससमेंट/नकद भुगतान मोड का विकल्प चुन रहा है। . चूँकि बीमित व्यक्ति पहले से ही टीपीए सर्विसिंग के अंतर्गत कवर है जिसके लिए हम नेटवर्क प्रदाता हैं, इसलिए हम इस मरीज को पीएचएस या बीमाकर्ता द्वारा सहमत दर सूची (जो भी कम हो) के अनुसार बिल देने के लिए सहमत हैं। एमओयू के अनुसार छूट का लाभ भी इस मरीज को दिया जायेगा.)

Signature: ……

Name of the Hospital Representative & Hospital Seal