zuno

So your patient needs to claim?
Relax, we're here to make it easy!

Zuno Group Health Insurance Policy

Claim form - B

Instructions:
1. This form should be filled in by the hospital
2. Issuance of this form does not imply acceptance of liability
3. Fill all details in BLOCK LETTERS
4. Please add the original pre-authorization request form with Part A

Section A : About 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: Some details about the patient

a) Name of the patient: _____ b) Name of the member: _____

c) Department: _____ d) Employee No: _____ e) Name of the Insured / Policyholder: _____

f) Branch: _____ g) Date of admission: D D M M Y Y Y Y h) Time: H H M M

i) Date of discharge: D D M M Y Y Y Y j) Time: H H M M

k) Type of admission: Emergency ☐ Planned ☐ Day care ☐ Maternity ☐

l) If maternity, (i) Date of delivery: D D M M Y Y Y Y (ii) Gravida status: _____

m) Status at time of discharge: Discharge to home ☐ Discharge to another hospital ☐ Deceased ☐

n) Total claim amount: ☐☐☐☐☐☐☐☐☐☐ o) Age: Y Y M M

p) Gender:Male ☐ Female ☐ Third gender ☐ q) Date of birth: D D M M Y Y Y Y

Section C: What was the primary ailment being treated?

a)	ICD 10 Codes	Description
(i) Primary diagnosis:		
(ii) Additional diagnosis:		
(iii) Co-morbidities:		
(iv) Co-morbidities:		
b)	**ICD 10 PCS**	**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 the network hospital has not agreed, please state the 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 prove this: Yes ☐ No ☐ (if yes, attach reports)

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

(v) If reported, FIR no.: ☐☐☐☐☐☐☐☐ (vi) If not reported, please state the reason: _____

Section D: Have all the documents you need?

- ☐ Signed Claim Form
- ☐ Original Pre-authorization request
- ☐ Copy of the Pre-authorization approval letter
- ☐ Copy of photo ID card of patient verified by 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 needed
- ☐ Any other, please specify: _____

Section E – Non-network hospital? Please help us with some details. (only fill in case of non-network hospital)

a) Address of hospital: _____ Landmark: _____

City: _____ State: _____ Pin code: ☐☐☐☐☐☐

b) Phone No: ☐☐☐☐☐☐☐☐☐☐ c) Registration No. with state code: ☐☐☐☐☐☐☐☐☐☐

d) Hospital PAN: ☐☐☐☐☐☐☐☐☐☐ e) Number of inpatient beds: ☐☐☐

f) Facilities given in the hospital: (i) OT: Yes ☐ No ☐ (ii) ICU: Yes ☐ No ☐

(iii) Medical Store: Yes ☐ No ☐ (iv) Pathology: Yes ☐ No ☐ (v) Radiology: Yes ☐ No ☐ Other: _____

Section F – Declaration by the hospital (please read very carefully)

We hereby declare that the information given in this Claim Form is true & correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppressed or hidden any material fact, our right to claim under this claim shall be taken away.

Date: D D M M Y Y Y Y

Place: _____

Signature and stamp of authorized signatory

Some tips on how to fill claim form– part B		(to be filled 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	Write if 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	Educational qualifications in short
f) Registration No. with state code	Enter the registration number of the doctor along with the state code	As given by the Medical Council of India Include STD code with telephone number
g) Phone No.	Enter the phone number of doctor	
Section B - Details of the patient admitted		
a) Name of patient	Enter the name of patient	Name of patient in full
b) Name of the member	Enter the name of member	Name of member in full
c) Department	Enter name of department	Name of department in full
d) Employee no.	Enter employee No.	
e) Name of the insured/ policyholder	Enter the full name of the policyholder	Surname, first name, middle name
f) Branch	Enter branch Location	
g) Date of admission	Enter date of admission	Use dd-mm-yyyy format
h) Time of admission	Enter time of admission	Use hh:mm format
i) Date of discharge	Enter date of release	Use dd-mm-yyyy format
j) Time of discharge	Enter time of release	Use hh:mm format
k) Type of admission	Indicate type of admission of patient	Tick the right option
l) If maternity		
Date of delivery	Enter date of delivery, in case of maternity	Use dd-mm-yyyy format
Gravida status	Enter gravida status if maternity	Use standard format
m) Status at time of discharge	Indicate status of patient at time of release	Tick the right option
n) Total claimed amount (in ₹)	Indicate the total claimed amount	In rupees (do not enter paise values)
o) Age	Enter age of the patient	Number of years and months
p) Gender: Male, Female, Third gender	Indicate gender of the hospitalized person	Tick on appropriate option
q) Date of birth	Enter date of birth of patient	Use dd-mm-yyyy format
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, 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 if test is done	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 - Non-network hospital? Please help us with some details.		
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 given by the Medical Council of India
d) Hospital PAN	Enter the permanent account number	As given 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 mention
Section F - Declaration by the hospital		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign and stamp.		