

CLAIM FORM FOR HOSPITAL CASH CLAIM

The issue of this form is not to be taken as an admission of liability.

(TO BE FILLED BY THE INSURED)

INSURED DETAILS	
POLICY NUMBER	
NAME OF THE INSURED	
DATE OF BIRTH	
GENDER	
PERMANENT ADDRESS	
ADDRESS FOR COMMUNICATION	
CONTACT DETAILS MOBILE NUMBER 1 MOBILE NUMBER 2 EMAIL ID ALTERNATE MAIL ID	
DETAILS OF OTHER HEALTH INSURANCE POLICIES HELD BY THE INSURED	POLICY NO PERIOD OF INSURANCE NAME OF INS CO
DETAILS OF CLAIM	
DATE OF ADMISSION : TIME :	DATE OF DISCHARGE : TIME :
ROOM CATEGORY:	Normal: ICU:
DETAILS OF AILMENT DIAGNOSED	
SYSTEM OF MEDICINE:	ALLOPATHIC: NON ALLOPATHIC :
NAME AND ADDRESS OF THE HOSPITAL YOU WHERE TREATED	

PLEASE PROVIDE YOUR BANK DETAILS: (PLEASE ATTACH CANCELLED CHEQUE LEAF OF BANK ACCOUNT IN THE NAME OF INSURED WITHOUT FAIL)

a) PAN		b) Account Number	
c) Bank Name and Branch			
d) 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 the 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.

Date

D	D	M	M	Y	Y	Y	Y
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Place

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Signature of the
Insured

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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

(Guidance for filling claim form- Part B is available on our website: www.royalsundaram.in)



ROYAL SUNDARAM INSURANCE

Sundaram Finance Group

DETAILS OF HOSPITAL

a) Name of the hospital	
b) Hospital ID	
(For Office use only)	
c) Type of Hospital	<input type="checkbox"/> Network <input type="checkbox"/> Non Network (If non network fill section D)
d) Name of the treating Doctor	
e) Qualification	
f) Registration No. with State Code	
g) Phone	

SECTION A

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient:	
b) IP Registration Number	
c) Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
d) Age	<input type="text"/> Years <input type="text"/> Months
e) Date of Birth	<input type="text"/>
f) Type of Admission	<input type="checkbox"/> Emergency <input type="checkbox"/> Planned <input type="checkbox"/> Day Care <input type="checkbox"/> Maternity
g) Date of Admission	<input type="text"/> Time <input type="text"/>
h) Date of Discharge	<input type="text"/> Time <input type="text"/>
i) If Maternity	
1. Date of Delivery	<input type="text"/>
2. Gravida Status	
j) Status at time of discharge	<input type="checkbox"/> Discharge to home <input type="checkbox"/> Discharge to another hospital <input type="checkbox"/> Deceased

SECTION B

DETAILS OF AILMENT DIAGNOSED

	ICD 10 Codes	Description	Duration
1. Primary Diagnosis	<input type="text"/>		<input type="text"/>
2. Additional Diagnosis	<input type="text"/>		<input type="text"/>
3. Co-morbidities	<input type="text"/>		<input type="text"/>
4. Co-morbidities	<input type="text"/>		<input type="text"/>
	ICD 10 PCS Codes		
1. Procedure(1)	<input type="text"/>		
2. Procedure(2)	<input type="text"/>		
3. Procedure(3)	<input type="text"/>		
4. Details of any other Procedure	<input type="text"/>		

SECTION C

a) Whether preauthorisation obtained	<input type="checkbox"/> Yes <input type="checkbox"/> No. If yes, Preauthorisation No. _____
b) If Authorisation by network hospital not obtained, please give reason	_____
c) Hospitalization due to Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, give cause _____
1. <input type="checkbox"/> Self-inflicted <input type="checkbox"/> Road Traffic Accident <input type="checkbox"/> Substance abuse/alcohol consumption	
2. If Injury due to Substance abuse/alcohol consumption, Test Conducted to establish this:	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, details of tests conducted _____	
3. If Medico legal	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Reported to Police	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. FIR No.	<input type="text"/>
6. If not reported to police, give reason	_____

d) When did the patient start suffering with the complaint? _____ Date of first consultation (prior to hospitalisation)

D	D	M	M	Y	Y	Y	Y
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e) Please give previous medical history of the patient

f) Is the patient suffering from any of the following diseases. If "yes" Please mention the duration below.

	Say Yes/No	Duration in Year	Duration in Month
1. Bronchial Asthma			
2. Chronic Obstructive Pulmonary disease			
3. Hypertension			
4. Diabetes			
5. Heart ailment			
6. Arthritis of any kind			
7. Cerebro vascular attack			
8. Seizure disorder			
9. Renal/Kidney Disorder			
10. Congenital conditions			
11. Developmental anomalies			
12. Any other			

g) Is the ailment a complication / sequel of a pre-existing disease or condition?

If Yes , please give details

h) History of alcoholism ☐ Yes ☐ No
If yes : No of years _____
Quantity consumed per day _____

i) History of Smoking/ Tobacco chewing ☐ Yes ☐ No
If yes : No of years _____
Units consumed per day _____

ADDITIONAL DETAILS IN CASE OF NON-NETWORK HOSPITAL

a) Address of the Hospital

b) Hospital Registration No

c) Hospital Registered with

City

 State

d) Hospital PAN

 e) Number of Inpatient beds

f) Facilities available in the hospital: 1. OT ☐ Yes ☐ No 2. ICU ☐ Yes ☐ No 3. Round the clock Doctor/Nurses ☐ Yes ☐ No
4. Maintains daily record of patients ☐ Yes ☐ No
5. Others _____

SECTION D

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, insured's right to claim under this policy shall be forfeited.

Date

D	D	M	M	Y	Y	Y	Y
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 Place

Signature and Seal of the Hospital Authority

SECTION E

Authorization Letter (Mandatory)

Date:

From:

To:

The Manager/ Medical Superintendent,
Medical Records

Dear Sir

Reg : Authorization Letter.

Name of the Patient:_____

IP Number_____ (First admission) in _____Hospital

IP Number_____ (Second admission) in _____Hospital

IP Number_____ (Third admission) in _____Hospital

I consent and authorize M/s Royal Sundaram General Insurance Co. Limited and their Authorized Service Providers to seek medical information from your hospital and share copies of indoor case sheets and such other relevant medical records and/or meet/obtain statement from the Medical Practitioner who has at any time attended on the patient for the hospitalization dated to

Thanking you,

Yours sincerely,

Signature of the Proposer

Signature of the Patient