माझगांव डाँक शिपबिल्डर्स लिमिटेड MAZAGON DOCK SHIPBUILDERS LIMITED

Date: 01st Aug 2024

All Ex-Employees

Post-Retirement Medical Scheme (PRMS)

Reference is made to Notice dated 28.06.2024 regarding Post-Retirement Medical facilities under PRMS.

- Cashless facility which was withdrawn temporarily for those ex-employees availed hospitalization facilities during the period from 01.04.2024 to 30.06.2024 has been restored w.e.f 01.08.2024.
- 2. Timelines for Claim submission:
 - a. Pre-Hospitalization 30 days Pre-Hospitalization Bills to be submitted within 07 days from Discharge.
 - Post-Hospitalization 60 days Post-Hospitalization Bills duly stamped and signed to be submitted within 07 days from end of 60 days from Hospitalization.
- 3. Further, it is to notify that the following procedure is to be adhered while availing Medical Facilities:
 - a) Carry Health cards issued by Medi Assist alongwith KYC document like PAN Card/ Aadhar Card while proceeding for hospitalization.
 - b) To view/check Claim status, and downloading E-card, Login to https://portal.mediassist.in

Username: EmpCode@Mazgaondock.com

Password: DDMMYYYY (date of birth of employee)

4. Original Bills and Reports in case of reimbursement of Claims to be submitted through enclosed format A & B. Sample claim format is enclosed.

 In order to continue PRMS, duly signed Life Certificates to be submitted to HR-SBC, MDL every Year by 30th November.

> (Dr. Santosh Kumar Mallick) Executive Director(HR)



REIMBURSEMENT CLAIM FORM

TO BE FILLED BY THE INSURED

The issue of this Form is not to be taken as an admission of liablity

(To be Filled in block letters)

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	DATA ELEMENT	DESCRIPTION	FORMAT
	DATA ELEMENT	DESCRIPTION SECTION A DETAILS OF DRIMARY INCLUDED.	FORMAT
		SECTION A - DETAILS OF PRIMARY INSURED	1
a)	Policy No.	Enter the policy number	As allotted by the Insurance Company
b)	SI. No/ Certificate No.	Enter the social Insurance number or the certificate number of social health insurance scheme	As allotted by the organization Licence number as allotted by IRDA and printed
c)	Company TPA ID No.	Enter the TPA ID No.	in TPA documents.
d)	Name	Enter the full name of the policyholder	Surname, First name, Middle name
e)	Address	Enter the full postal address	Include Street, City and Pin code
		SECTION B -DETAILS OF INSURANCE HISTORY	ı
a)	Currently covered by any other Mediclaim / Health Insurance?	Indicate whether currently covered by another Mediclaim / Health Insurance	Tick Yes or No
o)	Date of commencement of first Insurance without break	Enter the date of commencement of first Insurance	Use dd-mm-yy-forrmat
c)	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
d)	Have you been Hospitalized in the last four years since Inception of the contract?	Indicate whether hospitalized in the last four years	Tick Yes or No
	Date	Enter the date of Hospitalization	Use mm-yy format
	Diagnosis	Enter the diagnosis details	Open Text
e)	Previously covered by any other Mediclaim / Health Insurance?	Indicate whether previously covered by another mediclaim / Health Insurance	Tick Yes or No
)	Company Name	Enter the full name of the Insurance Company	Name of the organization in full
	SECT	TION C -DETAILS OF INSURED PERSON HOSPITALIZED	
a)	Name	Enter the full name of the patient	Surname, First name, Middle name
o)	Gender	Indicate Gender of the patient	Tick Male or Female
c)	Age	Enter age of the patient	Number of years and months
d)	Date of Birth	Enter Date of Birth of patient	Use dd-mm-yy format
e)	Relationship to primary Insured	Indicate relationship of patient with policyholder	Tick the right option, if others, please specify
)	Occupation	indicate occupation of patient	Tick the right option. If others, please specify.
3)	Address	Enter the full postal address	Include Street, City and Pin code
h)	Phone No	Enter the phone number of patient	Include STD code with telephone number
1)	E-mail ID	Enter e-mail address of patient	Complete e-mail address
		SECTION D - DETAILS OF HOSPITALIZATION	·
a)	Name of Hospital where admitted	Enter the name of hospital	Name of hospital in full
b)	Room category occupied	indicate the room category occupied	Tick the right option
c)	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
<u> </u>	Time	Enter time of admission	Use hh-mm- format
<u>'</u> 3)	Date of discharge	Enter date of discharge	Use dd-mm-yy format
<u>رر</u> ا(د	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 Medicene	Enter the system of medicine followed in treating the patient	Open Text
,	System of Medicente	SECTION E - DETAILS OF CLAIM	
a)	Details of Treatment Expenses	Enter the amount claimed as treatment Expenses	In rupees (Do not enter paise values)
a) b)	Claim for Domiciliary Hospitalization	indicate whether claim is for domiciliary hospitalization	Tick Yes or No
c)	Details of Lump sum/ Cash benifit claimed	Enter the amount claimed as lump sum / cash benefit	In rupees (Do not enter paise values)
d)	Claim documents Submitted-Check List	· ·	
۵)	C.a documente cubilitteu-Oriock List	indicate which supporting documents are submitted	Tick the right option
nd	cate which bills are enclosed with the amount in rupees	SECTION F - DETAILS OF BILLS ENCLOSED	
	SECTIO	N G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT	
a)	PAN	Enter the permanent account number	As allotted by the Income Tax Department
b)	Account Number	Enter the Bank account number	As allotted by the Bank
c)	Bank Name and Branch	Enter the Bank name along with the branch	Name of the Bank in full
c)	Cheque/ DD payable details	Enter the name of the beneficiary the cheque / DD should be made out to	Name of the individual / organization in full
		Enter the IFSC code of the Bank branch	IFSC code of the Bank branch in full
c)	IFSC Code		
;)	IFSC Code	SECTION H - DECLARATION BY THE INSURED	

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)

DETAILS OF HOSPITAL	
a) Name of the hospital: a) Hospital ID: c) Type of Hospital:	Network: Non Network: (if non network fill section E)
c) Name of the treating doctor: SURNAME FIRE	ST NAME MIDDLE NAME 5
e) Qualification: f) Registration No. with State Code:	g) Phone No.
DETAILS OF THE PATIENT ADMITTED	
a) Name of the Patient: SURNAME STATE STAT	
b) IP Registration Number: c) Gender: Male Female f) Date of Admission: D D M M Y Y A g) Time: H H M M	d) Age: Years Y Y Months M M e) Date of birth: D D M M Y Y Y h) Date of Discharge: D D M M Y Y I) Time: H H M M M
f) Date of Admission: D D M M Y Y g) Time: H H M M j) Type of Admission: Emergency Planned Day Care Maternity k) If Mater	ii) Data of Polivery D. D. M. M. V. V. ii) Cravida Status:
Notatus at time of discharge: Discharge to home Discharge to another hospital Deceased	
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: Yes No d) Pre-authorization N	lumber:
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:	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 CURMITTED, CUECK LIST	
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 break-up bill	Investigation reports CT/MR/USG/HPE investigation reports Doctor's reference slip for investigation ECG Pharmacy bills MLC reports & Police FIR Original death summary from hospital where applicable Any other, please specify
ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE O	F NON-NETWORK HOSPITAL)
a) Address of the Hospital City: Pin Code: b) Phone No. e) Number of inpatient beds	State: Code: Segistration No. with State Code: Segistration No. with State Code: No ii. ICU Yes No
iii. Others:	
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 our right to claim under this claim shall be forfeited.	If we have made any false or untrue statement, suppression or concealment of any material fact,
Date: D D M M Y Y	N.C. I S.
Place: Signature and Seal of the Ho	

	GUIDANCE FOR FI	LLING CLAIM FORM - PART B (To be filled in by the hos	pital)
	DATA ELEMENT	DESCRIPTION	FORMAT
		SECTION A - DETAILS OF HOSPITAL	
a)	Name of the hospital:	Enter the name of hospital	Name of the 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
c)	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
	SEC	TION B - DETAILS OF THE PATIENT ADMITTED	
a)	Name of Patient	Enter the name of patient	Name of patient in full
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
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		
i.	Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format
ii.	. 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)
,		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	·
	Co-morbidities	<u> </u>	Standard Format and Open text
		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 Code and description of the first procedure	Standard Format and Open text
	Procedure 2	Enter the ICD 10 Code and description of the second procedure	Standard Format and Open text
	Procedure 3	Enter the ICD 10 Code 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	Indicate whether test conducted	Tick Yes or No
	conducted to establish this	Indicate whether injury is medico legal	Tick Yes or No
	Medico Legal Reported to Police	Indicate whether injury is medico legal 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
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Indica	ate which supporting documents are submitted	TION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST	
iiiulica		ION E - DETAILS IN CASE OF NON NETWORK HOSPITA	.I
٥/		Enter the full postal address	Include Street, City and Pin Code
a) h)	Address Phone No.	Enter the full postal address Enter the phone number of hospital	Include Street, City and Pin Code Include STD code with telephone number
b)		Enter the phone number of nospital Enter the registration number of the Hospital obtained from local body	·
c)	Registration No. with State Code	like City Corporation / Municipality	As allocated by the City Corporation / Municipality
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	
Rea	d declaration carefully and mention date (in dd:mm:yy format),	place (open text) and sign. and stamp	

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)

DETAILS OF HOSPITAL	and request form in field of FART A
a) Name of the hospital:	
a) Hospital ID: c) Type of Hospital:	Network : Non Network : (if non network fill section E)
c) Name of the treating doctor:	Network: Non Network: (if non network fill section E) S T N A M E M I D D L E N A M E
e) Qualification: f) Registration No. with State Code:	g) Phone No.
DETAILS OF THE PATIENT ADMITTED	
a) Name of the Patient: S U R N A M E F I R	
	III) Idea dalinida anidan.
DETAILS OF AILMENT DIAGNOSED (PRIMARY)	
a) ICD 10 Codes Description I. Primary Diagnosis	b) ICD 10 PCS Description i. Procedure 1:
ii. Additional Diagnosis:	ii. Procedure 2:
iii. Co-morbidities:	iii. Procedure 3:
iv. Co-morbidities:	iv. Details of Procedure:
	Road Traffic Accident Substance abuse / alcohol consumption fes, 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 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 reports & Police FIR Original death summary from hospital where applicable Any other, please specify
DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWO	RK HOSPITAL)
a) Address of the Hospital City: Pin Code: b) Phone No. d) Hospital PAN:	State: Cole: C) Registration No. with State Code: No ii. ICU Yes No
iii. Others:	
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	<u> </u>
our right to claim under this claim shall be forfeited.	
Date: D D M M Y Y	

	GUIDANCE FOR FI	LLING CLAIM FORM - PART B (To be filled in by the hos	pital)
	DATA ELEMENT	DESCRIPTION	FORMAT
		SECTION A - DETAILS OF HOSPITAL	
a)	Name of the hospital:	Enter the name of hospital	Name of the 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
c)	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
		TION B - DETAILS OF THE PATIENT ADMITTED	
a)	Name of Patient	Enter the name of patient	Name of patient in full
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
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		
i.	Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format
ii.	. 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	I 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 Code and description of the first procedure	Standard Format and Open text
	Procedure 2	Enter the ICD 10 Code and description of the linst procedure	Standard Format and Open text
	Procedure 3	Enter the ICD 10 Code and description of the third procedure	Standard Format and Open text
	Details of Procedure	Enter the details of the procedure	Open text
	Pre-authorization obtained	'	Tick Yes or No
c)		Indicate whether pre-authorization obtained Enter pre-authorization number	
d)	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 authrities
	If not reported to police, give reason	Enter reason for not reporting to police	Open text
	SEC	TION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST	
Indica	ate which supporting documents are submitted		
	SECT	ION E - DETAILS IN CASE OF NON NETWORK HOSPITA	L
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 Hospital obtained from local body	As allocated by the City Corporation / Municipality
		like City Corporation / Municipality Enter the permanent account number	As allocated by the Income Tax Department
d)	Hospital PAN Number of Innatient hads	·	<u>·</u>
e)	Number of Inpatient beds	Enter the number of inpatient beds	Digits Tick the right option. If others, please specify
f)	Facilities available in the hospital	Indicate facilities available in the hospital	now the right option. If others, please specify
р.	d declaration corofully and mention data (in delicanous Co. 1)	SECTION F - DECLARATION BY THE HOSPITAL	
Kea	d declaration carefully and mention date (in dd:mm:yy format),	piace (open text) and sign. and stamp	



REIMBURSEMENT CLAIM FORM

TO BE FILLED BY THE INSURED
The issue of this Form is not to be taken as an admission of liability

Corporate Name:-Employee Code :-

/		DETAIL O OF DRIVARY INCURED	
NA!: A : - 4		DETAILS OF PRIMARY INSURED:	No/ Certificate no. Not Require
Medi Assist		3, 3	1. Softmond its
, , ,	Not Require		
c) Company / TPA I	D (MA ID)No: Patient Member ID	no As per E-card	
d) Name: Em	ployee name	A	TMENNAMEN SHOOLENNAMEN SHOOLENN
e)Address: Em	ployee Address as per Adhard	Card	SECTION SECTION
			<u> </u>
City:		State:	
Pin Cod	Phone	No:	Email ID:
a) Currently covered by	any other Mediclaim / Health Insurance:	Yes No DE Tick No(Even you have)	hout break: DD MM M YYYYY
c) If yes, company nam		Policy No.	
Sum insured (Rs.)		een hospitalized in the last four years since inception of t	he contract? Yes No Date: M M Y Y
Diagnosis:		Jan Hoophanized III the last roal years onless incophan at	e) Previously covered by any other Mediclaim /Health insurance : Yes No
f) If yes, company name	x		, , , , , ,
		DETAILS OF INSURED PERSON HOSPITALIZ	ED: ————————————————————————————————————
	ent name and Other Details	F I R S T N A	
,	Male Female C) Age year		
e) Relationship to Prima			ther (Please Specify)
, ,	ervice Self Employed Home M	aker Student Retired O	ther (Please Specify)
g) Address (if diffrent fro	Mention "Addr	ess as above" (even if patient s	tays at other Address)
City:			
Pin Code	Phone No		Email ID:
	, I none no	ALIZATION:	Linding.
a) Name of Hospital	where Admited: Hospital Nam	e As per Final Bill	
b) Room Category		e occupancy rwm snaring Date of injury / Date Disease	3 or more beds per room per first detected /Date of Delivery:
c) Hospitalization due) Date of Admission		f) Time H H M H g) Date of	of first detected /Date of Discharge
I) If injury give cause	Date of Autilission		
ii) Reported to Police	_		of Medicine:
		DETAILS OF CLAIM:	
a) Details of the TreatnI. Pre -hospitalization e		Hospitalization expenses Rs.	Claim Documents Submitted - Check List: Claim form duly signed
iii. Post-hospitalization		't Fill Health-Check up cost: Rs.	Copy of the claim intimation, if any
v. Ambulance Charges:	Rs.	Others (code):	Mention Only total claimable amount i.e Hospital
		Total Rs.	
vii. Pre -hospitalization	period: days	viii. Post -hospitalization period: d:	(Do not add Cashless Final bill amount in Reimbursement/Pre-post expenses claim)
b) Claim for Domiciliary		(If yes, provide details in annexure)	Reimbursement/Pre-post expenses claim)
c) Details of Lump sumi. Hospital Daily cash:	/ cash benefit claimed:	ii. Surgical Cash:	s. Coperation leater notes
iii. Critical Illness benef			Docto'rs request for investigation
v. Pre/Post hospitalizat	ion Lump sum benefit: Rs.		Investigation Reports (Including CT /MRI/USG/HPE)
		Total	Docto'rs Prescriptions es. Others
CL No Dill No	Dete	DETAILS OF BILLS ENCLOSED:	Amount (Da)
SI. No. Bill No.	Date Issued	Towards Hospital main Bill	Amount (Rs)
2.	NOT REQUIRE	Pre-hospitalization Bills:	Nos
3.	NOT REQUIRE	Post-hospitalization Bills:	Nos Sin C
4.		Pharmacy Bills	Mention Only total claimable amount i.e Hospital Final bill
5.	NOT REQUIRE		and Pre-Post expenses
7.	NOT REQUIRE	<u> </u>	(Do not add Cashless Final bill amount in
8.			Reimbursement/Pre-post expenses claim)
9.	NOT DECLUDE		
10.	NOT REQUIRE		
2) PAN:		DETAILS OF PRIMARY INSURED'S BANK ACC	ount:
a) PAN:	Do not fill this part. Pro	ovide employee bank details ald	ong with other claim documents
c) Bank Name and Brad) Cheque / DD Payab		e) IFSC Code:	
- onoque / DD Fayat	o dotalio.	DECLARATION BY THE INSURED:	
			f. If I have made any false or untrue statement, suppression or concealent of any material nsent & authorize TPA / insurance Company, to seek necessary medical information / ereby declare that I have included all the bills / receipts for the purpose of this claim & Tool of the purpose of this claim & Tool of the purpose of this claim & Tool of the purpose of the purpose of this claim & Tool of the purpose of the purpose of this claim & Tool of the purpose of this claim & Tool of the purpose of this claim & Tool of the purpose of
documents from any		ed on the person against whom this claim is made. I h	ereby declare that I have included all the bills / receipts for the purpose of this claim to
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D D M M	YYYY	

Filled by Hospital Only

CLAIM FORM - PART B
TO BE FILLED IN BY THE HOB NTAL
The issue of this Form is not to be taken as an admission of Sability

(To be Filled in block latters)

DETAILS OF HOSPITAL	Plame include the origin	nd preauthorization request form in lieu of PART A
n) Nome of the beginst	ospital name	
(Halle		(Type of Hospitals - Nationals - Handle
Chargest the country charge.	reating Doctor name	
Quiliculus	() Registrature No. with	Section
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Nerver the Patrice	ent name	
SEF Registration (Number:	OCO III III MA	District Control of the Control of t
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