Liberty General Insurance

Claim Form - Part A

TO BE FILLED IN BY THE INSURED

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

(To be filled in block letter)

SECTION A

DETAILS OF PRIMARY INSURED

a) Policy No : b) Sl. No/certificate No :

c) Company ID No :

d) Name : SURNAME FIRST NAME MIDDLE NAME

e) Address :

City : State :

Pin Code : Phone No : Email ID :

ABHA Id :

'If ABHA ID is not available, we urge you to visit https://abdm.gov.in/ for creation of ABHA ID and inform the same to us once created.'

SECTION B

DETAILS OF INSURANCE HISTORY

a) Currently covered by any other Mediclaim / Health Insurance : ☐ Yes ☐ No

b) Date of commencement of first insurance without break : d d m m y y (copy of policies to be attached)

c) If Company Name : Policy No :

Sum Insured (Rs.) :

d) Have you been hospitalized in the last 4 year? ☐ Yes ☐ No Date : d d m m y y Diagnosis :

e) Previously covered by any other Mediclaim / Health Insurance : ☐ Yes ☐ No f) If Yes, Company Name :

SECTION C

DETAILS OF INSURED PERSON HOSPITALIZED

a) Name : SURNAME FIRST NAME MIDDLE NAME

b) Gender : ☐ Male ☐ Female c) Age : Year y y Months m m d) Date of Brith d d y y m m

e) Relationship to Primary Insured : ☐ Self ☐ Spouse ☐ Child ☐ Father ☐ Mother ☐ Other (Please specify)

f) Occupation : ☐ Service ☐ Self Employed ☐ Homemaker ☐ Student ☐ Retired ☐ Other (Please specify)

e) Address (if different from Above) :

City : State :

Pin Code : Phone No : Email ID :

ABHA Id :

'If ABHA ID is not available, we urge you to visit https://abdm.gov.in/ for creation of ABHA ID and inform the same to us once created.'

SECTION D

DETAIL OF HOSPITALIZATION

a) Name of Hospital where Admitted :

b) Room Category Occupied : ☐ Day Care ☐ Single Occupancy ☐ Twin Sharing ☐ 3 Or more beds per room

c) Hospitalization due to : ☐ Injury ☐ Illness ☐ Maternity d) Date of Injury / Date Disease First Detected / Date of Delivery : d d y y m m

e) Date of Admission : d d y y m m f) Time : h h m m g) Date Of Discharge : d d y y m m h) Time : h h m m

i) If Injury Give Cause : ☐ Self Inflicted ☐ Road Traffic Accident ☐ Substance / Alcohol Consumption i) If Medico legal : ☐ Yes ☐ No

ii) Reported To Police : ☐ Yes ☐ No iii) MLC Report & Police FIR Attached : ☐ Yes ☐ No j) System of Medicine :

SECTION E

DETAIL OF CLAIM

a) Details of The Treatment Expenses Claimed

i. Pre-hospitalization Expenses : Rs.

ii. Hospitalization Expenses : Rs.

iii. Post-hospitalization Expenses : Rs.

iv. Health-Check up Cost : Rs.

v. Ambulance charges : Rs.

vi. Other (code) : Rs.

Total Rs.

vii. Pre-hospitalisation period : days

viii. Post-hospitalization Period : days d d y y m m

b) Claim for Domiciliary Hospitalization : ☐ Yes ☐ No (If yes, provide details in annexure)

c) Details Of Lump sum / Cash Benefit Claimed:

i. Hospital Daily Cash : Rs.

ii. Surgical Cash : Rs.

ii. Critical Illness Benefit : Rs.

iv. Convalescence : Rs.

v. Pre/Post Hospitalization Lump Sum Benefit : Rs.

vi. Other : Rs.

Total Rs.

(IMPORTANT : PLEASE TURN OVER)

SECTION E

Claim Documents Submitted - Check List

- ☐ Claim Form Duly Signed
- ☐ Copy of the claim Intimation
- ☐ Hospital Main Bill
- ☐ Hospital Break-up Bill
- ☐ Hospital Bill Payment Receipt
- ☐ Hospital Discharge Summary
- ☐ Pharmacy Bill
- ☐ Operation Theater Notes
- ☐ ECG
- ☐ Doctor's Request For Investigation
- ☐ Investigation Report (Including CT / MRI/ USG / HPE)
- ☐ Other

SECTION F

DETAILS OF BILL ENCLOSED

Sl. No	Bill No	Date	Issued by	Towards	Amount (Rs.)
1.		d d m m y y		Hospital Main Bill	
2.		d d m m y y		Pre-hospitalization: _____ Nos	
3.		d d m m y y		Pre-hospitalization: _____ Nos	
4.		d d m m y y		Pharmacy Bills	
5.		d d m m y y			
6.		d d m m y y			
7.		d d m m y y			
8.		d d m m y y			
9.		d d m m y y			
10.		d d m m y y			

SECTION G

DETAILS PRIMARY INSURED'S ACCOUNT

a) Pan : b) Account Number :

c) Bank Name and Branch :

d) Cheque/ DD Payable details : e) IFSC Code :

SECTION H

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 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.

I/We hereby give voluntary consent to Liberty General Insurance Limited/Company to process/share my/our personal information and data provided in this form with its group companies or any other person/ Service Provider of Company in connection with the Insurance Policy/ claims made there under or otherwise, including for providing other products of the Company that may be of interest to me/us, to be used in accordance with their respective privacy policies.

Date : d d m m y y

Place :

Signature of the insured

Liberty General Insurance

Claim Form - Part B

(To be filled in block letter)

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

SECTION A

DETAILS OF HOSPITAL

a) Name of Hospital :

b) Hospital ID : c) Type of Hospital : ☐ Network ☐ Non Network (If non network section E)

d) Name of the treating doctor : SURNAME FIRST NAME MIDDLE NAME

e) Qualification : f) Registration No. with State Code :

g) Phone No :

SECTION B

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient : SURNAME FIRST NAME MIDDLE NAME

b) IP Registration Number : c) Gender : ☐ Male ☐ Female d) Age : Year (yy) Months (mm)

e) Date of Brith : (dd mm yy) f) Date of Admission : (dd mm yy) g) Time : (hh mm)

h) Date of Discharge : (dd mm yy) i) Time : (hh mm) j) Type of Admission : ☐ Emergency ☐ Planned ☐ Day Care ☐ Maternity

k) If Maternity : i. Date of Delivery : (dd mm yy) ii. Grade of status :

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

SECTION C

DETAIL OF AILMENT DIAGNOSED (PRIMARY)

a)	ICD 10 Codes	Description	b)	ICD 10 Codes	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) Present ailment is a complication of PED? ☐ Yes ☐ No i) (If Yes, Specify Details) : _____

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

i) If injury due to substance abuse/ alcohol consumption, Test Conducted to establish this : ☐ Yes ☐ No (If Yes, Attach Report) iii) If Medico Legal : ☐ Yes ☐ No

v) FIR no : vi) If not reported to police give reason: _____

SECTION D

CLAIM DOCUMENTS SUBMITTED - CHECK LIST

- ☐ Claim From Duly Singed
- ☐ Original Pre-authorization request
- ☐ Copy of Pre-authorization Approval latter
- ☐ Copy of photo ID card of patient verified by hospital
- ☐ Hospital Discharge summary
- ☐ Operation Theater notes
- ☐ Hospital main bill
- ☐ Hospital break-up bill
- ☐ Investigation report
- ☐ CT/MR/USG/HPE investigation report
- ☐ Doctor's reference slip for investigation
- ☐ ECG
- ☐ Pharmacy bills
- ☐ MLC report & Police FIR
- ☐ Original death summary from hospital where applicable
- ☐ Any other, please specify

(IMPORTANT : PLEASE TURN OVER)

DETAILS IN CASE OF NON NETWORK HOSPITAL

a) Address of Hospital :

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) Other :

SECTION E

DECLARATION BY THE INSURED

(PLEASE READ VERY CAREFULLY)

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 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.

I/We hereby give voluntary consent to Liberty General Insurance Limited/Company to process/share my/our personal information and data provided in this form with its group companies or any other person/ Service Provider of Company in connection with the Insurance Policy/ claims made there under or otherwise, including for providing other products of the Company that may be of interest to me/us, to be used in accordance with their respective privacy policies.

Date : d d m m y y Place : Signature of the insured

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 my 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. The signature of the insured is taken on this form after Claim Form B is fully filled up by us.

Date : d d m m y y

Place : Signature and Seal of the hospital Authority

SECTION G