Liberty General Insurance Limited
Unit 1501&1502, 15th Floor, Tower 2, One International Center,
Senapati Bapat Marg, Prabhadevi, Mumbai – 400013
Phone: +91 22 6700 1313 Email: care@libertyinsurance.in
IRDA registration number: 150 • CIN: U66000MH2010PLC209656

(Standard Claim Form As prescribed by IRDA for Health Products)

Liberty Surro Assure Policy

Claim Form-Part A

TO BE FILLED IN BY THE INSURED PERSON
(The issue of this Form is not to be taken a s an admission of liability)

SECTION A- DETAILS OF PRIMARY INSURED

a)Policy Number: b) SL No / Certificate No/ Claim Number (If any):

c)Company/ TPA ID no

d)Name

h)Address

i) City j) State k) Pin Code

l) Phone No: m) Email ID:

n) 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: dd mm yy

c) If YES, -
Company Name: Policy Number:

Sum Insured:

d) Have you been hospitalized in the last four years since the inception of the contract? YES / NO DATE : MM YY

Diagnosis:

e) Previously covered by any other Mediclaim / Health Insurance: YES/ NO

f) If Yes company name:

SECTION C. DETAILS OF INSURED PERSON HOSPITALIZED

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a) Name:

b) Gender: Female c) Age: …. Years …. Months d) Date of Birth : DD MM YY

e) Relationship of Primary Insured: Surrogate Mother/Oocyte Donor (Please Specify… .....)

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

g) 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. DETAILS OF HOSPITALIZATION

a) Name of the Hospital where admitted

b) Room Category Occupied: Day care / / Single occupancy / Twin sharing / 3 or more

c) Hospitalization due to : Illness / Injury / Maternity

d) Date of Injury / Disease first detected / Date of Delivery: DD MM YYYY

e) Date of Admission: DD MM YY Time : HH MM f) Date of Discharge: DD MM YY Time : HH MM

h) If injury, give cause : Self Inflicted / Road Traffic Accident/ Substance Abuse or Alcohol Consumption

i) If Medico legal : YES/ NO j) Reported to Police: YES/ NO k) MLC report or Police FIR attached: YES / NO

l) System of medicine _____

SECTION E. DETAILS OF CLAIM

a Details of Treatment Expenses Claimed

1. Hospitalization Expenses: Rs…….
2. Ambulance Charges: Rs …… 3. Others (Code) Rs ..…

Total: Rs…....

Surgical cash: Rs ……

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Convalescence: Rs …….

Other- Rs …… Total : Rs……

Claim Documents Submitted Check List

- **Claim Form Duly Filled**
- **Copy of the Claim Intimation, if any**
- **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 Reports (Including CT/MRI/USG/HPE)**
- **Doctor's Prescription**
- **Others**

F.DETAILS OF BILLS ENCLOSED

Sl. No	Bill No	Date	Issued by	Towards	Amount
				Hospital Main Bill	
				Investigation Bills	
				Pharmacy Bills	
				Total	

Please attach separate sheet for additional bills / receipt details

G. DETAILS OF PRIMARY INSUREDS BANK ACCOUNT

a) PAN No: b) Account Number

c) Bank Name/ Branch:

d) Payable details: Cheque/ DD/NEFT* Payable to:

e) IFSC Code:

H. DECLARATION BY THE INSURED

Registered & Corporate Office: Unit 1501&1502, 15th Floor, Tower 2, One International Center, Senapati Bapat Marg, Prabhadevi, Mumbai – 400013 Phone: +91 22 6700 1313 | Email: care@libertyinsurance.in
Liberty Health 360 - Liberty General Insurance Limited: "The Capitol", 4th Floor, New D.P.Road, Near Ashoka Hotel, Vishal Nagar, Pimple Nilakh, Pune- 411027 | Phone No: 020 3085 6565 | Email:health360@libertyinsurance.in

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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 TPA / 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: PLACE Signature of the Insured

Liberty Surro Assure

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GUIDANCE FOR FILLING CLAIM FORM – PART A (To be filled in by the insured)		
DATA ELEMENT	**DESCRIPTION**	**FORMAT**
SECTION A - DETAILS OF PRIMARY INSURED		
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	As allotted by the organization
c) Company TPA ID No.	Enter the TPA ID No	License number as allotted by IRDA and printed 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		
a) Currently covered by any other Mediclaim / Health	Indicate whether currently covered by another Mediclaim / Health Insurance	Tick Yes or No
b) Date of Commencement of first Insurance	Enter the date of commencement of first insurance	Use dd-mm-yy format
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 4 years	Indicate whether hospitalized in the last 4 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	Indicate whether previously covered by another Mediclaim / Health Insurance	Tick Yes or No
f) Company Name	Enter the full name of the insurance company	Name of the organization in full
SECTION C - DETAILS OF INSURED PERSON HOSPITALIZED		
a) Name	Enter the full name of the patient	Surname, First name, Middle name
b) 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.
f) Occupation	Indicate occupation of patient	Tick the right option. If others, please specify.
g) 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
i) 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
) Hospitalization due to	Indicate reason of hospitalization	Tick the right option
d) Date of Injury/Date Disease first detected/ Date of	Enter the relevant date	Use dd-mm-yy format
e) Date of admission	Enter date of admission	Use dd-mm-yy format
f) Time	Enter time of admission	Use hh:mm format
g) Date of discharge	Enter date of discharge	Use dd-mm-yy format
h) Time	Enter time of discharge	Use hh:mm format
i) 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
j) System of Medicine	Enter the system of medicine followed in treating the patient	Open Text
SECTION E - DETAILS OF CLAIM		
a) Details of Treatment Expenses	Enter the amount claimed as treatment expenses	In rupees (Do not enter paise values)
b) Claim for Domiciliary Hospitalization	Indicate whether claim is for domiciliary hospitalization	Tick Yes or No
c) Details of Lump sum/ cash benefit claimed	Enter the amount claimed as lump sum/ cash benefit	In rupees (Do not enter paise values)

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d) Claim Documents Submitted-Check List	*Indicate which supporting documents are submitted*	*Tick the right option*
SECTION F - DETAILS OF BILLS ENCLOSED		
Indicate which bills are enclosed with the amounts in rupees		
SECTION 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*
d) 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*
e) IFSC Code	*Enter the IFSC code of the bank branch*	*IFSC code of the bank branch in full*
SECTION H - DECLARATION BY THE INSURED		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.		

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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

Please include the original preauthorization request form in lieu of PART A (To be filled in Block Letters)

SECTION A. Hospital Details:			
Name of the Hospital		Hospital ID	
Type of Hospital	Network	Non Network	
If Non Network fill sec E			
Name of the treating Doctor			
Qualification	Registration No with State Code:	Phone No:	

SECTION B. Details of the patient admitted:				
Name of the patient		IP Registration Number		
Gender	Female	Age	Date of Birth: DD MM YYYY	
Date of Admission		Time of Admission		
Date of Discharge		Time of Discharge		
Type of Admission	Emergency	Planned	Day-care	Maternity
If Maternity Date of delivery		Gravida Status		
Status at the time of Discharge: Discharge to Home/ Discharge to another Hospital/ Deceased Total Claimed Amount: …….				

SECTION C. DETAILS OF AILMENT DIAGNOSED						
Ailment Diagnosed (Primary)						
ICD 10 Code	Primary Diagnosis	Codes Description	Additional Diagnosis	Codes Description	Co-morbidities	Codes Description
Details of Procedure/s done						
ICD 10 PCS	Procedure 1	Code & Description	Procedure 2	Code & Description	Procedure 3	Code & Description

Pre authorization Obtained	YES/ NO	PRE AUTHRIZATION NUMBER	…….
Hospitalization due to Injury	Yes/ No	If Yes Give cause	Self-Inflicted/ Road Traffic Accident / Substance Abuse / Alcohol Consumption
Reported to police	YES / NO	Medico Legal	YES / NO
FIR No	If not reported to police , give reasons		
If injury due to Substance Abuse/ Alcohol consumption test conducted to establish this? If YES please attach Report			YES/ NO

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If authorization by network hospital not obtained, give reason	
Note: For details of Claim Documents to be submitted, please refer checklist	

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Claim Document Submitted - Checklist

Claim Form Duly signed
Original Pre-Authorisation Request
Copy of Pre-Authorisation Approval Letter
Copy of Photo Id Card of Patient verified by the Hospital
Hospital Discharge Summary
Operation Theater Notes
Hospital Main Bills

Hospital Break-up
BillInvestigation
reports
CT/MRI/USG/HPE investigation
reportsDoctor's reference slip for
investigation ECG
Pharmacy Bills
MLC report & Policy 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–network hospital)
Address of the Hospital

Address of theHospital	
City	
State	
Pin Code	
Phone No	
Registration no with state code	
Hospital PAN	
No of Inpatient Beds	
Facilities in the Hospital	OT □ Yes □ No ICU □ Yes □ No
Others	

DECLARATION BY THE HOSPITAL

We hereby declare thatthe information furnished in this Claim Form is true and correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppressed or concealed any material fact, our right to claim under this Policy shall be forfeited.

SEAL & SIGNATURE OF THE HOSPITAL AUTHORITY

Date
Place

Liberty Surro Assure

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