

LIBERTY HEALTH CONNECT 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 DETAILS OF PRIMARY INSURED		(To be filled in block letter)
a) Policy No. :	b) SI. No./certificate No. :	
c) Company ID No.:		
	V A M E	L E N A M E
e) Address :		
City:	Ptoto :	
	State:	
Pin Code : Phone No. :	Email ID :	
DETAILS OF INSURANCE HISTORY		
a) Currently covered by any other Mediclaim / Health Insurance :		
b) Date of commencement of first insurance without break : d d m m y	(copy of policies to be attached)	
c) If Company Name : Policy No :		
Sum Insured (Rs.):		
	m m y y Diagnosis:	
e) Previously covered by any other Mediclaim / Health Insurance : Yes No f) If Yes, C		
e) i reviously covered by any other medicianity freathful ander. — fes — No — i) i fes, c	ompany Name .	
DETAILS OF INSURED PERSON HOSPITALIZED		
a) Name :	V A M E M I D D I	L E N A M E
		m m
e) Relationship to Primary Insured : Self Spouse Child Father Mother		<u></u>
e) Address (if different from Above):	Other (Please specify)	
e) Address (il different from Above) .		
	State:	
Pin Code : Phone No : E	Email ID :	
DETAIL OF HOSPITALIZATION		
a) Name of Hospital where Admitted :		
	2 Or many hada nay raam	
b) Room Category Occupied : Day Care Single Occupancy Twin Sharing Alternity Alternity Date of Injury Date of I		d d V V m m
	Discharge: d d y y m m	
	cohol 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 :	
DETAIL OF CLAIM		
a) Details of The Treatment Expenses Claimed		
	ii. Hospitalization Expenses : Rs.	
	iv. Health-Check up Cost : Rs.	
	vi. Other (code) : Rs.	
	Total Rs	d d y y m m
		4 u 9 9 m m
b) Claim for Domiciliary Hospitalization :	7)	
	ii Surgical Cook :	
	ii. Surgical Cash : Rs.	
	iv. Convalescence : Rs.	
v. Pre/Post Hospitalization Lump Sum Benefit :	vi. Other: Rs.	
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(IMPORTANT : PLEASE TURN OVER)

Claim Documents Submitted - Check List

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Enter the full name of the insurance company

f) Company Name

Name of the organization in full



SECTION C - DETAILS OF INSURED PERSON HOS	PITALIZED	
a) Name	Enter the full name of the patient	Surname, Firstname, Middlename
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 policy holder	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) PhoneNo	Enter the phone number of patient	Include STD code with telephone number
I) E-mailID	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 reas on 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
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 If Medico legal Reported to Police MLC Report & Police FIR attached	Indicate cause of injury Indicate whether injury is medicolegal Indicate whether police report was filed Indicate whether MLC report and Police FIR attached	Tick the right option Tick Yes or No Tick Yes or No Tick Yes or No
j) System of Medicine	Enter the system of medicine followed intreating 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 notenter paise values)
d) Claim Documents Submitted - Check List	Indicate which supporting documents are submitted	Tick the right option
SECTION F - DETAILS OF BILLSEN CLOSED		
Indicate which bills are enclosed with the amount sin r	upees	
SECTION G - DETAILS OF PRIMARY INSURED'S B	ANK 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 - DETAILS OF PRIMARY INSURED'S B	ANK ACCOUNT	
Read declaration carefully and mention date (in dd : m	nm : yy format), place (open text) and sign.	



LIBERTY HEALTH CONNECT INSURANCE 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	(To be filled in block letter)
Please include the original preauthorization request form in lieu of PART 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 FI	R S T
e) Qualification :	f) Registration No. with State Code :
g) Phone No. :	
DETAILS OF THE PATIENT ADMITTED	
a) Name of the Patient : SURNAME FIRE	S T N A M E M I D D L E N A M E
b) IP Registration Number : c)	Gender: Male Female d) Age: Year Months M M
e) Date of Brith:	Gender : □ Male □ Female d) Age : Year y y Months m
h) Date of Discharge : d d m m y y i) Time : h h m m j) Typ	pe of Admission : ☐ Emergency ☐ Planned ☐ Day Care ☐ Maternity
k) If Maternity : i. Date of Delivery : d d m m y y ii. Grade of statu	s:
j) Status at time of discharge : $\ \square$ Discharge to home $\ \square$ Discharge to another	her hospital Deceased
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) Details of Procedure :
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 :	ion 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	sh this : ☐ Yes ☐ No (If Yes, Attach Report) iii) If Medico Legal : ☐ Yes ☐ No
v) FIR no : vi) If not reported to police give	reason:
CLAIM DOCUMENTS SUBMITTED - CHECK LIST	
□ Claim From Duly Singed	☐ Investigation report
☐ Original Pre-authorization request	☐ CT/MR/USG/HPE investigation report
☐ Copy of Pre-authorization Approval latter	☐ Doctor's reference slip for investigation
☐ Copy of photo ID card of patient verified by hospital	□ ECG
☐ Hospital Discharge summary	□ Pharmacy bills
☐ Operation Theater notes	☐ MLC report & Police FIR
☐ Hospital main bill	☐ Original death summary from hospital where applicable
☐ Hospital break-up bill	☐ Any other, please specify

(IMPORTANT : PLEASE TURN OVER)



) Address of Hospital :					<u> </u>				_					_					_	4		_	4	_	_						
City:											Sta	te:																			
Pin Code :			b) Phor	ie No	: [c)) Re	gistr	atio	n N	o : [
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) Other :									Ī					Т				Т				Т									
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at I have included all the bills	mation / do	ocume for the	ents fro	om any	hosp this c	oital /	Mec & th	dical at I w	Pradicial Pradic	ctition of be r	er when aking	no ha	s atte	ende ople gnat	ed o mer tture	on the	ie pe y clai the ir	rsor m e	n ag xce red	ains pt th	elie	omte/po	EAS	clainosp	m is pitali	insu madizati	rande. I	Y C	eby n, if a	dec nny.	LY



GUIDANCE FO	OR FILLING CLAIM FORM - PART B (To be filled in b	y the hospital)
DATA ELEMENT	DESCRIPTION	FORMAT
SECTION A - DETAILS OF PRIMARY INSURED		
a) Name of Hospital	Enter the policy number	Name of hospital in full
b) Hospital ID	Enter ID number of hospital	As allocated by the Liberty Health 360
c) Type of Hospital	Indicate whether 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	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
SECTION B - DETAILS OF THE PATIENT ADMITTE	D	
a) Name of Patient	Enter the name of hospital	Name of hospital 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 y ears and months
e) Date of Birth	Enter date of admission	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	**	
Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format
Gravida Status	Enter Gravida status if maternity	Use standard format
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 C - DETAILS OF AILMENT DIAGNOSED	(PRIMARY)	
a) ICD 10 Code		
a) ICD 10 Code Primary Diagnosis	Enter the ICD 10 Code and description of the primary diagnosis	Standard Format and Open text
·		Standard Format and Open text Standard Format and Open text
Primary Diagnosis	diagnosis Enter the ICD 10 Code and description of the	
Primary Diagnosis Additional Diagnosis	diagnosis Enter the ICD 10 Code and description of the additional diagnosis Enter the ICD 10 PCS and description of the first	Standard Format and Open text
Primary Diagnosis Additional Diagnosis Co-morbidities	diagnosis Enter the ICD 10 Code and description of the additional diagnosis Enter the ICD 10 PCS and description of the first	Standard Format and Open text
Primary Diagnosis Additional Diagnosis Co-morbidities b) ICD 10 PCS	diagnosis Enter the ICD 10 Code and description of the additional diagnosis Enter the ICD 10 PCS and description of the first procedure Enter the ICD 10 PCS and description of the second	Standard Format and Open text Standard Format and Open text
Primary Diagnosis Additional Diagnosis Co-morbidities b) ICD 10 PCS Procedure 1 Procedure 2 Procedure 3	diagnosis Enter the ICD 10 Code and description of the additional diagnosis Enter the ICD 10 PCS and description of the first procedure Enter the ICD 10 PCS and description of the second procedure Enter the ICD 10 PCS and description of the third procedure Enter the ICD 10 PCS and description of the third procedure	Standard Format and Open text
Primary Diagnosis Additional Diagnosis Co-morbidities b) ICD 10 PCS Procedure 1 Procedure 2 Procedure 3 Details of Procedure	Enter the ICD 10 Code and description of the additional diagnosis Enter the ICD 10 PCS and description of the first procedure Enter the ICD 10 PCS and description of the second procedure Enter the ICD 10 PCS and description of the third procedure Enter the ICD 10 PCS and description of the third procedure Enter the ICD 10 PCS and description of the third procedure Enter the ICD 10 PCS and description of the third procedure	Standard Format and Open text Open text
Primary Diagnosis Additional Diagnosis Co-morbidities b) ICD 10 PCS Procedure 1 Procedure 2 Procedure 3	diagnosis Enter the ICD 10 Code and description of the additional diagnosis Enter the ICD 10 PCS and description of the first procedure Enter the ICD 10 PCS and description of the second procedure Enter the ICD 10 PCS and description of the third procedure Enter the ICD 10 PCS and description of the third procedure	Standard Format and Open text
Primary Diagnosis Additional Diagnosis Co-morbidities b) ICD 10 PCS Procedure 1 Procedure 2 Procedure 3 Details of Procedure	Enter the ICD 10 Code and description of the additional diagnosis Enter the ICD 10 PCS and description of the first procedure Enter the ICD 10 PCS and description of the second procedure Enter the ICD 10 PCS and description of the third procedure Enter the ICD 10 PCS and description of the third procedure Enter the ICD 10 PCS and description of the third procedure Enter the ICD 10 PCS and description of the third procedure	Standard Format and Open text Open text
Primary Diagnosis Additional Diagnosis Co-morbidities b) ICD 10 PCS Procedure 1 Procedure 2 Procedure 3 Details of Procedure c) Pre-authorization obtained	Enter the ICD 10 PCS and description of the first procedure Enter the ICD 10 PCS and description of the first procedure Enter the ICD 10 PCS and description of the second procedure Enter the ICD 10 PCS and description of the third procedure Enter the ICD 10 PCS and description of the third procedure Enter the ICD 10 PCS and description of the third procedure Enter the details of the procedure Indicate whether pre-authorization obtained	Standard Format and Open text Open text Tick Yes or No As allotted by Liberty Health 360 Open text
Primary Diagnosis Additional Diagnosis Co-morbidities b) ICD 10 PCS Procedure 1 Procedure 2 Procedure 3 Details of Procedure c) Pre-authorization obtained d) Pre-authorization by network hospital not obtained,	Enter the ICD 10 PCS and description of the first procedure Enter the ICD 10 PCS and description of the first procedure Enter the ICD 10 PCS and description of the second procedure Enter the ICD 10 PCS and description of the third procedure Enter the ICD 10 PCS and description of the third procedure Enter the ICD 10 PCS and description of the third procedure Enter the details of the procedure Indicate whether pre-authorization obtained Enter pre-authorization number Enter reason for not obtaining pre-authorization	Standard Format and Open text Open text Tick Yes or No As allotted by Liberty Health 360
Primary Diagnosis Additional Diagnosis Co-morbidities b) ICD 10 PCS Procedure 1 Procedure 2 Procedure 3 Details of Procedure c) Pre-authorization obtained d) Pre-authorization Number e) If authorization by network hospital not obtained, give reason	Enter the ICD 10 PCS and description of the first procedure Enter the ICD 10 PCS and description of the first procedure Enter the ICD 10 PCS and description of the second procedure Enter the ICD 10 PCS and description of the second procedure Enter the ICD 10 PCS and description of the third procedure Enter the ICD 10 PCS and description of the third procedure Enter the ICD 10 PCS and description of the third procedure Enter the details of the procedure Indicate whether pre-authorization obtained Enter pre-authorization number Enter reason for not obtaining pre-authorization number	Standard Format and Open text Open text Tick Yes or No As allotted by Liberty Health 360 Open text
Primary Diagnosis Additional Diagnosis Co-morbidities b) ICD 10 PCS Procedure 1 Procedure 2 Procedure 3 Details of Procedure c) Pre-authorization obtained d) Pre-authorization Number e) If authorization by network hospital not obtained, give reason f) Hospitalization due to injury	Enter the ICD 10 PCS and description of the first procedure Enter the ICD 10 PCS and description of the first procedure Enter the ICD 10 PCS and description of the second procedure Enter the ICD 10 PCS and description of the third procedure Enter the ICD 10 PCS and description of the third procedure Enter the ICD 10 PCS and description of the third procedure Enter the ICD 10 PCS and description of the third procedure Enter the details of the procedure Indicate whether pre-authorization obtained Enter pre-authorization number Enter reason for not obtaining pre-authorization number Indicate if hospitalization is due to injury	Standard Format and Open text Open text Tick Yes or No As allotted by Liberty Health 360 Open text Tick Yes or No Tick the right option Tick Yes or No
Primary Diagnosis Additional Diagnosis Co-morbidities b) ICD 10 PCS Procedure 1 Procedure 2 Procedure 3 Details of Procedure c) Pre-authorization obtained d) Pre-authorization Number e) If authorization by network hospital not obtained, give reason f) Hospitalization due to injury Cause If injury due to substance abuse / alcohol	Enter the ICD 10 PCS and description of the first procedure Enter the ICD 10 PCS and description of the first procedure Enter the ICD 10 PCS and description of the second procedure Enter the ICD 10 PCS and description of the third procedure Enter the ICD 10 PCS and description of the third procedure Enter the ICD 10 PCS and description of the third procedure Enter the details of the procedure Indicate whether pre-authorization obtained Enter pre-authorization number Enter reason for not obtaining pre-authorization number Indicate if hospitalization is due to injury Indicate cause of injury	Standard Format and Open text Open text Tick Yes or No As allotted by Liberty Health 360 Open text Tick Yes or No Tick the right option
Primary Diagnosis Additional Diagnosis Co-morbidities b) ICD 10 PCS Procedure 1 Procedure 2 Procedure 3 Details of Procedure c) Pre-authorization obtained d) Pre-authorization Number e) If authorization by network hospital not obtained, give reason f) Hospitalization due to injury Cause If injury due to substance abuse / alcohol consumption, test conducted to establish this	Enter the ICD 10 PCS and description of the first procedure Enter the ICD 10 PCS and description of the first procedure Enter the ICD 10 PCS and description of the second procedure Enter the ICD 10 PCS and description of the third procedure Enter the ICD 10 PCS and description of the third procedure Enter the ICD 10 PCS and description of the third procedure Enter the details of the procedure Indicate whether pre-authorization obtained Enter pre-authorization number Enter reason for not obtaining pre-authorization number Indicate if hospitalization is due to injury Indicate whether test conducted	Standard Format and Open text Open text Tick Yes or No As allotted by Liberty Health 360 Open text Tick Yes or No Tick the right option Tick Yes or No
Primary Diagnosis Additional Diagnosis Co-morbidities b) ICD 10 PCS Procedure 1 Procedure 2 Procedure 3 Details of Procedure c) Pre-authorization obtained d) Pre-authorization Number e) If authorization by network hospital not obtained, give reason f) Hospitalization due to injury Cause If injury due to substance abuse / alcohol consumption, test conducted to establish this Medico Legal	diagnosis Enter the ICD 10 Code and description of the additional diagnosis Enter the ICD 10 PCS and description of the first procedure Enter the ICD 10 PCS and description of the second procedure Enter the ICD 10 PCS and description of the third procedure Enter the ICD 10 PCS and description of the third procedure Enter the ICD 10 PCS and description of the third procedure Enter the ICD 10 PCS and description of the third procedure Enter the details of the procedure Indicate whether pre-authorization obtained Enter pre-authorization number Enter reason for not obtaining pre-authorization number Indicate if hospitalization is due to injury Indicate cause of injury Indicate whether test conducted Indicate whether injury is medico legal	Standard Format and Open text Open text Tick Yes or No As allotted by Liberty Health 360 Open text Tick Yes or No Tick Yes or No Tick Yes or No Tick Yes or No
Primary Diagnosis Additional Diagnosis Co-morbidities b) ICD 10 PCS Procedure 1 Procedure 2 Procedure 3 Details of Procedure c) Pre-authorization obtained d) Pre-authorization Number e) If authorization by network hospital not obtained, give reason f) Hospitalization due to injury Cause If injury due to substance abuse / alcohol consumption, test conducted to establish this Medico Legal Reported To Police	diagnosis Enter the ICD 10 Code and description of the additional diagnosis Enter the ICD 10 PCS and description of the first procedure Enter the ICD 10 PCS and description of the second procedure Enter the ICD 10 PCS and description of the third procedure Enter the ICD 10 PCS and description of the third procedure Enter the ICD 10 PCS and description of the third procedure Enter the details of the procedure Indicate whether pre-authorization obtained Enter pre-authorization number Enter reason for not obtaining pre-authorization number Indicate if hospitalization is due to injury Indicate cause of injury Indicate whether test conducted Indicate whether injury is medico legal Indicate whether police report was filed	Standard Format and Open text Open text Tick Yes or No As allotted by Liberty Health 360 Open text Tick Yes or No Tick the right option Tick Yes or No Tick Yes or No Tick Yes or No Tick Yes or No

UIN: LVGHLIP15002V021415

Indicate which supporting documents are submitted

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GUIDANCE FOR FILLING CLAIM FORM - PART B (To be filled in by the hospital)											
DATA ELEMENT	DESCRIPTION	FORMAT									
SECTION E - DETAILS IN CASE OF NON NETWORK HOSPITAL											
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 allocated by the Medical Council of India									
d) Hospital PAN	Enter the permanent account number	As allotted 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	SECTION F - DECLARATION BY THE HOSPITAL										
Read declaration carefully and mention date (in dd:m	m:yy format), place (open text) and sign and stamp										