LIBERTY
HOSPI-CASH
CONNECT POLICY

Liberty General Insurance

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

LIBERTY HOSPI-CASH CONNECT 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

DETAILS OF PRIMARY INSURED

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

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.'

DETAILS OF INSURED PERSON HOSPITALIZED

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

c) If Yes Company Name : Policy No :

Sum Insured (Rs.) :

d) Have you been hospitalized in the last 4 years since the inception of the contract? ☐ 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 :

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.'

DETAIL OF HOSPITALIZATION

a) Name of Hospital where Admitted :

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

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 m m y y Time : h h m m f) Date Of Discharge : d d m m y y Time : h h m m

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

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

DETAIL OF CLAIM

a) Details of Treatment Expenses Claimed

i. Daily Hospital Cash (DHC) Benefit : _____

ii. Daily Hospital Cash (DHC) - Only Accidents Benefit : _____

iii. Double Accident Benefit (DAB) : _____

iv. Double ICU Benefit (DIB) - Sickness : _____

v. Double ICU Benefit (DIB) - Accident : _____

vi. Double Critical Illness Benefit (DCI) - Listed Critical Illnesses : _____

vii. Day care Procedure Cash - Listed Procedures : _____

UIN: LVGHLIP15003V011415

Liberty General Insurance Ltd., Unit 1501&1502, 15th Floor, Tower 2, One International Center, Senapati Bapat Marg, Prabhadevi, Mumbai – 400013. Phone: +91 22 6700 1313, Fax: +91 22 6700 1606.

viii. Recovery Benefit : ______

ix. Convalescence Benefit : ______

x. Special care on Minor Surgeries : ______

xi. Special care on Major Surgeries : ______

Total : Rs. ______

Claim Documents Submitted - Check List

- ☐ Original Claim Form Duly Filled
- ☐ Attested copy of Hospital Main Bill with Break Up Bill
- ☐ Attested copy of Hospital Discharge Summary
- ☐ Others
- ☐ Copy of the Claim Intimation, if any
- ☐ Attested copy of Hospital Bill Payment Receipt
- ☐ Attested copy of Operation Theater Notes

DETAILS OF BILL ENCLOSED

Sl. No	Bill No	Date	Issued by	Towards	Amount (Rs.)
1.		d d m m y y			
2.		d d m m y y			
3.		d d m m y y			
4.		d d m m y y			
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		**Total**	

Please attach separate sheet for additional bills / receipt details

DETAILS PRIMARY INSURED'S ACCOUNT

a) Pan No. : ______ b) Account Number : ______

c) Bank Name and Branch : ______

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

e) 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 Liberty Health 360 / 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

UIN: LVGHLIP15003V011415

GUIDANCE FOR FILLING CLAIM FORM – PARTA (TOBE FILLEDIN BYTHE 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 social health insurance scheme	As allotted by the organization
c) Company Liberty Health 360 ID No.	Enter the Liberty Health 360 ID No.	License number as allotted by IRDA and printed in Liberty Health 360 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 Insurance?	Indicate whether currently covered by another Mediclaim /Health Insurance	Tick Yes or No
b) Date of Commencement of first Insurance without break	Enter the date of commencement of first insurance	Use dd-mm-yy format
c) Company Name Policy No. Sum Insured	Enter the full name of the insurance company Enter the policy number Enter the total sum insured as per the policy	Name of the organization in full As allotted by the insurance company In rupees
d) Have you been Hospitalized in the last 4 years Date Diagnosis	Indicate whether hospitalized in the last 4 years Enter the date of hospitalization Enter the diagnosis details	Tick Yes or No Use mm-yy format Open Text
e) Previously Covered by any other Mediclaim/ Health Insurance?	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 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
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 medico legal 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 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)
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.		

For documents submission -
You are requested to send the claim documents at below address:
Liberty Health 360 - Liberty General Insurance Limited: "The Capitol", 4th Floor, New D.P.Road, Near Ashoka Hotel, Vishal Nagar, Pimple Nilakh, Pune- 411027
Alternatively, claim documents can also be sent to your nearest branch.

LIBERTY HOSPI-CASH CONNECT POLICY

Liberty General Insurance

LIBERTY GENERAL'S HOSPI-CASH CONNECT POLICY 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

HOSPITAL DETAILS

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 :

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 : (ddmmyy) f) Date of Admission : (ddmmyy) g) Time of Admission : (hhmm)

h) Date of Discharge : (ddmmyy) i) Time of Discharge : (hhmm) j) Type of Admission : ☐ Emergency ☐ Planned ☐ Day Care ☐ Maternity

k) If Maternity : i. Date of Delivery : (ddmmyy) ii. Grade of status :

l) Status at time of discharge : ☐ Discharge to home ☐ Discharge to another hospital ☐ Deceased m) Total Claimed Amount : **Rs.**

DETAILS OF AILMENT DIAGNOSED

a) Ailment Diagnosed (Primary)	ICD 10 Codes	Codes Description
i) Primary Diagnosis :		
ii) Additional Diagnosis :		
iii) Co-morbidities :		
iv) Details of Procedure/s done :		

b)	ICD 10 Codes	Code & Description
i) Procedure 1 :		
ii) Procedure 2 :		
iii) Procedure 3 :		

c) Pre-authorization obtained : ☐ Yes ☐ No d) 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: _____

vii) Reported to police : ☐ Yes ☐ No vii) Note: For details of Claim Documents to be submitted, please refer checklist

DETAILS OF HOSPITAL

a) Address of Hospital :

City : State :

Pin Code : b) Phone No : c) Registration no with state code :

d) Hospital PAN e) Number of Inpatient beds : f) Facilities in the Hospital : i) OT : ☐ Yes ☐ No ii) ICU : ☐ Yes ☐ No

iii) Other :

DECLARATION BY THE HOSPITAL

(PLEASE READ VERY CAREFULLY)

We hereby declare that the 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.

Date : (ddmmyy)

Place :

Seal & Signature of the Hospital Authority

UIN: LVGHLIP15003V011415