Liberty General Insurance Ltd.
Unit 1501&1502, 15th Floor, Tower 2, One International Center,
Senapati Bapat Marg, Prabhadevi, Mumbai – 400013,
Phone: +91 226700 1313, Fax: +91 226700 1606, Toll Free : 1800 266 5844
IRDAI of India Reg. No.150, CIN: U66000MH2010PLC269656
Website Link: www.libertyinsurance.in

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

Secure Health 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)

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:

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

a) Name:

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

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e) Relationship of Primary Insured: Self/ Spouse/ Child/ Father/ Mother/ Other (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:

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

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 _____

m) Please specify if the hospitalization was arranged/referred through any of the following:
Digital healthcare platform (Name_____)
TPA/Insurance helpline / call centre (Name_____)
Agent / intermediary

Direct hospital approach
Others (Please specify_____)

SECTION E. DETAILS OF CLAIM

a Details of Treatment Expenses Claimed

1. Pre Hospitalization Expenses: Rs ……. 2. Hospitalization Expenses: Rs ..... 3. Post Hospitalization Expenses: Rs……..
4. Health Check Up cost: Rs……. 5. Ambulance Charges: Rs …… 6. Others (Code) Rs ..…

Total: Rs…….....

☐ Pre Hospitalization Period : _days ☐ Post Hospitalization Period : _days

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b Claim for Domiciliary Hospitalization : YES / NO
(If Yes provide details on annexure)

c Detail of Lump Sum cash benefit claimed

Hospital Daily Cash: 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	
				Pre Hospitalization Bills	
				Post Hospitalization	
Please attach separate sheet for additional bills / receipt details				Pharmacy Bills	
				Total	

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

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 rightto claim reimbursement shall be forfeited. I also consent & authorize TPA / insurance company to seek necessary medical information / documents from any hospital / Medical Practitioner whohas 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

"I/We confirm that:

This claim has not been / also been lodged with other insurer(s) (details to be provided)

The total claim amount across all insurers shall not exceed the actual admissible expenses incurred

Date: PLACE Signature of the Insured

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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 /	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	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 /	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
f) Occupation	Indicate occupation of patient	Tick the right option. If others, please
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
c) 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	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

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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
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	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.		

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	Male/ 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		…….	

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

Claim Document Submitted - Checklist

- ❑ Claim Form Duly signed
- ❑ Original Pre-Authorisation Request
- ❑ Copy of Pre-Authorisation Approval Letter
- ❑ Hospital Discharge Summary
- ❑ Operation Theater Notes
- ❑ Hospital Main Bills
- ❑ Hospital Break-up Bill
- ❑ Investigation reports
- ❑ Copy of Photo Id Card of Patient verified by the Hospital
- ❑ Original Death Summary from Hospital where applicable
- ❑ CT/MRI/USG/HPE investigation reports
- ❑ Doctor's reference slip for investigation
- ❑ ECG
- ❑ Pharmacy Bills
- ❑ MLC report & Policy FIR
- ❑ 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 the Hospital	
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 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.

SEAL & SIGNATURE OF THE HOSPITAL AUTHORITY **Date**

Place