care HEALTH INSURANCE — Health Claim Form

Part A

1. To be filled in by the Insured.
2. The issue of this Form shall not be taken as an admission of liability.
3. To be filled in block letters.

Claim Intimation No: CPR0411202301044

Section A - Details of Primary Insured

a) Policy No. : 12093406
b) SI. No./Certificate No. :
c) Company/TPA ID No. :
d) Name : JOSHI (Surname) ANIL (First Name) SHANTARAM (Middle Name)
e) Address : B-8, Building NO-23, Near-sahkar cinema, Tilak Nagar
City : Mumbai
State : Maharashtra
Pin Code : 400089
Phone Number : 9869474799
E-mail : anil.joshi004@gmail.com

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 : 09/02/2018 (DD/MM/YYYY)
c) If yes, Company Name :
Policy Number : Sum Insured (Rs.):
d) Have you ever been hospitalized in the last 4 years since inception of the contract? ☐ Yes ☑ No
Date: / / (DD/MM/YYYY)
Diagnosis:
e) Previously covered by any other Mediclaim/Health Insurance : ☐ Yes ☑ No
f) If yes, Company Name :

Section C - Details of Insured Person Hospitalised

Title : ☐ Mr. ☑ Ms.
a) Name : JOSHI (Surname) ANVI (First Name) ANIL (Middle Name)
b) Gender : ☐ M ☑ F c) Age : / (YY/MM) d) Date of Birth : 27/11/1990
e) Relationship with Primary Insured : ☐ Self ☑ Spouse ☐ Child ☐ Father ☐ Mother
☐ Others (Please Specify)
f) Occupation : ☐ Service ☐ Self Employed ☑ Homemaker ☐ Retired ☐ Student ☐ Others (Please Specify)
g) Address (if different from above) : B-8, Building NO-23, Near-Sahkar cinema, Tilak Nagar
City : Mumbai
State : Maharashtra
Pin Code : 400089
Phone Number : 9653483661
E-mail : anvianiljoshi@gmail.com

care HEALTH INSURANCE

Health Claim Form

Part B

1. To be filled in by the hospital.
2. The issue of this form is not to be taken as an admission of liability.
3. Please include the original [illegible] PART A.
4. To be filled in block letters.

Section A - Details of Hospital

a) Name of the Hospital : JEEVAN JYOT HOSPITAL

b) Hospital ID : 7614899940

c) Type of Hospital : ☐ Network ☑ Non-network (if non-network fill section E)

d) Name of the treating doctor : DR. RITU P. AGRAWAL (Surname) (First Name) (Middle Name)

e) Qualification : M.D. (OBS & GYN.), D.G.O.

f) Registration No. with State Code : Reg. No. 076275

OBSTETRICIAN, GYNAECOLOGIST & INFERITILITY SPECIALIST

g) Contact No. :

Section B - Details of the Patient Admitted

a) Name of the Patient : JOSHI (Surname) ANVI (First Name) ANIL (Middle Name)

b) IP Registration No. : JJ07/11/2023

c) Gender ☐ M ☑ F d) Age : ___ / ___ (YY/MM) e) Date of Birth : __ / __ / ____

f) Date of Admission : 04 / 11 / 2023 (DD/MM/YYYY) g) Time of Admission : 02 : 20 (HH:MM) PM

h) Date of Discharge : 07 / 11 / 2023 (DD/MM/YYYY) i) Time of Discharge : 03 : 20 (HH:MM) PM

j) Type of Admission : ☐ Emergency ☐ Planned ☐ Day Care ☐ Maternity

k) If Maternity

(i) Date of Delivery : __ / __ / ____ (DD/MM/YYYY) (ii) Gravida Status : ______

l) Status at the time of discharge : ☑ Discharge to home ☐ Discharge to another hospital ☐ Deceased

m) Total Claimed Amount :

Section C - Details of Ailment Diagnosed (Primary)

a) (i) Primary Diagnosis : ICD 10 Code : ____ Description : LEFT RUPTURED ECTOPIC PREGNANCY

(ii) Additional Diagnosis : ICD 10 Code : ____ Description : TUBAL AMPULLARY

(iii) Co-morbidities : ICD 10 Code : ____ Description : ______

(iv) Co-morbidities : ICD 10 Code : ____ Description : ______

b) (i) Procedure 1 : ICD 10 PCS ____ Description : ______

(ii) Procedure 2 : ICD 10 PCS : ____ Description : ______

(iii) Procedure 3 : ICD 10 PCS : ____ Description : ______

(iv) Details of Procedure : ______

c) Present ailment is a complication of PED : ☐ Yes ☐ No

If yes, specify details : ______

d) Pre-authorization obtained : ☐ Yes ☐ No

e) Pre-authorization no. :

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

(ii) If Injury due to Substance abuse/Alcohol consumption, Test conducted to establish this ☐ Yes ☐ No
(If yes, attach reports)

(iii) If Medico Legal : ☐ Yes ☐ No

(iv) Reported to Police : ☐ Yes ☐ No

(v) FIR No. :

(vi) If not reported to Police, give reason : _____

Section D - Claim Documents Submitted - Checklist

(i)	Duly signed Claim Form	☐	(ix)	Investigation Report	☐
(ii)	Original Pre-authorization request	☐	(x)	CT/MRI/ USG /HPE investigation reports	☐
(iii)	Copy of Pre-authorization approval letter	☐	(xi)	Doctor's reference slip for investigation	☐
(iv)	Copy of photo ID card of patient verified by hospital	☐	(xii)	ECG	☐
(v)	Hospital Discharge Summary	☐	(xiii)	Pharmacy Bills	☐
(vi)	Operation Theatre notes	☐	(xiv)	MLC report & Police FIR	☐
(vii)	Hospital Main Bill	☐	(xv)	Original death summary from hospital where applicable	☐
(viii)	Hospital Break-up Bill	☐	(xvi)	Any other, please specify_____	☐

Section E - Additional Details in case of Non-Network Hospital (Only fill in case of non-network hospital)

a) Address of the Hospital :

JEEVAN JYOT HOSPITAL
Managed by : Smt. Pramila Zumbersing Patil
Healthcare (OPC) Pvt. Ltd.
Opp. Ghatkopar Railway Stn., Ghatkopar (W), Mumbai
Reg. No. 761489940

City :

State : Pin Code :

b) Contact No. : -

c) Registration No. with State Code :

d) Hospital PAN :

e) No. of inpatient beds :

f) Facilities available in the hospital : (i) OT : ☐ Yes ☐ No (ii) ICU : ☐ Yes ☐ No

(iii) Others : _____

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 knowledge and belief. If we have made any false or untrue statement, suppression or concealment of any material facts, our right to claim under this claim shall be forfeited.

Date : 09/11/2023 (DD/MM/YYYY)

Signature & Seal of the Hospital

JEEVAN JYOT HOSPITAL
Managed by : Smt. Pramila Zumbersing Patil
Healthcare (OPC) Pvt. Ltd.
Opp. Ghatkopar Railway Stn., Ghatkopar (W), Mumbai
Reg. No. 761489940

Place : MUMBAI

PAYMENTS CHEQUE ARE ACKNOWLEDGED SUBJECT TO REALIZATION

Section D - Details of Hospitalisation

a) Name of Hospital where Admitted : JEVAN JYOT HOSPITAL

b) Room Category occupied : ☐ Day Care ☑ Single Occupancy ☐ Twin Sharing ☐ 3 or more beds per room

c) Hospitalisation due to : ☐ Injury ☑ Illness ☐ Maternity

d) Date of Injury/Date Disease first detected/Date of Delivery 02/11/2023

e) Date of Admission 04/11/2023 (DD/MM/YYYY) f) Time of Admission 02 20 PM (HH:MM)

g) Date of Discharge 07/11/2023 (DD/MM/YYYY) h) Time of Discharge : 03 20 PM (HH:MM)

i) If Injury, give cause : ☐ Self Inflicted ☐ Road Traffic Accident ☐ Substance Abuse/Alcohol Consumption

j) If Medico Legal : ☐ Yes ☐ No ii) Reported to Police : ☐ Yes ☐ No

iii) MLC Report & Police FIR attached : ☐ Yes ☐ No i) System of Medicine : _____

Section E - Details of Claim

a) Details of the treatment expenses claimed

(i) Pre-hospitalization Expenses : Rs. 2300

(ii) Hospitalization Expenses : Rs. 119204

(iii) Post-hospitalization Expenses : Rs.

(iv) Health Check-up cost : Rs.

(v) Ambulance Charges : Rs.

(vi) Others (code) ☐☐☐ : Rs.

Total : Rs.

(vii) Pre-hospitalization period : ☐☐☐ days

(viii) Post-hospitalization period : ☐☐☐ days

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.

(iii) Critical Illness Benefit : Rs.

(iv) Convalescence : Rs.

(v) Pre/Post hospitalization Lump sum benefit : Rs.

(vi) Others ☐☐☐ : Rs.

Total : Rs.

d) Claim Documents Submitted - Checklist

(i) Claim Form Duly signed : ☐

(ii) Copy of the claim intimation, if any : ☐

(iii) Hospital Main Bill : ☑

(iv) Hospital Break-up Bill : ☐

(v) Hospital Bill Payment Receipt : ☑

(vi) Hospital Discharge Summary : ☑

(vii) Pharmacy Bill : ☑

(viii) Operation Theatre Notes : ☑

(ix) ECG : ☐

(x) Doctor's request for investigation : ☐

(xi) Investigation Reports (Including CT/MRI/USG/HPE) : ☐

(xii) Doctor's Prescriptions : ☑

(xiii) Others ☐ _____

Section F - Details of Bills Enclosed

S No.	Bill No.	Date	Issued by	Towards	Amount (INR)
1	0178/22-23	7/11/23		Hospital Main Bill	100350/-
2	4257/80928	2/11/23		Pre-hospitalization Bills: 2 Nos	2300/-
3	375/376	9/11/2023		Post-hospitalization Bills: 2 Nos	1300/-
4	15232	4/11/2023		Pharmacy bills	1779.69/-
5	15241	5/11/2023		Pharmacy Bill	264.75/-
6	15247	6/11/2023		Pharmacy Bhill	619.59/-
7	15257	6/11/2023		Pharmacy Bill	1639.70/-
8	15250	6/11/2023		Pharmacy Bill	9000.04/-
9	01217	4/11/2023		Blood test	2750/-
10	769044	5/11/2023		Histology Medium	1500/-

In case of more details, please attach a separate sheet.

Section G - Details of Primary Insured's Bank Account

a) PAN : AMUPJ2062P

b) Account Number : 520101263528983

c) Bank Name & Branch : UNION BANK OF INDIA GHATKOPAR-WE

d) Cheque/DD payable details :

e) IFSC Code : UBIN0903680

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 with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent & authorize TPA/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.

Date : 12/11/2023 (DD/MM/YYYY)

Signature of the Insured :

Place : Mumbai