

PART C (Revised)

Hospital ID :

TO BE FILLED IN BLOCK LETTERS ONLY

Name of the hospital:

Hospital Location:

Hospital Email ID:

Hospital ID:

ROHINIID:

DETAILS OF CLAIMS ADMINISTRATOR

a) Name of Insurer: SBI General Insurance Company Limited

b) Toll Free no.: 1800 210 3366 / 1800 210 6366

TO BE FILLED BY INSURED/PATIENT

a) Name of the patient:

b) Gender: ☐ Male ☐ Female ☐ Third Gender

c) Contact no.:

d) Alternate Contact

e) Age: Years Months

f) Date of Birth:

g) Insurer ID Card No.:

h) Policy number / Name of corporate:

i) Employee ID:

j) Currently do you have any other medical claim / health insurance: ☐ Yes ☐ No

j1) Insurer name:

j2) Give details:

k) Do you have family physician, if yes: Name:

k1) contact No.:

l) Occupation of insured patient :

m) Address of insured patient :

TO BE FILLED BY THE TREATING DOCTOR / HOSPITAL

a) Name of the treating doctor :

b) contact No.:

c) Name of illness / disease with presenting complaints:

d) Relevant clinical findings:

e) Duration of the present ailment: Days

e.1) Date of first consultation:

e.2) Duration of the present ailment:

f) Provisional diagnosis:

f.1) ICD 10 Code:

g) Proposed line of treatment:

☐ Medical Management☐ Surgical Management☐ Intensive Care☐ Investigation☐ Non-allopathic treatment

h) If investigation and/or medical management, provide details:

h.1) Route of drug administration

☐ IV ☐ Oral ☐ Other

i) If surgical, name of surgery:

i.1) ICD 10 PCS Code:

j) If other treatments, provide details:

k) How did injury occur:

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l) In case of accident: i) Is it RTA: ☐ Yes ☐ No ii) Date of Injury:

D	D	M	M	Y	Y	Y	Y
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 iii) Reported to Policy: ☐ Yes ☐ No iv) FIR No.:

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v) Injury / disease caused due to substance abuse/alcohol consumption: Yes No vi) Test conducted to establish this, if yes attach report: Yes No

D	D	M	M	Y	Y	Y	Y
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m) In case of Maternity: G

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 P

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n) Expected date of delivery:

HOSPITAL DECLARATION

- a. We have no objection to any authorized TPA / Insurance Company official verifying documents pertaining to hospitalization.
- b. All valid original documents duly countersigned by the insured / patient as per the checklist below will be sent to TPA/ Insurance Company within 7 days of the patient's discharge.
- c. We agree that TPA / Insurance Company will not be Liable to make the payment in the event of any discrepancy between the facts in this form and discharge summary or other documents.
- d. The patient declaration has been signed by the patient or by his representative in our presence.
- e. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications.
- f. We will abide by the terms and conditions agreed in the MOU.
- g. We confirm that no additional amount would be collected from the insured in excess of Agreed Package Rates except costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility choosing separate line of treatment which is not envisaged/ considered in package).
- h. We confirm that no recoveries would be made from the deposit amount collected from the Insured except for costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility/ choosing separate line of treatment which is not envisaged/considered in package).
- i. In the event of unauthorized recovery of any additional amount from the Insured in excess of Agreed Package Rates, the authorized TPA / Insurance Company reserves the right to recover the same from us (the Network Provider) and,/or take necessary action, as provided under the MOU or applicable laws.

DOCUMENTS TO BE PROVIDED BY THE HOSPITAL IN SUPPORT OF THE CLAIM

1. Detailed Discharge Summary and all Bills from the hospital.
2. Cash Memos from the Hospitals / Chemists supported by proper prescription.
3. Receipts and Pathological Test Reports from Pathologists, Supported by note from the attending Medical Practitioner / Surgeon recommending such pathological Tests.
4. Surgeon's Certificate stating nature of Operation performed and Surgeon's Bill and Receipt.
5. Certificates from attending Medical Practitioner / Surgeon that the patient is fully cured.

Doctor's Signature:

Time:

H	H	M	M
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