

Su-Swastha Yojna

A Government of Sikkim Initiative

REIMBURSEMENT CLAIM FORM - PART A TO BE FILLED BY THE INSURED

The issue of this Form is not to be taken as an admission of liability

TO BE FILLED IN BLOCK LETTERS



DETAILS OF PRIMARY INSURED

a) Su-Swastha ID No.

b) Name Mr./Mrs./Ms. First Name* Middle Name Last Name*

c) Address

Line 1 Line 2

Line 3 City Village/City/Town

District State Pin Code

Contact No. Email Id

DETAILS OF INSURANCE HISTORY

a) Currently covered by any other Mediclaim/Health Insurance Yes No

b) If Yes, Company Name Policy No.

Sum Insured (Rs.)

c) Have you been Hospitalized in the last Four years since inception of the contract Yes No

Date of Hospitalization MM YY YY Diagnosis

d) Previously covered by any other Mediclaim/Health Insurance Yes No

e) If Yes, Company Name

DETAILS OF INSURED PERSON HOSPITALIZED

a) Name Mr./Mrs./Ms. First Name* Middle Name Last Name*

b) Gender Male Female Other c) Age YY MM MM d) Date of Birth DD MM YY YY YY

e) Relationship to Primary Insured Self Spouse Child Father Mother Other (Please Specify)

f) Occupation Service Self Employed Home Maker Student Retired Other (Please Specify)

g) Address (If different from above)

Line 1 Line 2

Line 3 City Village/City/Town

District State Pin Code

Contact No. Email Id

DETAILS OF HOSPITALIZATION

a) Name Of Hospital where admitted

b) Room category occupied Day Care Single Occupancy Twin Sharing 3 or more beds per room

c) Hospitalization due to Injury Illness Maternity d) Date of Injury/Disease first detected/Delivery DD MM YY YY YY

e) Date of Admission DD MM YY YY YY f) Time HH MM MM

g) Date of Discharge DD MM YY YY YY h) Time HH MM MM

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

ii) If Medico legal Yes No iii) Reported to Police Yes No

iii) MLC Report & Police FIR attached Yes No j) System of medicine

REIMBURSEMENT CLAIM FORM - PART B TO BE FILLED 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

CLAIM DOCUMENTS SUBMITTED - CHECKLIST

- | | |
|--|--|
| <input type="checkbox"/> Claim Form Duly Signed | <input type="checkbox"/> Investigation reports |
| <input type="checkbox"/> Original Pre-authorization request | <input type="checkbox"/> CT/MR/USG/HPE investigation reports |
| <input type="checkbox"/> Copy of the Pre-authorization approval letter | <input type="checkbox"/> Doctor's reference slip for investigation |
| <input type="checkbox"/> Copy of Photo ID Card of patient Verified by hospital | <input type="checkbox"/> ECG |
| <input type="checkbox"/> Hospital Discharge summary | <input type="checkbox"/> Pharmacy bills |
| <input type="checkbox"/> Operation Theatre Notes | <input type="checkbox"/> MLC reports & Police FIR |
| <input type="checkbox"/> Hospital main bill | <input type="checkbox"/> Original death summary from hospital where applicable |
| <input type="checkbox"/> Hospital break-up bill | <input type="checkbox"/> Any other, please specify |

ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)

a) Address of the Hospital

Line 1 Line 2

Line 3 City

District State Pin Code

b) Phone No. c) Registration No. with State Code

d) Hospital PAN No. e) No. of Patient Beds

f) Facilities available in the Hospital i) OT Yes No i) ICU Yes No

iii) Others

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 fact, our right to claim under this claim shall be forfeited.

Date

Place

Signature

Signature & Seal of the Hospital Authority