# Health Insurance
## Aditya Birla Health Insurance Co. Limited
(A subsidiary of Aditya Birla Capital Ltd.)

ADITYA BIRLA CAPITAL
PROTECTING INVESTING FINANCING ADVISING

## Activ Assure 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)

### A. DETAILS OF HOSPITAL

a. Name of the hospital:
b. Hospital ID:
c. Type of Hospital: ☐ Network ☐ Non-Network (if non network fill section E)
d. Name of the treating doctor:
e. Qualification:
f. Registration No. with State Code:
g. Phone No:

### B. DETAILS OF THE PATIENT ADMITTED

a. Name of the Patient:
b. IP Registration Number:
c. Gender: ☐ Male ☐ Female d. Age: Y Y Years M M Months
e. Date of Birth: D D M M Y Y Y Y f. Date of Admission: D D M M Y Y Y Y g. Time:
h. Date of Discharge: D D M M Y Y Y Y i. Time:
j. Type of Admission: ☐ Emergency ☐ Planned Day Care ☐ Maternity
k. If Maternity: i) Date of Delivery: D D M M Y Y Y Y ii) Gravida Status:
l. Status at time of discharge: ☐ Discharge to home ☐ Discharge to another hospital ☐ Deceased
m. Total claimed amount: Rs.

### C. DETAILS OF AILMENT DIAGNOSED (PRIMARY)

| a) | ICD Codes | Description | b) | ICD PCS | Description |
|---|---|---|---|---|---|
| i. Primary Diagnosis: | | | i. Procedure 1: | | |
| ii. Additional Diagnosis: | | | ii. Procedure 2: | | |
| iii. Co-morbidities: | | | iii. Procedure 3: | | |
| iv. Co-morbidities: | | | iv. Details of Procedure: | | |

a) Pre-authorization obtained: ☐ Yes ☐ No b) Pre-authorization Number:
c) If authorization by network hospital not obtained, give reason: _____

_____

d) 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.
iv. If not reported to police give reason: _____

_____

Activ Assure, Product UIN: ADIHLIP21250V032021.

## D. CLAIM DOCUMENTS SUBMITTED - CHECK LIST:

- ☐ a. Claim Form duly signed
- ☐ b. Original Pre-authorization request
- ☐ c. Copy of the Pre-authorization approval letter
- ☐ d. Copy of photo ID Card of patient verified by hospital
- ☐ e. Hospital Discharge summary
- ☐ f. Operation Theatre Notes
- ☐ g. Hospital main bill
- ☐ h. Hospital break-up bill
- ☐ i. Investigation reports
- ☐ j. CT/MR/USG/HPE investigation reports
- ☐ k. Doctor's reference slip for investigation
- ☐ l. ECG
- ☐ m. Pharmacy bills
- ☐ n. MLC reports & Police FIR
- ☐ o. Original death summary from hospital where applicable
- ☐ p. Any other PLEASE SPECIFY

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

a. Address of the Hospital:

City: State: Pin Code:

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

d. Hospital PAN: e. Number of Inpatient beds:

f. Facilities available in the hospital: OT: ☐ Yes ☐ No ICU: ☐ Yes ☐ No

g. Others:

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

Date: DD MM YYYY

Place:

Signature and Seal of the Hospital Authority:

Activ Assure, Product UIN: ADIHLIP21250V032021.

| GUIDANCE FOR FILLING CLAIM FORM - PART B (To be filled in by the hospital) | | |
|---|---|---|
| **DATA ELEMENT** | **DESCRIPTION** | **FORMAT** |
| **SECTION A - DETAILS OF HOSPITAL** | | |
| a) Name of Hospital | Enter the name of hospital | Name of hospital in full |
| b) Hospital ID | Enter ID number of hospital | As allocated by the TPA |
| c) Type of Hospital | Indicate whether In network or non network hospital | Tick the right option |
| d) Name of treating doctor | Enter the name of the treating doctor | Name of doctor in full |
| e) Qualification | Enter the qualification of the treating doctor | Abbreviations of educational qualifications |
| f) Registration No. with State Code | Enter the registration number of the doctor along with the state code | As allocated by the Medical Council of India |
| g) Phone No. | Enter the phone number of doctor | Include STD code with telephone number |
| **SECTION B - DETAILS OF THE PATIENT ADMITTED** | | |
| a) Name of Patient | Enter the name of hospital | Name of hospital in full |
| b) IP Registration Number | Enter insurance provider registration number | As allotted by the insurance provider |
| c) Gender | Indicate Gender of the patient | Tick Male or Female |
| d) Age | Enter age of the patient | Number of years and months |
| e) Date of Birth | Enter date of birth of the patient | Use dd-mm-yy format |
| f) Date of Admission | Enter date of admission | Use dd-mm-yy format |
| g) Time | Enter time of admission | Use hh:mm format |
| h) Date of Discharge | Enter date of discharge | Use dd-mm-yy format |
| i) Time | Enter time of discharge | Use hh:mm format |
| j) Type of Admission | Indicate type of admission of patient | Tick the right option |
| k) If Maternity | | |
| Date of Delivery | Enter Date of Delivery if maternity | Use dd-mm-yy format |
| Gravida Status | Enter Gravida status if maternity | Use standard format |
| l) Status at time of discharge | Indicate status of patient at time of discharge | Tick the right option |
| m) Total claimed amount | Indicate the total claimed amount | In rupees (Do not enter paise values) |
| **SECTION C - DETAILS OF AILMENT DIAGNOSED (PRIMARY)** | | |
| a) ICD 10 Code | | |
| Primary Diagnosis | Enter the ICD 10 Code and description of the primary diagnosis | Standard Format and Open text |
| Additional Diagnosis | Enter the ICD 10 Code and description of the additional diagnosis | Standard Format and Open text |
| Co-morbidities | Enter the ICD 10 Code and description of the co -morbidities | Standard Format and Open text |
| b) ICD 10 PCS | | |
| Procedure 1 | Enter the ICD 10 PCS and description of the first procedure | Standard Format and Open text |
| Procedure 2 | Enter the ICD 10 PCS and description of the second procedure | Standard Format and Open text |
| Procedure 3 | Enter the ICD 10 PCS and description of the third procedure | Standard Format and Open text |
| Details of Procedure | Enter the details of the procedure | Open text |
| c) Pre-authorization obtained | Indicate whether pre-authorization obtained | Tick Yes or No |
| d) Pre-authorization Number | Enter pre-authorization number | As allotted by TPA |
| e) If authorization by network hospital not obtained, give reason | Enter reason for not obtaining pre-authorization number | Open text |
| f) Hospitalization due to injury | Indicate if hospitalization is due to injury | Tick Yes or No |
| Cause | Indicate cause of injury | Tick the right option |
| If injury due to substance abuse/alcohol consumption, test conducted to establish this | Indicate whether test conducted | Tick Yes or No |
| 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 |

| | | |
|---|---|---|
| FIR No. | Enter first information report number | As issued by police authorities |
| If not reported to police, give reason | Enter reason for not reporting to police | Open Text |
| **SECTION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST** | | |
| Indicate which supporting documents are submitted | | |
| **SECTION E - DETAILS IN CASE OF NON NETWORK HOSPITAL** | | |
| a) Address | Enter the full postal address | Include Street, City and Pin Code |
| b) Phone No. | Enter the phone number of hospital | Include STD code with telephone number |
| c) Registration No. with State Code | Enter the registration number of the doctor along with the state code | As allocated by the Medical Council of India |
| d) Hospital PAN | Enter the permanent account number | As allocated by the Income Tax department |
| e) Number of Inpatient beds | Enter the number of inpatient beds | Digits |
| f) Facilities available in the hospital | Indicate facilities available in the hospital | Tick the right option. If others, please specify |
| **SECTION F - DECLARATION BY THE HOSPITAL** | | |
| Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign and stamp | | |