

ICICI Lombard Health Care Claim Form - Hospitalisation

(Issuance of this form is not to be taken as an admission of liability)



Overview Health Claim Form - Hospitalization							
	Part A	To be filled	Requirement				
A1	Type of Claim- To be filled by Insured		-				
A2	Details of the insured person-To be filled by Insured						
A3	Available in Policy Copy/ Employee details						
A4	Available in Policy Copy						
A5	Available in Discharge Summary	By insured/ insured	To track the policy and other details of the insured				
A6	Other policy coverages	relatives					
A7	Currently covered by any other mediclaim						
A8	Available in Hospital Bills/ Self Declaration						
A9	Available in Hospital Bills						
A10	Checklist						
A11	Reason of delay-To be filled by Insured						
Page end	Self declaration						
	Part B						
B1	Hospital Details						
B2	Doctor Details	To be filled by Hospital/	To track the hospital				
B3	Patient details	Treating doctor	details and the treatment				
B4	Treatment / Procedure Details		details related to the				
B5	Required only for Retail/ Individual Customers		patient admission				
Page end	Hospital declaration						
	Part C						
C1	EFT Details	Copy of cancelled cheque/Copy of passbook or bank statement with Payee/account holders name and IFSC code					
C-KYC No.	(Only for Retail/ Individual customers for all claims)						
Yes	Please provide, if Central KYC (C-KYC) no. available:	To be filled by Inqueed	As per IRDA, C-KYC is mandate				
		To be filled by Insured	for for all claims				
No	Please fill the C-KYC form						

Documents Submitted							
S.No.	Document	Yes	No	Type of document			
1.	Claim form duly filled	Y	N	Original			
2.	. Discharge Summary/ Daycare Summary Original						
3.	ICICI Lombard Health card	Y	N	Original			
4.	Final Hospital Bill	Y	N	Original			
5.	Payment Receipts	Y	N	Original			
6.	Investigation Reports	Y	N	Original			
7.	Pharmacy Bills	Y	N	Original			
8.	Implant Sticker/ Invoice	Y	N	Original			
9.	EFT (Copy of cancelled cheque/Copy of passbook or bank statement with	Y	N	Photocopy			
	Payee/account holders name and IFSC code)						
10	Consultation Paper	Y	N	Photocopy			
11.	Age Proof	Y	N	Photocopy			
12.	Indoor Case Paper	Y	N	Photocopy			
13.	Doctor Prescriptions	Y	NJ	Photocopy			
14.	C-KYC Form (Only for Retail/ Individual customers for all claims)	Y	N	Original			
15.	PAN Card Copy of the Proposer/ Employee (Mandatory if claim amount is greater than 1 lakh)	Y		Photocopy			



IRDA Registration No. 115



ICICI Lombard Health Care Claim Form - Hospitalisation

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Do You Know

* Non-submission of original bills and receipts is the main reason for delay in claim settlements. Please provide the originals & mandatory documents

★ To receive update on your claim status, provide your mobile no. & E-mail ID

 \star You can track your claim by downloading ILTake Care App or by visiting are website at www.icicilombard.com \Rightarrow Claims \Rightarrow Services \Rightarrow Track your claims

	filled by Insured)
TO BE FILLED IN CAPITAL LETTERS ONLY A1. Type of Claim: Main Hospitalisation Expenses Pre & Post Hospitalisation	spitalisation Expenses Cashless Obtained: Yes No
A2. Details of the Insured person in respect of whom claim is made: (p	
Name of the Patient:	
Card No./ UHID of the Patient:	
Gender: Male Female Transgender Date of Birth:	D / M M / Y Y Y Y Completed age: Years Months
Occupation: Service Self Employed Homemaker Studen	
Are you previously covered by any other Mediclaim/ Health Insurance	
Current residential address:	
	City:
State:	J
Mobile noLandline no	
E-mail:	
ABHA Number	
ABHA is a 14 digit number that will uniquely identify you as a participa	ant in India's digital healthcare ecosystem.
A3. For Group/ Corporate Policy	For Individual/Retail Policy (*Mandatory)
Member ID No./ Employee ID (Client ID):	*Claim Intimation Service Request no.:
	Is this a renewal policy: Yes No
Group/ Company name:	If Yes, kindly mention your previous policy no.:
A4. Name of the Proposer/Employee:	
Relationship with Proposer*:	(*Policy Holder. For Retail policy, Proposer name required. For Corporate policy, provide Employee name)
Current Policy No.:	
A5. Diagnosis as per discharge summary:	
Name of hospital where admitted:	
•	January 12 augustus hada nagusaana 104hays
	naring 3 or more beds per room Others
	M Date of Discharge: DD/MM/YYYY Time: HH:MM
Date of injury sustained or disease/ Illness first detected:	
If Injury, give cause: Self inflicted Road traffic accident Substa	•
If Medico legal: Yes No Reported to police: Yes No ML	C Report & Police FIR attached: Yes No (If yes, attach report)
System of Medicine: Allopathy AYUSH	
Is there any another claim in any of our policies towards the above incide	
A6. Are you covered under any Topup/Additional policy: Yes No	
A7. Currently covered by any other Mediclaim/ Health Insurance: $oxdot$	
Have you been hospitalized in the last 4 years since inception of contract	
Have you lodged any claim against this particular admission date/ attach	ed bills with any other Insurance company: If yes, attach settlement letter,
	Sum Insured: ₹
A8. Details of Claim	
a) Details of the treatment expenses claimedi. Pre-hospitalization expenses: ₹	ii. Hospitalization expenses: ₹
i. Pre-hospitalization expenses: ₹	iv. Health-check up cost: ₹
v. Ambulance charges: ₹	vi. Others : ₹
v. Pilibululios situlgos.	Total: ₹
vii. Pre-hospitalization period Days	viii. Post-hospitalization period:
b) Claim for	22
i. Domiciliary Hospitalization: Yes No ii. Day care: Yes	No iii. Extended care/ Inpatient rehabilitation: Yes No

c) Details of Lump Sum/ Cash Benefit claimed:																	
i. Hospital daily cash: ₹		J		ii.	Ma	ater	nity	:			₹						
iii. Critical illness/PA/Donor Expenses: ₹			i	V.	Со	nva	les	cence	e:		₹			_]_			
v. Pre/ Post hospitalization lump sum benefit: ₹		J]] \	۷i.	Oth	hers	s:				₹		J	J			
											,						
A9. Details of the amount claimed																	
Bill heads (as applicable)		Bi	II number			Bill	dat	e		Bills a	ttached			An	oun	t	
Room rent				D	D	M	M	Υ	ΥJ	Υ	N	₹]			
Doctors consultation/ Visit charges				D		M	M	Y	Υ	Y	N	₹	<u> </u>	ĺ			
Investigation charges (Includes Radiology and Pathology reports	s)			D	D	M	M	J Y	Υ	_Y_	N	₹]		J	
Surgeon and Asst. surgeon charges				D	D	M	J	J Y J	ΥJ	Υ	N.J	₹]			
Anesthetist charges & Operation theatre charges				D	D	М	J M	Υ	ΥJ	Y	N	₹	J	J			
Equipment charges/ Procedure charges				D		M	J M	Y]	ΥJ	Υ	N.J	₹]			
Cost of implant (If any)				D	D	J M	J M) Y]	ΥJ	Y	N.)	₹	<u> </u>	J		<u> </u>	<u> </u>
Medicine charges & Pharmacy charges				D	D	M	M		γ]		N	₹					
Taxes/Surcharges/Service				D	D	M	M	J Y	ΥJ	Y	N	₹	<u> </u>				
Discount provided by Hospital/Miscellaneous charges				D	D	M	<u> </u>	J Y J	Υ	_Y	N	₹]			
Other TPA/Insurance settled amount				D		<u> </u>	<u> </u>	J Y	Υ	_Y	N	₹		<u> </u>			
Pre hospitalization bills & Post hospitalization bills (If any)				D		<u>M</u>	<u> </u>		Υ	_Y	N	₹		<u> </u>		<u> </u>]
Total claimed amount (In ₹) (Total claimed amount should be equal t	o the ar	mount in	attached bill doc	cumer	nts)							₹	_]_	J]
details along with Copy of cancelled cheque/Copy of p A10. In support of the above claim, I enclose following docu															C CO	de.)	
Type of Document(s) - *Mandatory	Yes	No	Type of Do	cun	nen	ıt(s) - /	ls A	ppli	cable)			1	Yes	N	lo
Claim form duly filled and signed*	У	N	9. ICICI Lon	nbaro	d GI	C A	utho	risat	ion L	etter					У		N
2. Cancelled cheque (for bank account details)	У	N	10. Implant				iovr	ce (if	any) with	implant s	ticker			Υ		
3. Discharge summary*	Y	N	11. Indoor C											\perp	У		
4. Hospital bills, Final/ Main hospital bill and other bills (if any)*	Y	N	12. Prescript											\perp	<u>Y</u>		
5. Hospital payment receipt & other receipts supporting bills*	<u> </u>	N	13. C-KYC FO			ly fo	r Ret	ail/Ind	ividu	al custo	mers for al	l claims)		\bot	<u> </u>		
6. Investigation reports* (Including ECG/ CT/ MRI/ USG/ HPE)	Y	N	14. Others (detai	ls)										<u>Y</u>		
	7. Medicine/ Pharmacy bills with doctors prescription*																
8. Age proof (Driving License/ PAN card/ Passport)	Ľ	N															
Kindly do not furnish Aadhaar card and send any other document for id pr																	
Please attach all the documents as per above serial number. Films like				Scan f	ilm,	etc	. are	not re	equire	ed. Pro	vide report	s only					
A11.Please provide the reason for delay in submitting the documents (Post 30 days from Date of Discharge) Provide Details (If Applicable) Declaration by the Insured:																	
I hereby declare that the information furnished in this claim for untrue statement, suppression or concealment of any mat reimbursement shall be forfeited. I also consent and authorize hospital/ Medical Practitioner who has attended on the pers receipts for the purpose of this claim and that I will not be ma give my consent to the Company to verify my identity the undertaking KYC. Date: DD/MM/YYYYY Place:	erial f e TPA/ son ag sking a rough	fact wi insura gainst v any sup Centra	th respect to nce company vhom this cla plementary o al KYC Regis	y, to aim i claim try o	esti see is m n ex or U	ions ek n nad kcel JID/	ece e. I ot th	ked ssar here ie pro r thr	in ro y mo by o e/ po oug	elation edical declar ost-ho h any	n to this informat e that I h spitaliza	claim, tion/ do nave ind tion cla	my clude aim, for t	righ nent ed a if an the p	nt to s fro all the ny. I h	clai m ar bill e bereb	m ny s/ oy
क्लेम फॉर्म हिन्दी के लिए कु																	
Claim documents to be dispatched to: ICICI Lombard Healthcare											rabad, Tela	angana,	Pinc	ode	- 50	0016	
In case the policy is serviced by exte								•	•	,							

Part - B (To be filled by Treating Doctor/ Hospital only)						
B1. Details of the Hospital/ Nursing homein which treatment was taken						
Name of the Hospital/ Nursing home:						
Address:						
City: State:						
Pincode: Mobile no.: Mobile no.:						
ROHINI ID*: Type of Hospital: Network Non Network If Non Network, provide below details						
Registration No. with State Code: PAN: Number of Inpatient beds: PAN: Number of Inpatient beds: PAN: PAN: PAN: PAN: PAN: PAN: PAN: PAN						
Facilities available in the hospital: OT: Y N ICU: Y N						
B2. *Details of the attending Medical Practitioner/ Doctor/ Treating Physician or Surgeon						
Name:						
Qualification: Registration no:						
Telephone no.: Mobile no.:						
B3. Details of the patient admitted						
Name of the patient:						
IP Registration no.: Gender: M F T Age:Years Months Date of Birth: D D M M Y Y Y						
Date of Admission: DD/MM/YYYY Time: HH:MM Date of Discharge: DD/MM/YYYYY Time: HH:MM						
Type of Admission: Emergency Planned Day Care Maternity						
Type of Treatment: Surgical Procedure Multiple Surgical Procedure Medical Treatment						
If Maternity, Date of Delivery: DD/MM/YYYY Gravida Status: G P A L						
Premature Baby: Yes No						
Status at time of discharge: Discharge to home Discharge to another hospital Deceased						
Total claimed amount: ₹						
B4. Details of the procedure						
Pre-authorization obtained: Yes No If yes, Pre-authorization No.:						
If authorization by network hospital not obtained, give reason:						
Date of injury sustained or disease/illness first detected: DD/MM/YYYYY						
If Injury, give cause: Self inflicted Road traffic accident Substance abuse/Alcohol consumption Others						
If Medico legal: Yes No Reported to police: Yes No MLC Report & Police FIR attached: Yes No (If yes, attach report)						
FIR no If not reported to Police, give reason:						
If injury due to substance abuse/alcohol consumption, test conducted to establish this: Yes No (If yes, attach report)						
B5. This section is mandatory only if your health policy is not provided by your employer						
A) Diagnosis (ICD 10 Code primary & additional dignosis)						
i) Primary diagnosis (with ICD 10 code)						
ii) Additional diagnosis (with ICD 10 code)						
iii) Procedure diagnosis (with ICD 10 PCS code)						
B) Nature of surgery/ treatment given for present ailment						
C) Date of first consultation (Prior to hospitalization)						
D) Presenting complaints of the patient during admission						
E) Past medical history of the patient along with duration of illness (If yes, attach first & all past consultation paper)						
F) Was the patient under influence of alcohol during admission						
G) Whether the present treatment ailment is a complication of pre-existing disease?						
i) If yes, please specify the disease (or) complication of any previous surgery done?						
ii) If yes, please specify the details						
H) Whether the disease/ disorder is congenital in nature?						
I) Number of in-patient beds in the hospital (including ICU)						
Declaration by the hospital*						
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

Registration No. of Hospital

(Rubber stamp of the hospital)



Part - C - NEFT Form (For Direct Electronic Fund Transfer)

Mandatory: All claim settlements should be made through NEFT(as per regulatory norms) Please provide your bank account details along with Copy of cancelled cheque/Copy of passbook or bank statement with Payee/account holders name and IFSC code.)

C1. Patient's Name:
C2. PAN No. of the Proposer (Mandatory if claim amount is greater than 1 lakh)
C3. Card No./ UHID No.:
C4. Claim Number (if allotted):
C5. Mobile/ Contact No.:
C6. Email:
C7. As per IRDA Circular No.: IRDA/F&A/CIR/GLD/056/02/2014, Proposer's/ Policy holder's bank account details are mandatory to process the claim through EFT.
Please provide below documents of Proposer/ Policy holder-
Please provide a self-attested copy of a valid Identity proof of the Proposer/Policy holder (provide any of the mentioned documents in Proof of Identity under Part-D) Cancelled cheque copy/ Bank attested copy of Passbook with IFSC code
C8. Please provide the below details (all fields are compulsory)
Proposer (Policy holder)/ Employee name*(as per bank records):
Proposer/ Policy holder Bank accou
Name of the bank:
Branch name:
Address of the bank:
IFSC code no. of the bank: (should be same as per the provided cheque leaflet)
*Proposer/ Policy holder is the person who has paid premium for the policy

For Retail policy, Name & Account details of Proposer required. For Corporate policy, Employee Name & Account details required.

Terms and Conditions for Payments through RTGS/NEFT

- The details provided by the Proposers/policy holder in the Mandate Form shall be considered as final and ICICI Lombard General Insurance Company Ltd. shall not be responsible for cross verification of any of the details
- The RTGS/NEFT facility shall be effective for the respective Proposer(s)/policy holder within 15 days of the receipt of the Mandate Form by ICICI Lombard General Insurance Company Ltd. and/or within such period as may be reasonably required by ICICI Lombard General Insurance Company Ltd. to activate the RTGS/NEFT facility.
- The Proposer/ policy holder agrees that under the RTGS/NEFT facility, there may be a risk of non-payment in the Proposer/ policy holder Accounts No. on the day of the credit of payments due to change in the applicable regulations pertaining to RTGS/NEFT facility or due to any other reasons without any fault/ inaction/ failure on part of ICICI Lombard General Insurance Company or any factor beyond the control of ICICI Lombard General
- The Proposer/ policy holder agrees to indemnify, without delay or demur, ICICI Lombard General Insurance Company Ltd. and its agents and keep ICICI Lombard General Insurance Company Ltd. and its agent indemnified harmless at all times from and against any and all claims, damages, losses, costs, and expenses (including attorney's fees) which ICICI Lombard General Insurance Company Ltd. may suffer or incur, directly or indirectly, arising from or in connection with, amongst other things, either of the aforesaid reasons stated in above clauses.
- ICICI Lombard General Insurance Company Ltd. May sub-contract and employ agents to carry out any of its obligations under the RTGS/ NEFT facility. The Proposer/ policy holder may discontinue or terminate the use of RTGS/ NEFT facility by giving a minimum of 15 days prior written notice to ICICI Lombard General Insurance Company Ltd. The notice of, such termination should be given to ICICI Lombard only at its corporate address and be addressed at ICICI Lombard GIC Ltd., ICICI Lombard House (Old Tata Press Building), 414, Veer Savarkar Marg, Near Siddhi Vinavak Temple, Prabhadevi, Mumbai - 400025.
- A confirmation of the receipt of termination notice given by the Proposer/policy holder will be acknowledged through a confirmation letter by ICICI Lombard General Insurance Company Ltd. In no case can the Proposer/ policy holder construe his termination notice as effective unless a confirmation has been provided by ICICI Lombard to the Proposer/ policy holder stating the date of receipt of such communication by the Proposer/ policy
- The Proposer/ policy holder agrees that transaction(s) through RTGS/ NEFT facility may attract inward RTGS/ NEFT charges, which if levied by the Proposer's/ policy holder's bank, shall be borne by the Proposer/ policy
- ICICI Lombard has the absolute discretion to amend or supplement any Terms and Condition stated herein at any time and will endeavor to give prior notice of ten days for such changes wherever feasible for the Terms and Conditions to be applicable. By using the new services, or at the completion of such period, whichever is earlier, the Proposer/policy holder shall be deemed to have accepted the changed Terms and Conditions.
- Submission of documents or bank details or any other information does not in any way, shape or form, imply or express or suggest admission of liability by the company.
- Notices under these Terms and Conditions may be given in writing by delivering them by hand or e-mail or on ICICI Lombard General Insurance Company Ltd. website www.icicilombard.com or by sending them by post to the last address of the Proposer/policy holder.
- These Terms and Conditions will be governed by the laws of India and any legal action or proceedings arising out of these Terms and Conditions shall be initiated in the courts or tribunals at Mumbai in India.
- I/We further undertake to refund any excess amount whether demanded by ICICI Lombard General Insurance Company Ltd. or not, which has been credited in excess to my account at any time due to any reason within 7 days of such receipt of such communication from ICICI Lombard of such excess credit or such information of excess credit coming to the knowledge of the Proposer/policy holder through any other source.
- I/We agree that my/our claim payment will be credited from the date ICICI Lombard General Insurance Company Ltd. gets confirmation from its bankers, This facility will continue unless it is revoked by any party and any issuance of relevant credit instruction from ICICI Lombard General Insurance Company Ltd. to its bankers will be valid till such instruction is complete irrespective of the fact that the notice period has expired provided such a credit request has been made by ICICI Lombard General Insurance Company Ltd. before the expiry of the notice period of the Proposer/ policy holder.

	Know Your Customer (KYC)
With reference to IRDAI holders for all claims.	Circular No. IRDAI/SDD/MISC/CIR/135/07/2016, KYC details are required for Individual/ Retail policy
To be filled by Proposer:	KYC Number (Mandatory for KYC update request) If KYC Number is not available, please fill this Central-KYC (C-KYC) form
1. PERSONAL DETAIL	.s
☐ Name* (Same as ID proof) Maiden Name (If any*) Father / Spouse Name* Mother Name* Date of Birth* Gender*	Prefix First Name Middle Name Last Name
	Signature / Thumb Impression
2. PROOF OF IDENTIT	TY (PoI)* (Please refer instruction C at the end)
	e following Proof of Identity[Pol] needs to be submitted)
A- Passport Number	Passport Expiry Date D D - M M - Y Y Y Y
□ B- Voter ID Card□ C- PAN Card	
□ C- PAN Card□ D- Driving Licence	
☐ E- UID (Aadhaar^)	Driving Licence Expiry Date DDDDDDDDDDDDDDDDDDDDDDDDDDDDDDDDDD
☐ F- NREGA Job Card	
Z- Others (any documer	Account - Document Type code Identification Number
☐ 3. PROOF OF ADDRE	ESS (PoA)*
CURRENT / PERMANENT / O	VERSEAS ADDRESS DETAILS (Please see instruction D at the end)
(Certified copy of <u>any one</u> of the	following Proof of Address [PoA] needs to be submitted)
Address Type*	sidential / Business Residential Business Registered Office Unspecified
□Vot	ssport
Address	
Line 1*	
Line 2	City / Town / Village*
District*	Pin / Post Code* State / U.T Code* ISO 3166 Country Code*
^ Mask first 8 digits of your aadha	ar number in claim form and claim documents submitted.



Account Holder's Signature