

## Overview Health Claim Form - Hospitalization

Part A		To be filled	Requirement
A1	Type of Claim- To be filled by Insured	By insured/ insured relatives	To track the policy and other details of the 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		
A6	Other policy coverages		
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	To be filled by Hospital/ Treating doctor	To track the hospital details and the treatment details related to the patient admission
B2	Doctor Details		
B3	Patient details		
B4	Treatment / Procedure Details		
B5	Required only for Retail/ Individual Customers		
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	
<b>C-KYC No.</b>	<b>(Only for Retail/ Individual customers for all claims)</b>		
Yes	Please provide, if Central KYC (C-KYC) no. available:  <input type="text"/>	To be filled by Insured	As per IRDA, C-KYC is mandate for for all claims
No	Please fill the C-KYC form		

## Documents Submitted

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





**Part - B (To be filled by Treating Doctor/ Hospital only)**

**B1. Details of the Hospital/ Nursing home in which treatment was taken**

Name of the Hospital/ Nursing home: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_  
 Pincode: \_\_\_\_\_ Telephone 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: \_\_\_\_\_  
 Facilities available in the hospital: OT:   ICU:

**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:      
 Date of Admission:  /  /  Time:  :  :  Date of Discharge:  /  /  Time:  :  :   
 Type of Admission: Emergency  Planned  Day Care  Maternity   
 Type of Treatment: Surgical Procedure  Multiple Surgical Procedure  Medical Treatment   
 If Maternity, Date of Delivery:  /  /  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:  /  /   
 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 diagnosis)	
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.**

Registration No. of Hospital \_\_\_\_\_  
 (Rubber stamp of the hospital) Date:  /  /   
 As per the policy Terms and Conditions, the Company reserves its right to have the Insured examined by a doctor appointed by it for verification of diagnosis. \_\_\_\_\_  
 Doctor's Seal and Signature

**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:** \_\_\_\_\_  
(in respect of whom claim is made):

**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 account: \_\_\_\_\_
- 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**

1. 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 provided therein.
2. 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.
3. 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 Insurance Company Limited.
4. 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.
5. 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 Vinayak Temple, Prabhadevi, Mumbai - 400025.
6. 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 holder.
7. 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 holder only.
8. 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.
9. 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.
10. 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](http://www.icicilombard.com) or by sending them by post to the last address of the Proposer/ policy holder.
11. 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.
12. 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.
13. 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 Circular No. IRDAI/SDD/MISC/CIR/135/07/2016, KYC details are required for Individual/ Retail policy holders for all claims.

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 DETAILS

<input type="checkbox"/> Name* (Same as ID proof)	Prefix	First Name	Middle Name	Last Name
<input type="checkbox"/> Maiden Name (If any*)				
<input type="checkbox"/> Father / Spouse Name*				
<input type="checkbox"/> Mother Name*				
Date of Birth*	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Gender*	<input type="checkbox"/> M- Male <input type="checkbox"/> F- Female <input type="checkbox"/> Transgender			

PHOTO

Signature / Thumb Impression

### 2. PROOF OF IDENTITY (PoI)\* (Please refer instruction C at the end)

(Certified copy of any one of the following Proof of Identity [PoI] needs to be submitted)

<input type="checkbox"/> A- Passport Number <input type="text"/>	Passport Expiry Date <input type="text"/>
<input type="checkbox"/> B- Voter ID Card <input type="text"/>	
<input type="checkbox"/> C- PAN Card <input type="text"/>	
<input type="checkbox"/> D- Driving Licence <input type="text"/>	Driving Licence Expiry Date <input type="text"/>
<input type="checkbox"/> E- UID (Aadhaar^)	
<input type="checkbox"/> F- NREGA Job Card <input type="text"/>	
<input type="checkbox"/> Z- Others (any document notified by the central government) <input type="text"/>	Identification Number <input type="text"/>
<input type="checkbox"/> S- Simplified Measures Account - Document Type code <input type="text"/>	Identification Number <input type="text"/>

### 3. PROOF OF ADDRESS (PoA)\*

CURRENT / PERMANENT / OVERSEAS ADDRESS DETAILS (Please see instruction D at the end)

(Certified copy of any one of the following Proof of Address [PoA] needs to be submitted)

Address Type*	<input type="checkbox"/> Residential / Business	<input type="checkbox"/> Residential	<input type="checkbox"/> Business	<input type="checkbox"/> Registered Office	<input type="checkbox"/> Unspecified
Proof of Address*	<input type="checkbox"/> Passport	<input type="checkbox"/> Driving Licence	<input type="checkbox"/> UID (Aadhaar^)		
	<input type="checkbox"/> Voter Identity Card	<input type="checkbox"/> NREGA Job Card	<input type="checkbox"/> Others <input type="text"/>		
	<input type="checkbox"/> Simplified Measures Account - Document Type code <input type="text"/>		<input type="text"/>		

Address

Line 1\*

Line 2

Line 3

District\*  Pin / Post Code\*  State / U.T Code\*  City / Town / Village\*  ISO 3166 Country Code\*

^ Mask first 8 digits of your aadhaar number in claim form and claim documents submitted.

\_\_\_\_\_  
Account Holder's Signature



**Mailing Address:** ICICI Lombard Healthcare, Varun Tower II, 1st, 4th, 5th & 6th Floor, Begumpet, Hyderabad, Telangana, Pincode – 500016.

**Registered Office Address:** ICICI Lombard House, 414, Veer Savarkar Marg, Near Siddhi Vinayak Temple, Prabhadevi, Mumbai 400 025.

**Visit us at:** www.icicilombard.com. • **E-Mail us at:** ihealthcare@icicilombard.com. • **Toll Free Number:** 1800 2666.

• **Toll Free Fax Number:** 1800 209 8880 • **IRDA Registration No.** 115