Bajaj Allianz General Insurance Company Limited.
Regd. & Head Office : GE Plaza, Airport Road, Yerawada, Pune 411 006
Email id: customercare@bajajallianz.co.in, **Toll free no.** 1800-209-5858, 020-30305858

CLAIM FORM- PART B

TO BE FILLED IN BY THE HOSPITAL
The issue of this form is not to be taken as admission of liability
Please include the original preauthorization request form in lieu of PART-A

(To be filled in block letters)

SECTION 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 treating doctor: _____

e) Qualification: _____ f) Registration No with State Code _____ g) Phone No: _____

SECTION B

DETAILS OF THE PATIENT ADMITTED

a) Name of the patient : _____

b) IP registration Number : _____ c) Gender: Male ☐ Female ☐ d) Age : Years ☐☐ Months: ☐☐ e) Date of birth: D D M M Y Y

f) Date of admission: D D M M Y Y g) Time : H H M M h) Date of discharge : D D M M Y Y i) Time: H H M M

j) Type of Admission : Emergency ☐ Planned ☐ Day Care ☐ Maternity ☐ k) If Maternity i) Date of delivery D D M M Y Y ii)Gravida Status: ☐☐

l) Status at time of discharge: Discharge to home ☐ Discharge to another hospital ☐ Deceased: ☐ m) Total claimed Amount: ☐☐☐☐☐☐

SECTION C

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a)	ICD 10 Codes	Description	b)	ICD 10 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:		

d) Pre-Authorization Obtained: Yes ☐ No ☐ e) Pre-Authorization Number: ☐☐☐☐☐☐☐☐☐☐

f) If authorization by network hospital no obtained, give reason: _____

g) 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)Medico Legal: Yes ☐ No ☐

iv)Reported to Police: Yes ☐ No ☐ v) FIR no: _____ vi) if not reported to police give reason: _____

SECTION D

CLAIM DOCUMENTS -CHECK LIST

- ☐ Claim form duly signed
- ☐ Original Pre-Authorization request
- ☐ Copy of Pre-Authorization letter
- ☐ Copy of photo ID card of patient verified by hospital
- ☐ Hospital discharge summary
- ☐ Operation theatre notes
- ☐ Hospital main bill
- ☐ Hospital break up bill
- ☐ Ingestion reports
- ☐ CT/MR/USG/HPE investigation report
- ☐ Doctor's reference slip for investigation
- ☐ ECG
- ☐ Pharmacy bills
- ☐ MLC report & Police FIR
- ☐ Original death summary from hospital where applicable
- ☐ Any other, please specify

SECTION E

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

a) Address of hospital _____

City: _____ State: _____ Pin Code: _____ Phone No: _____ c) Registration no with State Code: _____

d) Hospital PAN: _____ e) Number of Inpatient beds: ☐☐☐ Facilities available in hospital: i) OT: Yes ☐ No ☐ ii) ICU: Yes ☐ No ☐

iii) Others: _____

SECTION F

DECLARATION BY THE HOSPITAL: (PLEASE READ VERY CAREFULLY)

We hereby declare that the information furnished in the Claim Form is true and correct to the best of our knowledge and belief. If we have made any false and untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited.

Date : D D M M Y Y

Place : _____

Signature and Seal of the Hospital Authority