Liberty General Insurance Limited
Unit 1501 & 1502, 15th Floor, Tower 2, One International Center,
Senapati Bapat Marg, Prabhadevi, Mumbai - 400 013.
Phone: +91 22 6700 1313 Fax: +91 22 6700 1606
Email: care@libertyinsurance.in
IRDA of India registration number: 150 ● CIN: U66000MH2010PLC209656

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(Standard Claim Form As prescribed by IRDA for Health Products)

HEALTH CONNECT SUPRA POLICY
CLAIM FORM - PART A

TO BE FILLED IN BY THE INSURED PERSON (To be filled in Block Letters)

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

SECTION A - DETAILS OF PRIMARY INSURED

a) Policy Number : b) SL No. / Certificate No./ Claim Number (If any) :

c) Company / TAP ID No. :

d) Name :

e) Address :

i) City : j) State :

k) Pin Code : l) Phone No :

m) Email ID :

SECTION B : DETAILS OF INSURANCE HISTORY

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

b) Date of commencement of first Insurance without break : d d m m y y

c) If Yes, Company Name :

Policy No. : Sum Insured :

d) Have you been hospitalized in the last four years since the inception of the contract? ☐ Yes ☐ No Date : d d m m y y

Diagnosis :

e) Previously covered by any other Mediclaim / Health Insurance : ☐ Yes ☐ No

f) If Yes, Company name :

SECTION C : DETAILS OF INSURED PERSON HOSPITALIZED

a) Name :

b) Gender : ☐ Male ☐ Female c) Age : Year y y Months m m d) Date of Brith d d y y m m

e) Relationship of Primary Insured : ☐ Self ☐ Spouse ☐ Child ☐ Father ☐ Mother ☐ Other (Please specify) _____

f) Occupation : ☐ Service ☐ Self Employed ☐ Homemaker ☐ Student ☐ Retired ☐ Other (Please specify) _____

g) Address (If different from above) :

City : State :

Pin Code : Phone No :

Email ID :

SECTION D : DETAILS OF HOSPITALIZATION

a) Name of the Hospital where admitted :

b) Room Category Occupied : ☐ Day Care ☐ Single Occupancy ☐ Twin Sharing ☐ 3 or more

c) Hospitalization due to : ☐ Illness ☐ Injury d) Date of Injury / Disease First Detected / Date of Delivery: d d y y m m

e) Date of Admission : d d y y m m Time : h h m m f) Date of Discharge : d d y y m m Time : h h m m

h) If Injury, give cause : ☐ Self Inflicted ☐ Road Traffic Accident ☐ Substance / Substance Abuse or Alcohol Consumption

i) If Medico legal : ☐ Yes ☐ No j) Reported to Police : ☐ Yes ☐ No k) MLC Report or Police FIR Attached : ☐ Yes ☐ No

l) System of Medicine : _____

SECTION E : DETAIL OF CLAIM

a) Details of Treatment Expenses Claimed

1. Pre Hospitalization Expenses : INR.
2. Hospitalization Expenses : INR.
3. Post Hospitalization Expenses : INR.
4. Health Check Up Cost : INR.
5. Ambulance Charges : INR.
6. Other (Code) : INR.

Total INR.

Pre Hospitalisation Period : Days d d y y m m

Post Hospitalization Period : Days d d y y m m

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b) Claim for Domiciliary Hospitalization : ☐ Yes ☐ No (If Yes, provide details on annexure)

c) Detail of Lump Sum Cash benefit claimed:

i. Hospital Daily Cash :	INR.	ii. Surgical Cash :	INR.
iii. Critical Illness :	INR.	iv. Convalescence :	INR.
v. Pre/Post Lump Sum :	INR.	vi. Other :	INR.
		Total	**INR.**

Claim Documents Submitted Check List

- ☐ Claim Form Duly Filled
- ☐ Copy of the Claim Intimation, if any
- ☐ Hospital Main Bill
- ☐ Hospital Break Up Bill
- ☐ Hospital Bill Payment Receipt
- ☐ Hospital Discharge Summary
- ☐ Pharmacy Bill
- ☐ Operation Theater Notes
- ☐ ECG
- ☐ Doctor's request for investigation
- ☐ Investigation Report (Including CT / MRI / USG / HPE)
- ☐ Doctor's Prescription
- ☐ Others

SECTION F : DETAILS OF BILL ENCLOSED

Sl. No.	Bill No.	Date	Issued by	Towards	Amount (Rs.)
		d d m m y y		Hospital Main Bill	
		d d m m y y		Pre Hospitalization Bills	
		d d m m y y		Post Hospitalization	
		d d m m y y		Pharmacy Bills	
		d d m m y y			
		d d m m y y			
		d d m m y y			
		d d m m y y			
		d d m m y y			
		d d m m y y		**Total**	

Please attach separate sheet for additional bills / receipt details

SECTION G : DETAILS OF PRIMARY INSUREDS BANK ACCOUNT

a) PAN No. : b) Account Number :

c) Bank Name / Branch :

d) Payable details : ☐ Cheque ☐ DD ☐ NEFT *Payable to _____

e) IFSC Code :

SECTION H : DECLARATION BY THE INSURED

I hereby declare that the information furnished in this claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent & authorize TPA / insurance company, to seek necessary medical information / documents from any hospital / Medical Practitioner who has attended on the person against whom this claim is made. I hereby declare that I have included all the bills / receipts for the purpose of this claim & that I will not be making any supplementary claim except the pre/post-hospitalization claim, if any.

Date : d d m m y y Place : _____

_____
Signature of the Insured

GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled in by the insured)		
DATA ELEMENT	**DESCRIPTION**	**FORMAT**
SECTION A - DETAILS OF PRIMARY INSURED		
a) Policy No.	Enter the policy number	As allotted by the insurance company
b) Sl. No. / Certificate No.	Enter the social insurance number or the certificate number of	As allotted by the organization
c) Company TPA ID No.	Enter the TPA ID No.	License number as allotted by IRDA and printed in TPA documents.
d) Name	Enter the full name of the policyholder	Surname, First Name, Middle Name
e) Address	Enter the full postal address	Include Street, City and Pin Code

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SECTION B - DETAILS OF INSURANCE HISTORY		
a) Currently covered by any other Mediclaim / Health Insurance?	Indicate whether currently covered by another Mediclaim /Health Insurance	Tick Yes or No
b) Date of Commencement of first Insurance without break	Enter the date of commencement of first insurance	Use dd-mm-yy format
c) Company Name	Enter the full name of the insurance company	Name of the organization in full
Policy No.	Enter the policy number	As allotted by the insurance company
Sum Insured	Enter the total sum insured as per the policy	In rupees
d) Have you been Hospitalized in the last 4 years Date Diagnosis	Indicate whether hospitalized in the last 4 years Enter the date of hospitalization Enter the diagnosis details	Tick Yes or No Use mm-yy format Open Text
e) Previously Covered by any other Mediclaim / Health Insurance?	Indicate whether previously covered by another Mediclaim/	Tick Yes or No
f) Company Name	Enter the full name of the insurance company	Name of the organization in full
SECTION C - DETAILS OF INSURED PERSON HOSPITALIZED		
a) Name	Enter the full name of the patient	Surname, First Name, Middle Name
b) Gender	Indicate Gender of the patient	Tick Male or Female
c) Age	Enter age of the patient	Number of years and months
d) Date of Birth	Enter Date of Birth of patient	Use dd-mm-yy format
e) Relationship to primary Insured	Indicate relationship of patient with policyholder	Tick the right option. If others, please specify.
f) Occupation	Indicate occupation of patient	Tick the right option. If others, please specify.
g) Address	Enter the full postal address	Include Street, City and Pin Code
h) Phone No.	Enter the phone number of patient	Include STD code with telephone number
i) E-mail ID	Enter e-mail address of patient	Complete e-mail address
SECTION D - DETAILS OF HOSPITALIZATION		
a) Name of Hospital where admitted	Enter the name of hospital	Name of hospital in full
b) Room category occupied	Indicate the room category occupied	Tick the right option
c) Hospitalization due to	Indicate reason of hospitalization	Tick the right option
d) Date of Injury/Date Disease first detected/ Date of Delivery	Enter the relevant date	Use dd-mm-yy format
e) Date of admission	Enter date of admission	Use dd-mm-yy format
f) Time	Enter time of admission	Use hh:mm format
g) Date of discharge	Enter date of discharge	Use dd-mm-yy format
h) Time	Enter time of discharge	Use hh:mm format
i) If Injury give cause If Medico legal Reported to Police MLC Report & Police FIR attached	Indicate cause of injury Indicate whether injury is medico legal Indicate whether police report was filed Indicate whether MLC report and Police FIR attached	Tick the right option Tick Yes or No Tick Yes or No Tick Yes or No
j) System of Medicine	Enter the system of medicine followed in treating the patient	Open Text
SECTION E - DETAILS OF CLAIM		
a) Details of Treatment Expenses	Enter the amount claimed as treatment expenses	In rupees (Do not enter paise values)
b) Claim for Domiciliary Hospitalization	Indicate whether claim is for domiciliary hospitalization	Tick Yes or No
c) Details of Lump sum/ cash benefit claimed	Enter the amount claimed as lump sum/ cash benefit	In rupees (Do not enter paise values)
d) Claim Documents Submitted-Check List	Indicate which supporting documents are submitted	Tick the right option
SECTION F - DETAILS OF BILLS ENCLOSED		
Indicate which bills are enclosed with the amounts in rupees		
SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT		
a) PAN	Enter the permanent account number	As allotted by the Income Tax department
b) Account Number	Enter the bank account number	As allotted by the bank
c) Bank Name and Branch	Enter the bank name along with the branch	Name of the Bank in full
d) Cheque/ DD payable details	Enter the name of the beneficiary the cheque/ DD should be made out to	Name of the individual/ organization in full
e) IFSC Code	Enter the IFSC code of the bank branch	IFSC code of the bank branch in full
SECTION H - DECLARATION BY THE INSURED		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.		

Health Connect Supra Policy UIN : LVGHLIP16003V011516

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HEALTH CONNECT SUPRA POLICY
CLAIM FORM - PART B

TO BE FILLED IN BY THE HOSPITAL (To be filled in Block Letters)

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

SECTION A - HOSPITAL DETAILS

a) Name of Hospital :

b) Hospital ID : c) Type of Hospital : ☐ Network ☐ Non Network (If Non Network fill Sec E)

d) Name of the 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 : Year (y y) Months (m m)

e) Date of Brith : (d d m m y y) f) Date of Admission : (d d m m y y) g) Time of Admission : (h h m m)

h) Date of Discharge : (d d m m y y) i) Time of Discharge : (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

Ailment Diagnosed (Primary)	ICD 10 Codes	Code & Description	Details of Procedure/s done	ICD 10 Codes	Code & Description
i) Primary Diagnosis			i) Procedure 1		
ii) Codes Description			ii) Code & Description		
iii) Additional Diagnosis			iii) Procedure 2		
iv) Code Description			iii) Code & Description		
v) Co-morbidities			iii) Procedure 3		

Pre-authorization obtained : ☐ Yes ☐ No Pre-authorization Number :

Hospitalization due to Injury : ☐ Yes ☐ No (If Yes, give cause) ☐ Self-inflicted ☐ Road Traffic Accident ☐ Substance abuse/ alcohol consumption

Reported to Police : ☐ Yes ☐ No

Medico Legal : ☐ Yes ☐ No

FIR no : vi) If not reported to police give reason : _____

If injury due to Substance Abuse / Alcohol consumption test conducted to establish this? ☐ Yes ☐ No
If YES please attach Report

If authorization by network hospital not obtained, give reason _____

Note : For details of Claim Documents to be submitted, please refer checklist

SECTION D : CLAIM DOCUMENTS SUBMITTED - CHECKLIST

- ☐ Claim From Duly Singed
- ☐ Original Pre-Authorization Request
- ☐ Copy of Pre-Authorization Approval Letter
- ☐ Copy of photo ID card of patient verified by Hospital
- ☐ Hospital Discharge Summary
- ☐ Operation Theater Notes
- ☐ Hospital Main Bill
- ☐ Hospital Break-up Bill
- ☐ Investigation reports
- ☐ CT / MRI / USG / HPE investigation reports
- ☐ Doctor's reference slip for investigation
- ☐ ECG
- ☐ Pharmacy bills
- ☐ MLC report & Police FIR
- ☐ Original death summary from hospital where applicable
- ☐ Any other, please specify

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DETAILS IN CASE OF NON NETWORK HOSPITAL

(Only fill in case of non - network hospital)

a) Address of Hospital :

City : State :

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

d) Hospital PAN : e) No, of Inpatient beds : f) Facilities in the Hospital : i) OT : ☐ Yes ☐ No ii) ICU : ☐ Yes ☐ No

iii) Other :

DECLARATION BY THE HOSPITAL

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

Date : d d m m y y

Place : _____

_____
Seal & Signature of the Hospital Authority