Liberty General Insurance Limited
10th Floor, Tower A, Peninsula Business Park,
Ganpatrao Kadam Marg, Lower Parel, Mumbai - 400 013
Phone: +91 22 6700 1313 Fax: +91 22 6700 1606
Email: care@libertyinsurance.in
IRDA registration number: 150 ● CIN: U66000MH2010PLC209656

Liberty General Insurance™

LIBERTY GROUP HEALTH POLICY - REIMBURSEMENT CLAIM FORM
CLAIM FORM - PART A

TO BE FILLED IN BY THE INSURED

(The issue of this form is not to be taken as an admission of liability) (To be filled in Block Letters)

DETAILS OF PRIMARY INSURED

SECTION A

a) Policy Number : b) SL No. / Certificate No. :

c) Company ID No. :

d) Name : SURNAME FIRST NAME MIDDLE NAME

e) Address :

City : State :

Pin Code : Phone No :

Email ID :

DETAILS OF INSURANCE HISTORY

SECTION B

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 (copy of policies to be attached)

c) If Company Name :

Policy No : Sum Insured (Rs.) :

d) Have you been hospitalized in the last four years? ☐ 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 :

DETAILS OF INSURED PERSON HOSPITALIZED

SECTION C

a) Name : SURNAME FIRST NAME MIDDLE 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 to 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 :

DETAIL OF HOSPITALIZATION

SECTION D

a) Name of Hospital where admitted :

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

c) Hospitalization due to : ☐ Illness ☐ Injury ☐ Maternity d) Date of Injury / Date 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 / Alcohol Consumption i) If Medico legal : ☐ Yes ☐ No

j) Reported to Police : ☐ Yes ☐ No k) MLC Report & Police FIR Attached : ☐ Yes ☐ No

l) System of Medicine :

DETAIL OF CLAIM

SECTION E

a) Details of Treatment Expenses Claimed

I. Pre Hospitalization Expenses : Rs.

ii. Hospitalization Expenses : Rs.

iii. Post Hospitalization Expenses : Rs.

iv. Health Check Up Cost : Rs.

v. Ambulance Charges : Rs.

vi. Other (Code) : Rs.

Total **Rs.**

vii. Pre Hospitalisation Period : Days d d y y m m

viii. 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 in annexure)

c) Details of Lump Sum Cash benefit claimed:

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

SECTION E

Claim Documents Submitted - Check List

SECTION E

- ☐ 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)
- ☐ Others

DETAILS OF BILL ENCLOSED

SECTION F

Sl. No.	Bill No.	Date	Issued by	Towards	Amount (Rs.)
1.		d d m m y y		Hospital Main Bill	
2.		d d m m y y		Pre Hospitalization:_____Nos	
3.		d d m m y y		Pre Hospitalization:_____Nos	
4.		d d m m y y		Pharmacy Bills	
5.		d d m m y y			
6.		d d m m y y			
7.		d d m m y y			
8.		d d m m y y			
9.		d d m m y y			
10.		d d m m y y		**Total**	

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

SECTION G

a) PAN No. : b) Account Number :

c) Bank Name / Branch :

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

e) IFSC Code :

DECLARATION BY THE INSURED

SECTION H

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.

I also consent TPA/Insurance company to share my claim related information / documents to any third party agency or service provider for the sole purpose of claim related enquiry/transaction only

Date : d d m m y y Place : _____

_____

Signature of the Insured

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LIBERTY GROUP HEALTH POLICY - REIMBURSEMENT CLAIM FORM
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

HOSPITAL DETAILS

SECTION A

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 : SURNAME FIRST NAME MIDDLE NAME

e) Qualification : f) Registration No. with State Code :

g) Phone No :

DETAILS OF THE PATIENT ADMITTED

SECTION B

a) Name of the Patient : SURNAME FIRST NAME MIDDLE NAME

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 : (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. Grade of Status :

l) Status at time of Discharge : ☐ Discharge to Home ☐ Discharge to another Hospital ☐ Deceased

DETAIL OF AILMENT DIAGNOSED (PRIMARY)

SECTION C

a)	ICD 10 Codes	Description	b)	ICD 10 Codes	Description
i) Primary Diagnosis			i) Procedure 1		
ii) Additional Diagnosis			ii) Procedure 2		
iii) Co-morbidities			iii) Procedure 3		
iii) Co-morbidities			iii) Details of Procedure:		

c) Present ailment is a complication of PED? ☐ Yes ☐ No (If Yes, Specify Details): _____

d) Pre-authorization obtained : ☐ Yes ☐ No e) Pre-authorization Number :

f) If authorization by network hospital not obtained, give reason _____

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

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

k) Medico Legal : ☐ Yes ☐ No

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

CLAIM DOCUMENTS SUBMITTED - CHECKLIST

SECTION D

- ☐ 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 / MR / 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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CLAIM FORM - PART B

SECTION E

DETAILS IN CASE OF NON NETWORK HOSPITAL

a) Address of Hospital :

City : State :

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

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

iii) Other :

SECTION F

DECLARATION BY THE INSURED

(PLEASE READ VERY CAREFULLY)

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, my right to claim reimbursement shall be forfeited. I also consent & authorize 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

SECTION G

DECLARATION BY THE HOSPITAL

(PLEASE READ VERY CAREFULLY)

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. The signature of the insured is taken on this form after Claim Form B is fully filled up by us.

Date : d d m m y y

Place :

_____
Seal & Signature of the Hospital Authority

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