Liberty General Insurance Limited
Unit 1501&1502, 15th Floor, Tower 2, One International Center, Senapati Bapat Marg, Prabhadevi, Mumbai – 400013
Phone: +91 22 6700 1313 Email: care@libertyinsurance.in
IRDA registration number: 150 ● CIN: U66000MH2010PLC209656

SECURE HEALTH CONNECT POLICY
CLAIMS MANUAL

INDEX

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SECURE HEALTH CONNECT POLICY
CLAIMS MANUAL

1. Objectives

This manual is written with the following purpose:

- *To outline process in handling and processing of claims*
- *To outline process and roles of Liberty Health 360*

2. Scope

This manual enumerates activities related to:

- *Claim Intimation*
- *Claim Submission*
- *Claim Registration*
- *Claim Processing*
- *Claim Settlement*

3. Philosophy

It would be our mission to promptly and fairly handle, resolve all claims in a professional, efficient and courteous manner. Effective response when a claim is made adds value to our product. We will achieve fair, reasonable, equitable disposition with utmost integrity in every respect and by providing superior service to our customers.

4. Service Providers

When a claim is reported, making immediate contact is of vital importance. Details would be obtained at the time of reporting as to when and how the policy holders may be reached. In order to provide quality service to the customers and to provide for speedy disposal of claims the company has a dedicated team - Liberty Health 360.

5. Communication with the Insured

Written communication to the Insured would be given for claims related correspondence. Legibility and clarity would be maintained.

6. Service Parameters

We have set following standards to facilitate efficient service in claim disposition and ensure client loyalty.

i. Cashless service will be provided
ii. Liberty Health 360 has a wide reach in terms of number of network hospitals.
iii. Liberty Health 360 will provide the User guide & identity card to insured. User guide will have following details:
  a. Contact details of all Liberty Health 360 offices
  b. Website address of Liberty Health 360
  c. Network list of hospitals with their contact details
  d. Claim submission guidelines.
  e. Call center details for registration of claims and other services
iv. The claim would be settled within thirty working days after receiving all the required documents.
v. Wherever necessary, periodic meetings will be held with the Liberty Health 360 team / Client on all pending claims and discuss ways to resolve the Claim.
vi. The Appointed Service provider shall provide Preventive Care benefits

7. Mode of claim intimation and Notification

1. Claim Procedure:

a. Claim Notification: Upon the happening of any event giving rise or likely to give rise to a claim under this Policy, the Insured Person/s shall give immediate notice to the Liberty Health 360 named in the Policy/Health Card or the Company by calling toll-free number as specified in the Policy/Health Card or in writing to the address shown in the Schedule with Particulars below:
  i. Policy Number / Health Card No.
  ii. Name of the Insured / Insured Person availing treatment
  iii. Details of the disease/illness/injury
  iv. Name and address of the Hospital
  v. Any other relevant information

Intimation must be given at least 48 hours prior to planned hospitalization and within 24 hours of hospitalization in case of emergency hospitalization. In event of any claim for Pre - Post Hospitalization expenses incurred, all claim related documents needs to be submitted within 7 days from the date of completion of treatment or eligible Post Hospitalization period as mentioned in the policy schedule whichever is earlier.

b. For opting Cashless Facility: (applicable where the Insured Person/s has opted for cashless facility in a Network Hospital) - The Insured Person must call the helpline and furnish membership no and Policy Number and take an eligibility number to confirm communication. The same has to be quoted in the claim form. The call must be made 48 hours before admission to Hospital and details of hospitalization like diagnosis, name of Hospital, duration of stay in Hospital should be given. In case of emergency hospitalization the call should be made within 24 hours of admission.
  i. The company may provide Cashless facility for Hospitalisation expenses through the Liberty Health 360 if treatment is undergone at a Network Hospital by issuing Pre-Authorisation letter to the health care service provider.
  ii. For the purpose of considering Pre-Authorisation and Cashless facility, the Insured Person/s shall submit to the Liberty Health 360 complete information of the disease, requiring treatment along with necessary certification from the Hospital/Medical Practitioner.

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iii. *If the claim for treatment appears admissible, the Company either directly or through the Liberty Health 360 shall issue Pre-Authorisation to the Hospital concerned for cashless facility whereby hospitalization expenses shall be paid directly by the Company/ through the Liberty Health 360 as confirmed in the Pre-Authorisation.*

iv. *Cashless facility will not be available in Non-network Hospital and may be declined even for treatment at a network hospital where the information available does not conclusively establish that a claim in respect of the treatment would be admissible. In such cases, the Insured Person/s shall bear such expenses and claim reimbursement immediately after discharge from the Hospital.*

c. *Reimbursement Claims- Notice of claim with particulars relating to Policy numbers, name of the Insured Person in respect of whom claim is made, nature of illness/injury and name and address of the attending Medical Practitioner/ Hospital/ Nursing Home should be given to Us immediately on hospitalization /injury/ death, failing which admission of claim would be based on the merits of the case at our discretion. The Insured Person/s shall after intimation as aforesaid, further submit at his/her own expense to the Liberty Health 360 within 15 days of discharge from the hospital the following:*

i. *Claim form duly completed in all respects*
ii. *Original Bills, Receipt and Discharge certificate / card from the Hospital.*
iii. *Original Cash Memos from Hospital(s)/Chemist(s), supported by proper prescriptions.*
iv. *Original Receipt and Pathological test reports from a Pathologist supported by the note from the attending Medical Practitioner / Surgeon demanding such Pathological tests.*
v. *Surgeon's certificate stating nature of operation performed and Surgeons' original bill and receipt.*
vi. *Attending Doctor's/ Consultant's/ Specialist's/ -Anesthetist's original bill and receipt, and certificate regarding diagnosis.*
vii. *Medical Case History/ Summary.*
viii. *Original bills & receipts for claiming Ambulance Charges*
ix. *Any additional documents or information, as may be deemed necessary by the Company or Liberty Health 360.*

The Insured Person/s shall at any time as may be required authorize and permit the Liberty Health 360 and/or Company to obtain any further information or records from the Hospital, Medical Practitioner, Lab or other agency, in connection with the treatment relating to the claim. The Company may call for additional documents/information and/or carry out verification on a case to case basis to ascertain the facts/collect additional information/documents of the case to determine the extent of loss. Verification carried out will be done by professional Investigators or a member of the Service Provider and costs for such investigations shall be borne by the Company. The Company may accept claims where documents have been provided after a delayed interval in case such delay is proved to be for reasons beyond the control of the Insured/ Insured Person/s. The Insured shall tender to the Company all reasonable information, assistance and proofs in connection with any claim hereunder.

Applicable Taxes prevailing at the time of claim will be considered as part of the Claim Amount and the aggregate liability of the Company, including any payment towards such Taxes shall in no case exceed the Basic Sum Insured opted.

No sum payable under this Policy shall carry interest except as required by section 9(6) of the Protection of Policy Holder's Interest, Regulation 2002 whereby payment of the claim amount due shall be made within 7 days from the date of acceptance of the offer of settlement by the Insured/ Insured Person. In case of any delay in payment, the Company shall be liable to pay interest at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed .

No person other than the Insured / Insured Person(s) and/ or nominees named in the proposal can claim or sue us under this Policy.

8. Claim Submission

INDICATIVE CHECK LIST OF ENCLOSURES FOR SUBMISSION OF CLAIM

- ***In-patient Treatment /Day Care Procedures***
- ☐ *Duly filled and signed Claim Form.*
- ☐ *Photocopy of ID card / Photocopy of current year policy.*
- ☐ *Original Detailed Discharge Summary /Day care summary from the hospital. Original consolidated hospital bill with bill numbero and break up of each Item, duly signed by the insured.*
- ☐ *Original payment Receipt of the hospital bill with receipt number*
- ☐ *First Consultation letter and subsequent Prescriptions. Original bills, original payment receipts and Reports for investigation supported by the note from Attending Medical Practitioner / Surgeon demanding such test.*
- ☐ *Surgeons certificate stating nature of Operation performed and Surgeons Bills and Receipts*
- ☐ *Attending Doctors/ Consultants/ Specialist's/ Anesthetist Bill and receipt and certificate regarding same*
- ☐ *Original medicine bills and receipts with corresponding Prescriptions.*
- ☐ *Original invoice/bills for Implants (viz. Stent /PHS Mesh/ IOL etc.) with original payment receipts.*
- ***Road Traffic Accident***
- ☐ *In addition to the In-patient Treatment documents:*
- ☐ *Copy of the First Information Report from Police Department / Copy of the Medico-Legal Certificate.*
- ☐ *In Non Medico legal cases*
- ☐ *Treating Doctor's Certificate giving details of injuries (How, when and where injury sustained)*
- ☐ *In Accidental Death cases*
- ☐ *Copy of Post Mortem Report (if conducted) & Death Certificate*
- ***Pre and Post-hospitalisation expenses***
- ☐ *Duly filled and signed Claim Form.*

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- □ *Photocopy of ID card / Photocopy of current year policy.*
- □ *Original Medicine bills, original payment receipt with prescriptions.*
- □ *Original Investigations bills, original payment receipt with prescriptions and report.*
- □ *Original Consultation bills, original payment receipt with prescription.*
- □ *Copy of the Discharge Summary of the main claim.*

We may call for additional documents/ information as relevant to the claim.

Applicable to all claims under the Policy:
In the event of the original documents being provided to any other Insurance Company or to a reimbursement provider, the Company shall accept verified photocopies of such documents attested by such other Insurance Company/ reimbursement provider.

9. Appointment of Investigators
On receipt of the claim intimation and other details, in case if required an Investigator would be appointed depending on the facts of claim and any other criteria that evolves from time to time.

10. Claim Registration
On intimation of claims and after performing the basic validity checks the claims team of the TPA would allot a claim number which would be intimated to the Insured. A centralised Claims Register would be maintained with Liberty General in the system to track all the claims.

11. Claims Processing
- *The Claims team will ensure complete control on all Claims at all points of time. Prompt and fair action has to be ensured. Underwriters will also be informed on all Major Claims and Major Clients at regular interval and also on all significant developments immediately.*
- *Claims teams will co-ordinate and attend meetings with Investigators / Clients / TPAs, wherever required.*
- *All Clarifications / documents that may be required from the TPA or the Client will be called in consolidate manner.*
- *TPA doctors will scrutinize the claims and recommend the claim for Settlement / Repudiation / Reopening or flag the claim as Pending for necessary Document*
- *We would review the decision of the TPA for Settlement / Repudiation / Reopening and intimate TPA accordingly*
- *We would settle the payment directly with the Insured (In case of reimbursement) and Hospital (in case of cashless claims)*
- *Repudiated claims- Letter would be shared to the Insured detailing the clause for repudiation along with the details*
- *Pending claims will be asked for submission of incomplete documents*
- *TPA will forward daily/weekly claims handling report.*
- *We will go through the report and flag the claim in our records*

12. Claim Assessment Report
Based on, relevant documents received by the insured / hospital, claim assessment would be made, which would include various findings and the final payable amount.

13. Claim Settlement Methodology
Claims settlement will be either by way of cashless or reimbursement method.

14. Tracking Pending Claims
Our systems will be capable of tracking the pending claims Branch wise and close them at the earliest. These claims would be reviewed by Claims Head regularly and issues in respect of the pending claims would be discussed.

15. Claims Authorisation Matrix
There would be Claims Authorities at different level, based on cadre, experience etc. Initially the claims approval authority will be with the corporate claims manager and will be delegated in phased manner.
There would be 5 levels of claims authorities viz. CL 1 to CL 5, of which CL1 being the highest and CL 5 would be lowest.
The highest authority would be involved in overall review of claims.
Subrogation and co-insurance recoveries would be handled from corporate office.
All the claims in excess of INR._____would be informed to the Board.
Authority matrix for claims will be based on the individual skill sets, experience in handling claims, longevity of service, working location, cadre in the organisation…etc.
We will review the claims authority at all levels from time to time based on internal review mechanism.

16. Legal and arbitration matters:
Legal issues as a matter of policy would be handled by the corporate office. Appointment of Arbitrators, experts and Legal Counsels will be done as per procedures laid down for the same by Corporate Office.

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SECURE HEALTH CONNECT POLICY
CLAIMS MANUAL

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

CLAIM FORM-PART A
TO BE FILLED IN BY THE INSURED PERSON
(The issue of this Form is not to be taken a s an admission of liability)

SECTION A - DETAILS OF PRIMARY INSURED

a. Policy Number:_____ b. Sl.L No./Certificate No./ Claim Number (If any):_____

c. Company ID No.no:_____

d. Name:_____

e. Address:_____

City:_____ State:_____ Pin Code:_____

Phone No.:_____ 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: DD / MM / YY

c. If YES,_____

Company Name:_____ Policy Number:_____

Sum Insured:_____

d. Have you been hospitalized in the last four years since the inception of the contract? YES / NO

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:_____Years_____Months_____ d. Date of Birth : DD / MM / YY

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: DD / MM / YY

e. Date of Admission: DD / MM / YY Time : HH MM f. Date of Discharge: DD / MM / YY Time : HH MM

h. If injury, give cause : Self Inflicted / Road Traffic Accident/ 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 _____

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SECTION E - DETAILS 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. Others (Code) INR…….....

Total: INR…….....

☐ Pre Hospitalization Period :_____days ☐ Post Hospitalization Period :_____days

b Claim for Domiciliary Hospitalization : YES / NO
(If Yes provide details on annexure)

c Detail of Lump Sum cash benefit claimed

Hospital Daily Cash: INR…….....
Surgical cash: INR…….....
Critical Illness: INR…….....
Convalescence: INR…….....
Pre Post Lump Sum: INR…….....
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 Reports (Including CT/MRI/USG/HPE)
- ☐ Doctor's Prescription
- ☐ Others

F. DETAILS OF BILLS ENCLOSED

Sr. No.	Bill No.	Date	Issued by	Towards	Amount
				Hospital Main Bill	
				Pre Hospitalization Bills	
				Post Hospitalization Bills	
				Pharmacy Bills	
				Total	

Please attach separate sheet for additional bills / receipt details

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:_____

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SECURE HEALTH CONNECT POLICY CLAIMS MANUAL

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 Liberty Health 360/ 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/We hereby give voluntary consent to Liberty General Insurance Limited/Company to process/share my/our personal information and data provided in this form with its group companies or any other person/ Service Provider of Company in connection with the Insurance Policy/ claims made there under or otherwise, including for providing other products of the Company that may be of interest to me/us, to be used in accordance with their respective privacy policies

*Date:*_____ *Place:*_____

_____
Signature of the Insured

GUIDANCE FOR FILLING CLAIM FORM - PARTA(Tobe filledin bythe 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.	SI. No./ Certificate No.	Enter the social insurance number or the certificate number of social health insurance scheme	As allotted by the organization
c.	Company Liberty Health 360 ID No.	Enter the Liberty Health 360 ID No	License number as allotted by IRDA and printed in Liberty Health 360 documents.
d.	Name	Enter the full name of the policy holder	Surname, First name, Middle name
e.	Address	Enter the full postal address	Include Street, City and Pin Code
		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	Indicate whether hospitalized in the last 4 years	Tick Yes or No
	Date	Enter the date of hospitalization	Use mm-yy format
	Diagnosis	Enter the diagnosis details	Open Text
e.	Previously Covered by any other Mediclaim/Health Insurance?	Indicate whether previously covered by another Mediclaim/Health Insurance	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 policy holder	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-maillD	Enter e-mail address of patient	Complete e-mail address

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GUIDANCE FOR FILLING CLAIM FORM - PARTA(Tobe filledin bythe insured)			
	DATA ELEMENT	**DESCRIPTION**	**FORMAT**
	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	Indicate cause of injury	Tick the right option
	If Medico legal	Indicate whether injury is medico legal	Tick Yes or No
	Reported to Police	Indicate whether police report was filed	Tick Yes or No
	MLC Report & Police FIR attached	Indicate whether MLC report and Police FIR attached	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.		

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CLAIM FORM-PART B
TO BE FILLED IN BY THE HOSPITAL
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 (To be filled in Block Letters)

SECTION A - HOSPITAL DETAILS
*Name of the Hospital:*_____ *Hospital ID:* _____
*Type of Hospital:*_____ *Network:*_____ *Non Network:* _____
If Non Network fill sec E
Name of the treating Doctor: _____
*Qualification:*_____ *Registration No. with State Code:*_____ *Phone No.:* _____

SECTION B - DETAILS OF THE PATIENT ADMITTED
*Name of the patient:*_____ *IP Registration Number:* _____
*Gender:*_____ *Age:*_____ *Date of Birth:* DD MM YYYY
Date of Admission: _____ *Time of Admission:* _____
*Date of Discharge:*_____ *Time of Discharge:* _____
Type of Admission: Emergency / Planned / Day-care | Maternity
*If Maternity Date of delivery:*_____ *Gravida Status:* _____
*Status at the time of Discharge:*_____ *Discharge to Home / Discharge to another Hospital / Deceased*
Total Claimed Amount: _____

SECTION C - DETAILS OF AILMENT DIAGNOSED						
Ailment Diagnosed (Primary)						
ICD 10 Code	*Primary Diagnosis*	*Codes Description*	*Additional Diagnosis*	*Codes Description*	*Co-morbidities*	*Codes Description*
Details of Procedure/s done:						
ICD 10 PCS	*Procedure 1*	*Code & Description*	*Procedure 2*	*Code & Descriptio*	*Procedure 3*	*Code & Description*

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:	*If not reported to police , give reasons:*
If injury due to Substance Abuse/ Alcohol consumption test conducted to establish this? If Yes please attach Report: Yes / No	
If authorization by network hospital not obtained, give reason:	
Note: For details of Claim Documents to be submitted, please refer checklist	

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Claim Document Submitted - Checklist

- ☐ *Claim Form Duly signed*
- ☐ *Original Pre-Authorisation Request*
- ☐ *Copy of Pre-Authorisation Approval Letter*
- ☐ *Copy of Photo Id Card of Patient verified by the Hospital*
- ☐ *Hospital Discharge Summary*
- ☐ *Operation Theater Notes*
- ☐ *Hospital Main Bills*
- ☐ *Hospital Break-up Bill*
- ☐ *Investigation reports*
- ☐ *CT/MRI/USG/HPE investigation reports*
- ☐ *Doctor's reference slip for investigation*
- ☐ *ECG*
- ☐ *Pharmacy Bills*
- ☐ *MLC report & Policy FIR*
- ☐ *Original Death Summary from Hospital where applicable*
- ☐ *Any other, please specify.*

Details in case of Non network Hospital (only fill in case of non–network hospital)	
Address of the Hospital	
City	
State	
Pin Code	
Phone No.	
Registration no with state code	
Hospital PAN	
No. of Inpatient Beds	
Facilities in the Hospital	**OT** ☐ *Yes* ☐ *No* **ICU** ☐ *Yes* ☐ *No*
Others	

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: _____

Place: _____

SEAL & SIGNATURE OF THE HOSPITAL AUTHORITY

UIN: LVGHLIP18065V011718