ICICI Lombard Health Insurance

ICICI Lombard Health Care

ICICI Lombard Health Care Claim Form - Hospitalisation

(The issue of this form is not to be taken as an Admission of Liability)

Do You Know

- ★ Non-submission of Original Bills and Receipts is the largest cause of delay in claim settlements. Please provide the originals
- ★ You can get your payment 5 days early: Provide Your Bank details for direct fund transfer (refer Part - C)
- ★ You will receive updates on your Claim status: Provide your Mobile no. & E-mail address
- ★ You can check your claim status at: www.icicilombard.com/track-your-claim-status.html

Part A (To be filled by Insured)

TO BE FILLED IN CAPITAL LETTERS ONLY

1. Type of Claim : Main Hospitalisation Expenses ☐ Pre & Post Hospitalisation Expenses ☐ Cashless Obtained : Yes ☐ No ☐

2. Name of Policy Holder/Proposer :

Current Policy Number :

Card No./UHID:

3. For **Group/Corporate** Policy

Member ID No. / Employee ID (Client ID):

Group/Company Name:

For **Individual/Retail** Policy

Is this a renewal policy : **Yes** ☐ **No** ☐

If Yes, kindly mention your previous policy no. :

4. Details of the Insured Person in respect of whom claim is made:

Name of Insured :

Relationship with the Policy Holder : Date of Birth : D D M M Y Y Y Y

Present completed age (In Years) : Gender : M ☐ F ☐ Current Residential address :

City :

State: Pin Code :

Mobile No. Landline No.

E-mail :

5. Nature of disease / illness contracted or injury suffered for which insured was hospitalized (Diagnosis):

Date of Admission : D D M M Y Y Y Y Date of Discharge : D D M M Y Y Y Y

Date of injury sustained or disease / illness first detected : D D M M Y Y Y Y

6. Have you lodged any claim against this particular admission date /attached bills with any other Insurance company: Y N

If yes, provide Name of Insurance Company & TPA:

Settled Amount (Rs.):

7. Details of the Amount Claimed

Bill Heads (as Applicable)	**Bill Number**	**Bill Date**	**Bills attached**	**Amount (In Rs.)**
Room Rent		D D M M Y Y	Y N	
Doctors Consultation/Visit Charges		D D M M Y Y	Y N	
Investigation Charges (Includes Radiology and Pathology Reports)		D D M M Y Y	Y N	
Surgeon and Asst. Surgeon Charges		D D M M Y Y	Y N	
Anesthetist Charges & Operation Theatre Charges		D D M M Y Y	Y N	
Equipment Charges/Procedure Charges		D D M M Y Y	Y N	
Cost of Implant (If Any)		D D M M Y Y	Y N	
Medicine Charges (Includes Ward and OT Medicines and Consumables)		D D M M Y Y	Y N	
Taxes/Surcharges/Service Charge		D D M M Y Y	Y N	
Miscellaneous/Other Charges		D D M M Y Y	Y N	
Pre Hospitalisation Bills (If Any)		D D M M Y Y	Y N	
Post Hospitalisation Bills (If Any)		D D M M Y Y	Y N	
Total Claimed Amount (In Rs.) (Total claimed amount should be equal to the amount in attached bill documents)				

क्लेम फॉर्म हिन्दी के लिए कृपया हमारी वेबसाइट पर जाँच कीजिए : www.icicilombard.com

Claim documents to be dispatched to: ICICI Lombard Healthcare, ICICI Bank Tower, Plot No. 12, Financial District, Nanakram Guda, Gachibowli, Hyderabad-500032

8. In support of the above claim, I enclose following documents in **ORIGINAL** (Please indicate by ticking in the **Yes/No** column below)

Type of Document(s) - *Mandatory	Yes	No	Type of Document(s) - As Applicable	Yes	No
1. Claim form Duly Filled*	Y	N	8. ICICI Lombard GIC Authorisation Letter	Y	N
2. Discharge Summary*	Y	N	9. Implant Name and Invoice (If any) with Implant Sticker	Y	N
3. Hospital Bills, Final hospital bill and other bills (if any)*	Y	N	10. Indoor Case Papers/Prescription Papers/Consultation Papers	Y	N
4. Hospital Payment Receipt & other receipts supporting Bills*	Y	N	11. Part C (If payment is through RTGS/NEFT)	Y	N
5. Investigation Reports* (films# not required)	Y	N	12. Others_____	Y	N
6. Medicine/Pharmacy Bills with Doctors Prescription*	Y	N			
7. Age proof (Driver Licence/ photocopy of PAN card / Passport copy / School Leaving cert. of the proposer)*	Y	N			

Please attach all the documents as per above serial number. #Films mean x-ray film, CT Scan film, MRI Scan film, etc.

Part B

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. :

Details of the attending Medical Practitioner / Doctor / Treating Physician or Surgeon

Name:

Qualification & Registration No. : Telephone No. / Mobile No.

(To be filled by Treating Doctor/Hospital only)

This section is Mandatory *only* if your health policy was not provided by your employer

A) Diagnosis	
B) Date of First Consultation (Prior to Hospitalization)	
C) With what complaints was the patient admitted for	
D) Past medical history of the patient with duration of illness	
E) Was the patient under influence of alcohol during admission	
F) 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	
G) Whether the disease / disorder is congenital in nature ?	
H) Nature of surgery / treatment given for present ailment	
I) Number of in-patient beds in the hospital (including ICU)	

Registration No. of Hospital
(Rubber stamp of the hospital)

Date : D D M M Y Y Y Y

Doctor's Seal and Signature

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.

DECLARATION

I hereby agree, affirm and declare that

a) The statements/information given/stated by me/us in this claim form is true, correct and complete.
b) No material information which is relevant to the processing of the claim or which in any manner has a bearing on the claim has been withheld or not disclosed.
c) If I have given/made any false or fraudulent statement/information, or suppressed or concealed or in any manner failed to disclose material information, the policy shall be void & that I shall not be entitled to all/any rights ro recover there under in respect of any or all claims, past, present or future.
d) The receipt of this claim form/other supporting/related documents does not constitute or be deemed to constitute an agreement by the Company of the claim and the Company reserves the right to process or reject or require further/additional information in respect of the claim.
e) I hereby provide my consent and authorize ICICI Lombard Health Care to seek any medical information from any hospital/Medical Practitioner who has at any time attended on the insured person.

I/We hereby declare that the particulars made by the insured person in the claim form are true to the best of our knowledge and belief.

Place :

Date : D D M M Y Y Y Y

Signature of Claimant

क्लेम फॉर्म हिन्दी के लिए कृपया हमारी वेबसाइट पर जाँच कीजिए : www.icicilombard.com

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Part - C (For Direct Fund Transfer/EFT)

A) Would you like to opt for Electronic Fund Transfer as mode of payment ? A) Yes ☐ B) No ☐

B) If yes, kindly provide the below mentioned details :

- Proposer Name*(as per bank records): ☐☐
- Proposer Account No.: ☐☐
- Name of the Bank : ☐☐
- Branch Name : ☐☐
- Address of the Bank : ☐☐
  ☐☐
- IFSC code no. of the Bank: ☐☐☐☐☐☐☐☐☐☐☐
- Permanent Account Number (PAN) of Proposer : ☐☐☐☐☐☐☐☐☐☐

1) Please attach an **Original Blank Cancelled Cheque** signed by the proposer.	**Mandatory** ☐
2) Please attach a **PAN Card** copy of proposer	**Mandatory** ☐

* Proposer is the person who has paid premium for the policy. * Please note all the details and the above documents (1 & 2)should be of the proposer only.

Terms and Conditions for Payments through RTGS / NEFT

1. The details provided by the Customers 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 Customer(s) 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 Customer agrees that under the RTGS/ NEFT facility, there may be a risk of non-payment in the Account of Customer 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 Customer 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 Customer 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 date of notice for ICICI Lombard will be the date of receipt of such notice by ICICI Lombard. 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 Customer will be acknowledged through a confirmation letter by ICICI Lombard General Insurance Company Ltd. In no case can the Customer construe his termination notice as effective unless a confirmation has been provided by ICICI Lombard to the Customer stating the date of receipt of such communication by the Customer.
7. The Customer agrees that transaction(s) through RTGS/ NEFT facility may attract inward RTGS/ NEFT charges, which if levied by the Customer's bank, shall be borne by the Customer
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 Customer 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 or by sending them by post to the last address of the Customer.
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 Customer 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 Customer.

Signature of the Account Holder

Mailing Address : ICICI Lombard Healthcare, ICICI Bank Tower, Plot No. 12, Financial District, Nanakram Guda, Gachibowli, Hyderabad-500032
Toll Free Number: 1800 2666 • Toll Free Fax Number: 1800-209-8880
Corporate Office : 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