Optima Plus
Claim Form

ApolloMunich HEALTH INSURANCE

10th Floor, Building No. 10, Tower B, DLF City Phase II, DLF Cyber City, Gurgaon-122002

PART A

TO BE FILLED IN BY THE INSURED

The issue of this Form is not to be taken as an admission of liability

1. Policy No. : _____ 2. Sl. No/ Certificate No. : _____ 3. Company/ TPA ID No : _____
4. Name & Address of the Policyholder : _____

5. Details of the Insured Person Hospitalised :
   a) Name : _____
   b) Relationship : _____ c) Date of Birth : _____ d) Age/Years : _____
   e) Address : _____
   f) Gender: Male ☐ / Female ☐ g) Occupation : _____
   h) Telephone No : _____ i) Mobile No : _____
   j) E-mail ID, if any : _____
6. Hospitallisation due to Illness ☐/ Injury ☐/ Maternity ☐ : Details : _____
   a) Date of Injury sustained/ Disease first detected / LMP : _____
   b) If injury, how it occurred : _____
   c) If injury, whether Medico legal : Yes ☐ / No ☐ d) If MLC, whether reported to police? Yes ☐ / No ☐
   e) System of medicine : Allopathic ☐ / Other systems of medicine ☐
7. Insurance History :
   a) Date of commencement of first Insurance for the person (without break) : _____
   b) Are you presently covered with any other Mediclaim / Health Insurance? : Yes ☐ / No ☐
   c) If Yes, give details - Company / Policy Number / Sum Insured (copies of policies to be attached) : _____
8. Name of the Hospital where admitted : _____
9. Room Category occupied : Day care ☐ / Single occupancy ☐ / Twin sharing ☐ / 3 or more ☐
10. Past Hospitalisation History :
    a) Have you been hospitalised in the last 4 years? : Yes ☐ / No ☐
    b) If Yes, Diagnosis : _____
    c) Month and Year : _____
11. Is claim is for Domiciliary Hospitalisation? : Yes ☐ / No ☐ (If Yes, provide details in annexure)
12. Policyholder's Bank Account particulars :
    Payable details: Cheque ☐ / DD ☐ / NEFT* ☐ Payable to : _____
    Bank Name : _____ Bank Branch : _____
    Bank Account Number : _____ IFSC Code : _____
    MICR No. : _____ Policyholder's PAN : _____
    Note: It is agreed that the Policyholder/ Claimant will intimate in writing to Apollo Munich about any change in bank account details.
    *Please attach a cancelled cheque pertaining to the same account.
13. Details of the treatment expenses claimed :
    a) Pre-hospitalisation Expenses : Rs. _____ b) Hospitalisation Expenses : Rs. _____
    c) Post-hospitalisation Expenses : Rs. _____ d) Health check-up Cost : Rs. _____
    e) Ambulance Charges : Rs. _____ f) Others (code) : Rs. _____
13A. Details of Lumpsum / cash benefit claimed :
    a) Hospital Daily Cash : Rs. _____ b) Surgical Cash : Rs. _____
    c) Critical Illness Benefit : _____ d) Convalescence : _____
    e) Pre / Post hospitalisation lumpsum benefit : _____
    f) Others : _____
14. Details of bills enclosed :

Sl. No.	Bill No.	Date	Issued by	Towards	Amount

(If there is insufficient space to provide additional relevant information, whether as requested or otherwise, please attach extra sheet duly signed.)

15. For details of Claim Documents to be submitted, please refer CHECK LIST.

Date : _____ Signature of the Policyholder / Claimant : _____

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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 preauthorisation request form in lieu of PART A

1. Name of the Hospital where treated : _____
2. Hospital ID : _____ 3. Type of Hospital : Network ☐ / Non-Network ☐
4. In case of non network , please provide below details :
   a) Address of the Hospital with Pin Code : _____
   b) Telephone No : _____ c) Registration No : _____
   d) Number of Inpatient beds : _____ e) PAN : _____
   f) Other Facilities available in the hospital :
      i) OT : Yes ☐ / No ☐ ii) ICU : Yes ☐ / No ☐ iii) Others : _____
5. Details of the patient admitted :
   a) Name of the patient : _____
   b) IP Registration Number : _____ c) Gender: Male ☐ / Female ☐ d) Age : _____
   e) Date of Admission (DD/MM/YYYY) : _____ f) Time of Admission : _____
   g) Date of Discharge (DD/MM/YYYY) : _____ h) Time of Discharge : _____
6. Ailment Diagnosed (Primary) : _____
   a) ICD 10 Code :
      Primary Diagnosis : _____
      Additional Diagnosis : _____
      Co-morbidities : _____
   b) Details of Procedure/s done : _____
   c) ICD 10 PCS :
      Procedure 1 : _____
      Procedure 2 : _____
      Procedure 3 : _____
7. a) Type of Admission : Emergency ☐ / Planned ☐ / Day-care ☐ / Maternity ☐
   b) Date of delivery, if maternity (DD/MM/YYYY) : _____ c) Gravida Status : _____
8. Is the treatment for an injury? If Yes, give details _____
   a) Was it self inflicted? : Yes ☐ / No ☐ b) Whether RTA : Yes ☐ / No ☐
   c) If MLC, whether notified to police : Yes ☐ / No ☐ d) MLC / FIR No : _____
   e) If MLC not notified, give reasons : _____
9. Was the Injury/ disease caused due to Substance abuse / Alcohol consumption : Yes ☐ / No ☐
   a) If Yes, whether any test was conducted to establish this? : Yes ☐ / No ☐ If Yes, please attach Report.
10. Whether the present ailment is a complication of any illness suffered in the past : Yes ☐ / No ☐
    If Yes, specify details : _____
11. Whether Pre-authorisation obtained : Yes ☐ / No ☐
    a) If Yes, Pre Auth Number : _____
    b) If authorisation by network hospital not obtained, give reason : _____
12. Details of the Treating Doctor :
    a) Name of the Treating Doctor: _____
    b) Registration No with state code : _____
    c) Mobile No. : _____ d) Qualification : _____
13. For details of Claim Documents to be submitted, please refer CHECK LIST.

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, my right to claim reimbursement shall be forfeited.
I also consent & authorise TPA / Insurance Company, to seek necessary medical information / documents from any hospital / Medical Practitioner/Insurer 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 – hospitalisation claim, if any.

DECLARATION BY THE HOSPITAL

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

Signature of the Insured : _____
Date : _____

Seal & Signature of the Hospital Authority : _____
Date : _____

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PART C

For Office Use Only (Refer IRDA / TAC Master for codes wherever applicable)

1. TPA Code : _____
2. Insurer Code : _____
3. Product Code : _____
4. Policy Number : _____
5. Policy Start Date : _____
6. Policy End Date : _____
7. Sum Insured : _____
8. Bonus Sum Insured Accrued, if any : _____
9. Master Claim ID : _____
10. Diagnosis Code :
    - Primary Diagnosis : _____
    - Additional Diagnosis : _____
    - Co-morbidities : _____
11. Procedure Code :
    - Procedure 1 : _____
    - Procedure 2 : _____
    - Procedure 3 : _____
12. Details of Claim Paid :
    - A) Indemnity Benefit :
        - a) Room & Nursing Charges : _____
        - b) ICU Charges : _____
        - c) OT Charges : _____
        - d) Medicine & Consumable Charges : _____
        - e) Professional Fees' Charges : _____
        - f) Investigation Charges : _____
        - g) Ambulance Charges : _____
        - h) Miscellaneous Charges : _____
    - B) Fixed / Lumpsum Benefit :
        - a) Hospital Daily Cash : _____
        - b) Surgical Cash : _____
        - c) Critical Illness Benefit : _____
        - d) Convalescence : _____
        - e) Pre / Post hospitalisation lumpsum benefit : _____
        - f) Others : _____
13. Total Claim Paid : _____
14. Total Rejected Amount : _____
15. Reason for Rejection of Claim : _____
16. Reason for Reduction of Claim : _____
17. Whether claim paid was for PED : _____
18. If Yes, PED Code : _____
19. Whether claim paid under alternate medicine : Yes ☐ / No ☐
20. Amount of co-payment / deductible applicable : _____
21. Corporate Buffer Utilised, if any : _____
22. Date of Payment (DD/MM/YYYY) : _____
23. Payment Reference Number : _____
24. Date of Claim Intimation (DD/MM/YYYY) : _____
25. Date of receipt of complete claim documents (DD/MM/YYYY) : _____

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CHECK LIST OF ENCLOSURES FOR SUBMISSION OF CLAIM

Note:

1) When original bills, receipts, prescriptions, reports and other documents are submitted to the other insurer or to the reimbursement provider, verified photocopies attested by such other organisation/provider have to be submitted.

2) If original bills, receipts, prescriptions, reports and other documents are submitted to Us and Insured Person requires same for claiming from other organisation/provider, then on request from the Insured Person We will provide attested copies of the bills and other documents submitted by the Insured Person.

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 break up of each Item, duly signed by the insured.
- ☐ Original payment Receipt of the hospital bill.
- ☐ First Consultation letter and subsequent Prescriptions.
- ☐ Original bills, original payment receipts and Reports for investigation.
- ☐ 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 & Death Certificate

For Death Cases

In addition to the In-patient Treatment documents:

- ☐ Original Death Summary from the hospital.
- ☐ Copy of the Death certificate from treating doctor or the hospital authority.
- ☐ Copy of the Legal heir certificate, if the claim is for the death of the principle insured.

Pre and Post-hospitalisation expenses

- ☐ Duly filled and signed Claim Form.
- ☐ 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.

Organ Donation/Transplantation

In addition to the documents of general hospitalization

- ☐ Organ Function test / blood test proving organ failure.
- ☐ Treatment Certificate issued by the Transplant Surgeon of the hospital concerned.

Ambulance Benefit

- ☐ Duly filled and signed Claim Form.
- ☐ Photocopy of ID card / Photocopy of current year policy.
- ☐ Original Bill with Original Payment Receipt.
- ☐ Treating Doctor's consultation prescription indicating Emergency Hospitalization.

Customer Identification Procedure (as per KYC norms of IRDA)	
Please submit the following documents in case of claim amount exceeds Rs. 100,000	
Legal name and any other names used (Any one of the mentioned documents)	Passport/ PAN Card/ Voter's Identity Card/ Driving License/ Letter from a recognized public authority or public servant verifying the identity and residence of the customer
Proof of Residence (Any one of the mentioned documents)	Telephone bill/ Bank account statement/ Letter from any recognized public authority/ Electricity bill/ Ration card

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