

FORM 2: CLAIM FORM						
IFFCO TOKIO GENERAL INSURANCE COMPANY LIMITED						
CLAIM FORM - PART A (TO BE FILLED IN BY INSURED)						
INSURANCE DETAILS						
Policy No			SNo/ Certificate No:			
Company/ TPA ID No			Name of Proposer			
Address of Proposer (Primary Insured)						
Name of Claimant						
Relation to proposer			Date of Birth		Age	
Address						
Gender		Male / Female		Occupation		
Telephone No			Mobile No			
E-mail ID, if any						
Insurance History		Date of commencement of first Insurance for the person				
Are you presently covered with any other Mediclaim / Health Insurance?					Y/N	
If Y, give details - Company / Policy No / Sum Insured (Attach Policy copies)						
Primary Insured's Bank Account particulars			PAN No.			
Account Number				Bank Name		
Branch				IFSC Code		
HOSPITALIZATION DETAILS						
Name of the Hospital where admitted						
Room Type-Day care / Single / Twin sharing etc...						
Past Hospitalisation		Y/N	Month and Yr		DIAGNOSIS:	
Hospitalisation due to: Illness / Injury / Maternity				Details		
Date of Injury / Disease first detected / LMP						
If injury, how it occurred						
If injury, whether Medico legal		Y/N	If MLC, reported to police?		Y/N (Enclose MLC /FIR)	
Is claim is for Domiciliary Hospitalisation ?			Y/N (If Y, provide details in annexur			
EXPENSES AND BILLING DETAILS						
Pre-hospitalisation Expenses		Rs.	Hospitalisation Expenses		Rs.	
Post-hospitalisation Expenses		Rs.	Health-Check up Cost		Rs.	
Ambulance Charges		Rs.	Others		Rs.	
Details of Lumpsum / cash benefit claimed:						
Hospital Daily Cash		Surgical Cash			Critical Illness benefit	
Convalescence:		Pre / Post hosp lumpsum benefit:			Others	
Details of bills enclosed (attach separate sheet, if space inadequate)						
Sl.	Bill No	Date	Issued By		Towards	Amount
Details of Claim Documents submitted - CHECK LIST						
Claim Form Duly signed		Y	N	Pre-hosp Bills: ____ Nos		Y N
Copy of the claim intimation		Y	N	Post-hosp Bills: ____ Nos		Y N
Hospital Discharge Summary		Y	N	Investigation Reports		Y N
Operation Theatre Notes		Y	N	Doctor request for investigation		Y N
Hospital Main Bill		Y	N	ECG		Y N
Hospital Break-up Bill		Y	N	Pharmacy Bills		Y N
Hospital Bill Payment Receipt		Y	N	MLC Report & Police FIR		Y N
Doctor's Prescriptions		Y	N	Any other, please specify		Y N
Date:			Signature of the Primary Insured / Claimant			



CLAIM FORM - PART B			
TO BE FILLED IN BY THE HOSPITAL			
Name of the Hospital			Hosp ID
Type of Hospital	Network	Non Network	
In case of non network , please provide below details			
Address of the Hospital with Pin Code			
Telephone No		Registration no.	
Number of Inpatient beds		PAN	
Other Facilities available in the hospital		OT	Y/N
ICU	Y/N	Others	
Details of the patient admitted			
Name of the patient		IP Registration Number	
Gender		Age	
Date of Admission		Time of Admission	
Date of Discharge		Time of Discharge	
Ailment Diagnosed (Primary)			
ICD 10-CM Code	Primary	Additional	Co-
Details of Procedure/s			
ICD 10 PCS Code	Proc 1	Proc 2	Proc 3
Type of Admission	Emergency	Planned	Day-care Maternity
Date of delivery if Maternity		Gravida Status	
8. Is the treatment for an injury? If, Y, details.			
Was it self inflicted?	Y/N	Whether RTA	Y/N
If MLC, notified to police?	Y/N	MLC / FIR No.	
If MLC not notified, give reasons			
Was the Injury/ disease caused due to Substance abuse / Alcohol consumption			Y/N
If Y, whether any test was conducted to establish this? If Y, please attach Report			Y/N
Is present ailment a complication of Pre-existing disease		Y/N	
If Y, specify details			
Whether Pre-authorisation obtained - Y/N		If Y, Pre Auth Number	
If authorisation by network hospital not obtained, reason?			
Name of Treating Doctor		Registration No	
Mobile No		Qualification	
13. Claim Documents submitted (CHECK LIST)			
Claim Form Duly signed		Investigation Reports	
Original Pre-authorisation request		Investigation Reports (Including CT / MRI / USG / HPE)	
Copy of the preauthorisation approval letter		Doctor's Reference Slip for investigation	
Hospital Discharge Summary		ECG	
Operation Theatre Notes		Pharmacy Bills	
Hospital Main Bill		MLC Report & Police FIR	
Hospital Break-up Bill		Any other, please specify	
Date:	Signature of the Primary Insured / Claimant		