



**ICICI LOMBARD GENERAL INSURANCE COMPANY LIMITED**

**CLAIM FORM – SWASTHYA BIMA YOJNA**

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

Please give the following information correctly and completely

ICICI Lombard Claim No \_\_\_\_\_

Package  Non-Package

Pre Authorization obtained: Yes  No

1.	Type of Claim : Day Care / Other Hospitalization	
2.	Name of the Policy Holder	
3.	Details of the Insured Person in respect of whom claim is made: Name of Insured Relationship with the Policy Holder Present completed age Occupation: Current Residential address with Telephone No.	
4.	Member ID No.( Client ID ) UHID No. ( Insurance Scheme ID ) Sum Insured ( Claimant )	
5.	Nature of disease / illness contracted or injury suffered for which insured was hospitalized	
6.	Date of injury sustained or disease / illness first detected	
7.	Details of the Hospital/ Nursing Home in which treatment was taken Name of the Hospital/ Nursing Home Is it a government Hospital	

	Registration number ( Rubber stamp of the doctor & hospital																															
8.	Date of Admission: Date Of Discharge :																															
9.	Date of attending Details of the attending Medical practitioner Name Qualification & Registration No. Address with Telephone No.																															
10.	Details of the amount claimed :Total Claimed amount																															
	<table border="1"> <thead> <tr> <th></th> <th>Bill No. / Date</th> <th>Amount .</th> <th>Whether Bills attached</th> <th>Whether bills attested by Treating Doctor / Medical Officer</th> </tr> </thead> <tbody> <tr> <td>Doctors Fees</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Medicines</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Hospitalization Bills</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Other charges</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td><b>Total</b></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		Bill No. / Date	Amount .	Whether Bills attached	Whether bills attested by Treating Doctor / Medical Officer	Doctors Fees					Medicines					Hospitalization Bills					Other charges					<b>Total</b>					
	Bill No. / Date	Amount .	Whether Bills attached	Whether bills attested by Treating Doctor / Medical Officer																												
Doctors Fees																																
Medicines																																
Hospitalization Bills																																
Other charges																																
<b>Total</b>																																
11.	Details of Claimed amount ( Part two) Pre - hospitalization Hospitalization Post – hospitalization																															

In support of the above claim, I enclose documents in original as per the checklist annexed.  
(Annexure-I)

{Please indicate by ( ✓ )}

Total No. of Pages enclosed:

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 are 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 and that I shall not be entitled to all/any rights to 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.

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:

Address for correspondence

Signature of Claimant



Corporate Office Address : ICICI Lombard General Insurance company limited, Zenith house,  
Keshavrao Khadye Marg, Opp. Race course, Mahalaxmi , Mumbai - 400034

**Annexure – I**

**CHECKLIST OF DOCUMENTS TO BE SUBMITTED ALONG WITH THE CLAIM FORM**

- Attested Copies of Final Bill for the period of hospitalization.
- Attested Copies of Discharge Summary.
- Attested Copies of Prescriptions for the medicines.
- Attested Copies of Relevant Diagnostic reports.
- Copy of Authorization letter issued in response to Admission request letter (Annexure-II) for Non-Package / Offline transactions.
- Copy of Smart Card / BPL card issued to the beneficiary.
- Copy of Transaction slips generated at the POS i.e. Block & Claim entries.
- Receipt of Travel allowance paid to the beneficiary.
- Acknowledgement by the beneficiary of Pre / Post hospitalization treatment provided.



ADMISSION REQUEST LETTER

PART - A TO BE FILLED BY THE TREATING CONSULTANT

Name of the Insured : \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_\_\_

UHID No.: \_\_\_\_\_ Policy No.: \_\_\_\_\_

Insured Contact No.: \_\_\_\_\_

Corporate/Organization Name: \_\_\_\_\_

Individual: Yes/No

Advised Admission/Admitted under Dr.: \_\_\_\_\_

Hospital Name: \_\_\_\_\_

Date of First consultation: \_\_\_\_\_

Name of Doctor first consulted: \_\_\_\_\_

History of presenting complaints: \_\_\_\_\_

Relevant Clinical Findings: \_\_\_\_\_

Provisional/Differential Diagnosis: \_\_\_\_\_

Proposed Line of Treatment: \_\_\_\_\_

Surgery/Procedure Detail (if any): \_\_\_\_\_

Details of Past History: \_\_\_\_\_

History of the following:

Past History of Hypertension: Yes/No/Notknown If Yes, since when \_\_\_\_\_

Past History of Diabetes: Yes/No/Notknown If Yes, since when \_\_\_\_\_

Past History of IHD: Yes/No/Notknown If Yes, date of 1<sup>st</sup> Episode \_\_\_\_\_

Is it a Accident Case: Yes/No If Yes, was the patient under the influence of alcohol: Yes/No

In case of Accident fax the MLC Copy.

In Maternity Cases: Gravida \_\_\_\_\_ Para \_\_\_\_\_ Living Children \_\_\_\_\_

Likely Date of Admission: \_\_\_\_\_ Approximate duration of stay: \_\_\_\_\_

Approximate Expenses: \_\_\_\_\_ Class of accomodation: \_\_\_\_\_

Name of Doctor: \_\_\_\_\_ Signature/Stamp of Doctor \_\_\_\_\_

Contact No.: \_\_\_\_\_ Registration No.: \_\_\_\_\_

PART - B TO BE FILLED BY THE INSURED

I have no objection to ICICI Lombard obtaining details of my treatment/collecting documents and also hereby authorize ICICI Lombard to pay the hospital bill.

If my Claim is rejected, I here by undertake to pay for the hospital & related expenses.

I acknowledge and agree that information provided by me is true & to the best of my knowledge.

Previous Policy details - Policy No. \_\_\_\_\_ Insurance Company \_\_\_\_\_

Previous claim details, Ailment \_\_\_\_\_ Date \_\_\_\_\_ Amount \_\_\_\_\_

Name \_\_\_\_\_ Signature \_\_\_\_\_