RELIANCE
Life Insurance

Reimbursement Claim Form

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

(To be filled in BLOCK LETTERS)

DETAILS OF THE PRIMARY INSURED

Policy No. **SI No./Certificate No.**

Company/TPA ID No.

Name FIRST LAST

Address C/o. FIRST LAST FLAT NO.

BUILDING ROAD NAME/NO.

LANDMARK 1

DISTRICT/TALUKA LANDMARK 2

CITY/VILLAGE STATE

Pincode MOBILE 1 MOBILE 2

STD ISD Code LANDLINE EMAIL ADDRESS

DETAILS OF INSURANCE HISTORY

Currently covered by any other Mediclaim/Health Insurance Yes No

Date of commencement of first insurance without break (copies of policies to be attached) DDMMYEAR

If yes, Company name **Policy No.**

Sum Insured (Rs.) **Have you been hospitalised in the last 4 years?** Yes No

Date DDMMYEAR **Diagnosis**

Previously covered by any other Mediclaim/Health insurance Yes No **If yes, Company name**

DETAILS OF INSURED PERSON HOSPITALISED

Name FIRST LAST

Gender Male Female **Age** Years Months **Date of Birth** DDMMYEAR

Relationship to Primary Insured Self Spouse Child Father Mother Other (Please Specify)

Occupation Service Self-Employed Homemaker Student Retired Other (Please Specify)

Address (if different from above) FIRST LAST FLAT NO.

BUILDING ROAD NAME/NO.

LANDMARK 1

DISTRICT/TALUKA LANDMARK 2

CITY/VILLAGE STATE

Pincode MOBILE 1 MOBILE 2

STD ISD Code LANDLINE EMAIL ADDRESS

DETAILS OF INSURED PERSON HOSPITALISED

Name of the hospital where admitted

Room category occupied Day care Single occupancy Twin sharing 3 or more beds per room

Hospitalisation due to Injury Illness Maternity

Date of injury/Date disease first detected/Date of delivery DDMMYEAR

Date of admission DDMMYEAR **Time** MMHH

Date of discharge DDMMYEAR **Time** MMHH

If injury, give cause Self-Inflicted Road traffic accident Substance abuse/Alcohol consumption

If Medico legal Yes No **Reported to police** Yes No **MLC report & police FIR attached** Yes No

System of medicine

(Important: Please Turn Over)

DETAILS OF THE CLAIM

Details of the treatment expenses claimed

Pre-hospitalisation expenses		Hospitalisation expenses	
Post-hospitalisation expenses		Health check-up cost	
Ambulance charges		Others (code)	
		Total	

Pre-hospitalisation period ____ Days Post-hospitalisation period ____ Days

Claim for domiciliary hospitalisation ☐ Yes ☐ No (If yes, provide details in the annexure)

Details of lump cum/Cash benefit claimed

Hospital daily cash		Surgical cash	
Critical illness benefit		Convalescence	
Pre/Post hospitalisation		Others	
Lump sum benefit		**Total**	

CLAIM DOCUMENTS SUBMITTED (CHECK LIST)

☐ **Claim form duly signed**	☐ **Copy of the claim intimation**	☐ **Hospital discharge summary**	☐ **Doctors request for investigation**
☐ **Hospital main bill**	☐ **Hospital break-up bill**	☐ **Operation theatre notes**	☐ **Doctors prescriptions**
☐ **Hospital bill payment receipt**		☐ **Pharmacy bill**	☐ **ECG**
☐ **Investigation reports (Including CT/MRI/USG/HPE)**	☐ **Others**		

Details of Bills Enclosed

Sl No.	Bill No.	Date	Issued by	Towards	Amount (Rs)
1		D D M M Y Y Y Y		Hospital Main Bill	
2				Pre-hospitalisation Bills __ Nos	
3				Post-hospitalisation Bills __ Nos	
4				Pharmacy Bills	
5					
6					
7					
8					
9					
10					

DETAILS OF THE PRIMARY INSUREDS BANK ACCOUNT

PAN Card No. **Account No.**

Bank name and Branch BANK NAME

BRANCH NAME

Cheque/DD Payable details **IFSC Code**

Declaration by the Insured

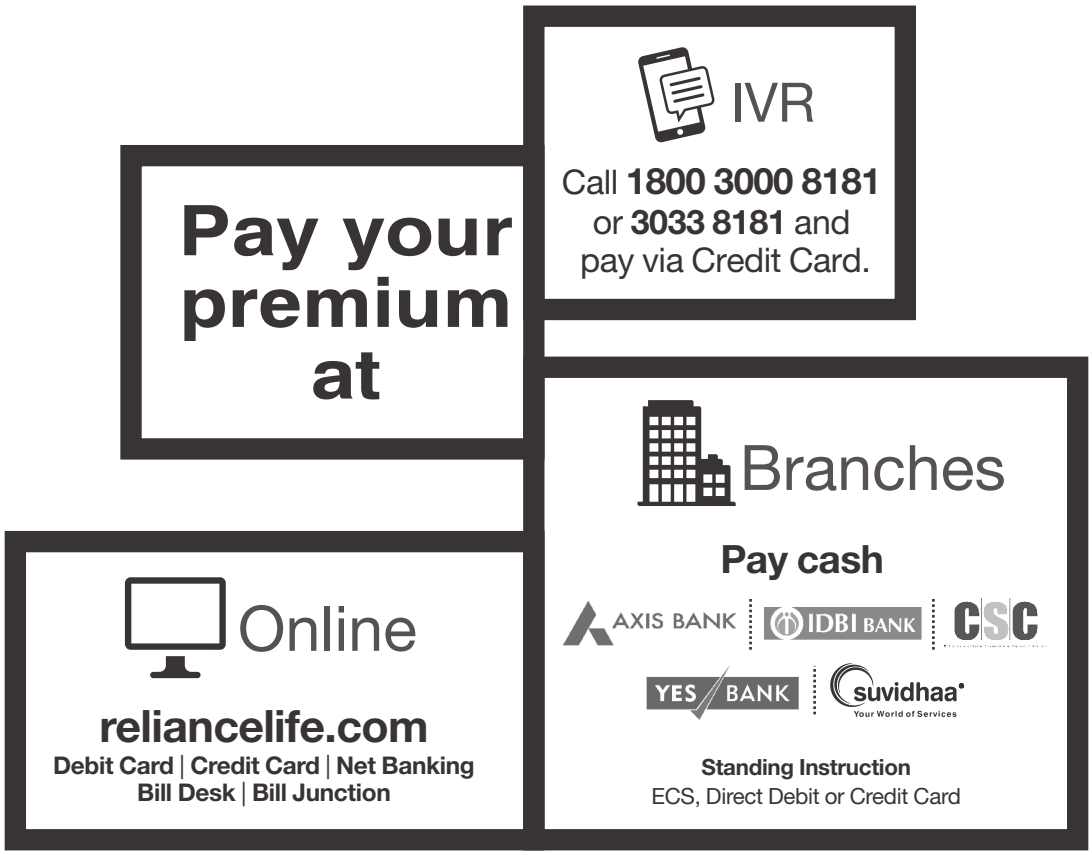
I hereby declare that the information furnished in this claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact, my right to claim reimbursement shall be forfeited. I also consent & authorise TPA/Insurance company, to seek necessary medical information/documents from any hospital/Medical Practitioner 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.

Date D D M M Y E A R **Place**

Signature of the Insured

GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled in by the 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 the social health insurance scheme	As allotted by the organisation
c) Company TPA ID No.	Enter the TPA ID No.	License number as allotted by IRDAI
d) Name	Enter the full name of the policyholder	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 organisation 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 hospitalised in the last	Indicate whether hospitalised in the last 4 years	Tick Yes or No
4 years		
Date	Enter the date of hospitalisation	Use mm-yy format
Diagnosis	Enter diagnosis details	Open text
e) Previously Covered by any other Mediclaim/Health Insurance?	Indicate whether previously covered by any other Mediclaim/Health Insurance	Tick Yes or No
f) Company name	Enter the full name of the insurance company	Name of the organisation in full
SECTION C DETAILS OF THE INSURED PERSON HOSPITALISED		
a) Name	Enter 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 & months
d) Date of Birth	Enter Date of Birth of the patient	Use dd-mm-yy format
e) Relationship to primary Insured	Indicate relationship of patient with the policyholder	Tick the right option. If others, please specify
f) Occupation	Indicate occupation of the 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 the patient	Include STD code with telephone number
i) E-mail ID	Enter e-mail address of the patient	Complete e-mail address
SECTION D DETAILS OF HOSPITALISATION		
a) Name of the hospital where admitted	Enter the name of the hospital	Name of the hospital in full
b) Room category occupied	Indicate the room category occupied	Tick the right option
c) Hospitalisation due to	Indicate reason of hospitalisation	Tick the right option
d) Date of injury/date of diseases 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 the 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 & police FIR attached	Tick Yes or No

GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled in by the Insured)		
DATA ELEMENT	**DESCRIPTION**	**FORMAT**
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 hospitalisation	Indicate whether claim is for domiciliary hospitalisation	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 THE BILLS ENCLOSED		
Indicate which bills are enclosed with the amount in Rupees		
SECTION G DETAILS OF PRIMARY INSUREDS BANK ACCOUNT		
a) PAN Card No.	Enter the permanent account number	As allotted by the Income Tax department
b) Account No.	Enter the Bank account number	As allotted by the Bank
c) Bank name & 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/organisation 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) & sign.		



Reliance Life Insurance Company Limited IRDAI Registration No. 121.
Insurance is the subject matter of the solicitation.

Mktg/Premium Payment-Sticker/V1/April 2015.

Reliance Life Insurance Company Limited

Registered Office: H Block, 1st Floor, Dhirubhai Ambani Knowledge City, Navi Mumbai, Maharashtra 400710, India.

Corporate Office: 9th & 10th Floor, Building No 2, R-Tech Park, Nirlon Compound, Goregaon (East) Mumbai 400063, India.

Call us: 3033 8181 or 1800 3000 8181 (Toll Free)

Email us: rlife.customerservice@relianceada.com

Visit us: www.reliancelife.com

Like us on Facebook www.facebook.com/RelianceLifeInsurance

Follow us on Twitter @rel_life

CIN:U66010MH2001PLC167089

Reimbursement Claim Form

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 pre-authorisation request form in lieu of PART A

(To be filled in BLOCK LETTERS)

DETAILS OF THE HOSPITAL

Name of the hospital
Hospital ID **Type of hospital** ☐ Network ☐ Non-network (If non-network, fill Section E)
Name of the treating doctor
Qualification **Registration No. with state code**
Phone No.

DETAILS OF THE PATIENT ADMITTED

Name of the patient FIRST LAST
IP registration No. **Gender** ☐ Male ☐ Female **Age** Years Months
Date of birth DDMMYEAR **Date of admission** DDMMYEAR **Time** MMHH
Date of discharge DDMMYEAR **Time** MMHH **Type of admission** ☐ Emergency ☐ Planned ☐ Day Care
☐ Maternity If Maternity, date of delivery DDMMYEAR Gravida Status
Status at the time of discharge ☐ Discharge to home ☐ Discharge to another hospital ☐ Deceased

DETAILS OF THE AILMENT DIAGNOSED (PRIMARY)

ICD 10 quotes	Description	CD 10 PCS	Description
i. Primary diagnosis		i Procedure 1	
ii Additional diagnosis		ii Procedure 2	
iii Co-morbidities		iii Procedure 3	
iv Morbidities		iv Details of procedure	

Present ailment is a complication of PED? ☐ Yes ☐ No (If Yes, specify details)
Pre-authorisation obtained ☐ Yes ☐ No **Pre-authorisation No.**
If authorisation by network hospital not obtained, give reasons
Hospitalisation due to injury ☐ Yes ☐ No If yes, give cause ☐ Self-inflicted ☐ Road traffic accident ☐ Substance abuse/Alcohol consumption
If injury due to substance abuse/alcohol consumption. Test conducted to establish this ☐ Yes ☐ No (If Yes, attach reports)
If Medico legal ☐ Yes ☐ No **Reported to police** ☐ Yes ☐ No **FIR No.**
If not reported to police, give reasons

CLAIM DOCUMENTS SUBMITTED-CHECK LIST

- ☐ **Claim Form Duly Signed**
- ☐ **Original pre-authorisation request**
- ☐ **Copy of pre-authorisation approval letter**
- ☐ **Copy of photo ID card of patient verified by hospital**
- ☐ **Hospital discharge summary**
- ☐ **Operation theatre notes**
- ☐ **Hospital main bills**
- ☐ **Hospital break-up bills**
- ☐ **Investigation reports**
- ☐ **CT/MR/USH/HPE Investigation reports**
- ☐ **Doctors reference slip for investigation**
- ☐ **ECG**
- ☐ **Pharmacy bills**
- ☐ **MLC report and police 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 BUILDING

ROAD NAME/NO.

DISTRICT/TALUK LANDMARK 1

CITY/VILLAGE LANDMARK 2

STATE

Pincode LANDLINE

Registration No. **PAN Card No.**

No. of inpatient beds **Facilities available at the hospital** **OT** Yes No **ICU** Yes No **Others**

DECLARATION BY THE INSURED (PLEASE READ VERY CAREFULLY)

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 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.

Date DDMMYEAR **Place**

Signature of the Insured

DECLARATION BY THE HOSPITAL (PLEASE READ VERY CAREFULLY)

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. This signature of the insured is taken on this form after claim Form B is fully filled up by us.

Date DDMMYEAR **Place**

Signature of Hospital Authority (with Hospital stamp)

GUIDANCE FOR FILLING THE CLAIM FORM PART B (to be filled in by the Hospital)		
DATA ELEMENT	**DESCRIPTION**	**FORMAT**
SECTION A DETAILS OF HOSPITAL		
a) Name of the hospital	Enter the name of the hospital	Name of the hospital
b) Hospital ID	Enter ID number of the hospital	As allocated by the TPA
c) Type of the hospital	Indicate whether in network or non-network hospital	Tick the right option
d) Name of the treating doctor	Enter the name of the treating doctor	Name of the doctor in full
e) Qualification	Enter the qualifications of the treating doctor	Abbreviation of educational qualification
f) Registration No. with state code	Enter the registration number of the doctor along with the state code	As allocated by the Medical Council of India
g) Phone No.	Enter the phone number of the doctor	Include STD code with telephone number
SECTION B DETAILS OF THE PATIENT ADMITTED		
a) Name of the patient	Enter the name of the patient	Name of the patient in full
b) IP Registration No.	Enter insurance provider registration number	As allotted by the insurance provider
c) Gender	Indicate gender of the patient	Tick Male or Female
d) Age	Enter age of the patient	Number of years and month
e) Date of admission	Enter the date of admission	Use dd-mm-yy format
f) Time	Enter the time of admission	Use hh-mm format
g) Date of discharge	Enter the date of discharge	Use dd-mm-yy format
h) Time	Enter the time of discharge	Use hh-mm format
i) Type of admission	Indicate type of admission of patient	Tick the right option
j) If Maternity		
Date of delivery	Enter the date of delivery, if maternity	Use dd-mm-yy format
Gravida Status	Enter Gravida Status, if maternity	Use standard format
k) Status at the time of discharge	Indicate the status of the patient at time of discharge	Tick the right option

GUIDANCE FOR FILLING THE CLAIM FORM PART B (to be filled in by the Hospital)		
DATA ELEMENT	**DESCRIPTION**	**FORMAT**
SECTION C DETAILS OF AILMENT DIAGONISED (PRIMARY)		
a) ICD 10 Code		
Primary diagnosis	Enter the ICD 10 Code and description of the primary diagnosis	Standard format and open text
Additional diagnosis	Enter the ICD 10 Code and description of the additional diagnosis	Standard format and open text
Co-morbidities	Enter the ICD 10 Code and description of the co-morbidities	Standard format and open text
b) ICD 10 PCS		
Procedure 1	Enter the ICD 10 PCS and description of the first procedure	Standard format and open text
Procedure 2	Enter the ICD 10 PCS and description of the second procedure	Standard format and open text
Procedure 3	Enter the ICD 10 PCS and description of the third procedure	Standard format and open text
Details of the procedure	Enter the details of the procedure	Open text
c) Present ailment is a complication of PED	Indicate whether present ailment is a complication of some pre-existing disease	Tick Yes or No
d) Pre-authorisation obtained	Indicate whether pre-authorisation is obtained	Tick Yes or No
e) Pre-authorisation number	Enter pre-authorisation number	As alloted by TPA
f) If authorisation by network hospital not obtained, give reasons	Enter reason for not obtaining pre-authorisation number	Open text
g) Hospitalisation due to injury	Indicate whether hospitalisation is due to injury	Tick Yes or No
Cause	Indicate cause of injury	Tick the right option
If injury due to substance abuse/alcohol consumption, test conducted to establish this	Indicate whether test conducted	Tick Yes or No
Medico legal	Indicate whether injury was Medico legal	Tick Yes or No
Reported to police	Indicate whether police report was filed	Tick Yes or No
FIR No.	Enter the first information report number	As issued by the police authorities
If not reported to police, give reason	Enter the reason for not reporting it to police	Open text
SECTION D CLAIM DOCUMENTS SUBMITTED - CHECK LIST		
Indicate which supporting documents are submitted		
SECTION E DETAILS IN CASE OF NON NETWORK HOSPITAL		
a) Address	Enter the full Postal address	Include Street, City & Pin Code
b) Phone No.	Enter the phone number of the hospital	Include STD code with telephone number
c) Registration No.	Enter registration number of the patient	As allotted by the hospital
d) PAN Card No.	Enter the permanent account number	As allotted by the Income Tax department
e) Number of in patient beds	Enter the number of in patient beds	Digits
f) Facilities available at the hospital	Indicate facilities available at the hospital	Tick the right option. If others, please specify
SECTION F DECLARATION BY THE INSURED		
Read Declaration carefully and mention date in (dd/mm/yy format), place (open text) & sign.		
SECTION G DECLARATION BY THE HOSPITAL		
Read Declaration carefully and mention date in (dd/mm/yy format), place (open text), sign & stamp.		