

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 F I R S T										
Address C/o. F I R S T										
B U I L D I N G									N	
D I S T R I C T / T A L U K									K	2
C I T Y / V I L L A G E							Т	А	Т	Е
Pincode M 0 B I L	E 1 M	0 B	I L							
STD ISD Code L A N D L I N E										
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)	D D								
If yes, Company name	Po	olicy No.								
Sum Insured (Rs.) Have you be	een hospitalised in the last 4	4 years?	Yes	- N	lo					
Date D D M M Y E A R Diagnosis										
Previously covered by any other Mediclaim/Health insurance	Yes No If yes, Con	npany na	ime							
DETAILS OF INSURED PERSON HOSPITALISED		_		_	-					_
Name F I R S T							L	Α	S	
Canalau Mala Fanada Ana Vasus										
Gender Male Female Age Years	Months Date of Birth	D D	ММ							
Relationship to Primary Insured Self Spouse Child	Father Mother		M M er (Pleas							
Relationship to Primary Insured Self Spouse Child Occupation Service Self-Employed Homemaker			M Mer (Pleaser (Please							
Relationship to Primary Insured Self Spouse Child	Father Mother									0.
Relationship to Primary Insured Self Spouse Child Occupation Service Self-Employed Homemaker	Father Mother									0.
Relationship to Primary Insured Self Spouse Child Occupation Service Self-Employed Homemaker	Father Mother									0. 0. 1
Relationship to Primary Insured Self Spouse Child Occupation Service Self-Employed Homemaker	Father Mother									0. 0. 1
Relationship to Primary Insured Self Spouse Child Occupation Service Self-Employed Homemaker Address (if different from above) F I R S T B U I L D I N G D I S T R I C T / T A L U K C I T Y / V I L L A G E	Father Mother						T E A A T	/ R R	N N K K	0. 0. 1 2 E
Relationship to Primary Insured Self Spouse Child Occupation Service Self-Employed Homemaker Address (if different from above) F I R S T B U I L D I N G D I S T R I C T / T A L U K C I T Y / V I L L A G E Pincode M O B I L	Father Mother	Others T R O	A D L L	A A E			T E A A T	/ R R	N N K K	0. 0. 1 2 E
Relationship to Primary Insured Self Spouse Child Occupation Service Self-Employed Homemaker Address (if different from above) F I R S T B U I L D I N G D I S T R I C T / T A L U K C I T Y / V I L L A G E Pincode M O B I L SID ISO Code L A N D L I N E	Father Mother	Others T R O		A A E		A M M M S	T E A A T	/ R R	N N K K T	0. 0. 1 2 E
Relationship to Primary Insured Self Spouse Child Occupation Service Self-Employed Homemaker Address (if different from above) F I R S T B U I L D I N G D I S T R I C T / T A L U K C I T Y / V I L L A G E Pincode L A N D L I N E DETAILS OF INSURED PERSON HOSPITALISED	Father Mother	Others T R O	A D L L	A A E		A M M S	T E A A T	/ R R	N N K T	0. 0. 1 2 E
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DE	ETAILS OF THE CLAIM																		
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	hospitalisation expenses											Health check-up cost							
Ambı	ulance charges											Others (code)							
												Total							
	ospitalisation period					D	ays					st-hospitalisation period	Day	/S					
Clain	n for domiciliary hospita	lisa	tion		Ye	S	N	lo (l	lf ye	s, provide detail	s in the an	nexure)							
Detai	ils of lump cum/Cash be	enefi	it cla	aime	ed														
Hosp	ital daily cash											Surgical ca	ish						
Critic	al illness benefit											Convalescer	ice						
Pre/P	ost hospitalisation											Oth	ers						
Lump	sum benefit											То	tal						
CL	AIM DOCUMENTS SUBMITT	ED (0	CHEC	K LI	ST)														
•	Claim form duly signed				С	ору	of t	he c	lain	n intimation	Hospital	discharge summary	Doctor	s requ	est f	or in	vest	tigat	tion
	Hospital main bill				Н	osp	ital	brea	ık-u	p bill	Operation	on theatre notes	Doctor	s pres	cript	ions			
ı	Hospital bill payment re	ceip	t								Pharma	cy bill	ECG						
	Investigation reports (In	clud	ling	CT/	MRI	/US	G/H	IPE)		Others									
Detai	ils of Bills Enclosed																		
					_												(D.)		
SI N	o. Bill No.				Da	ate				Issu	ed by	Toward	S		Amo	ount	(Ks)		
1		D	D	M	M	Υ	Υ	Υ	Υ			Hospital Main Bill							
2												Pre-hospitalisation E	Bills Nos						
3												Post-hospitalisation	Bills Nos						
4												Pharmacy Bills							
5																			
6																			
7																			
8																			
9																			
10																			
DE	ETAILS OF THE PRIMARY INS	SURE	DS B	ANK	ACC	OUN	T												
	Card No.		Т	Т	Т	T	П	T	П	Account No									
Bank	name and Branch																		
Cheo	ue/DD Payable details											IFSC Code							
	aration by the Insured											11 00 0000							
												est of my knowledge and b							
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claim		e tha	at I h	nave	incl	ude						of this claim & that I will n							
Date		E	A	R		,. Pla	се												

DATA ELEMENT DESCRIPTION SECTION A DETAILS OF PRIMARY INSURED a) Policy No. Enter the policy number As allotted by the insurance compound of the social insurance number or the certificate number of the social health insurance scheme c) Company TPA ID No. Enter the TPA ID No. License number as allotted by IRE a) Policy No. Enter the full name of the policyholder 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? b) Date of commencement of first insurance without break c) Company name Enter the full name of the insurance company Name of the organisation in full Enter the full name of the insurance company Name of the organisation in full)AI
a) Policy No. Enter the policy number As allotted by the insurance composition number of the social insurance number or the certificate number of the social health insurance scheme c) Company TPA ID No. Enter the TPA ID No. Enter the full name of the policyholder Enter the full postal 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? b) Date of commencement of first insurance without break c) Company name Enter the full name of the insurance company Name of the organisation Name of the organisation Name of the organisation Name of the organisation Name of the organisation in full)AI
b) SI. No./Certificate No. Enter the social insurance number or the certificate number of the social health insurance scheme c) Company TPA ID No. Enter the TPA ID No. Enter the full name of the policyholder Enter the full postal 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? b) Date of commencement of first insurance without break c) Company name Enter the full name of the insurance company Name of the organisation Name of the organisation Name of the organisation in full)AI
number of the social health insurance scheme c) Company TPA ID No. Enter the TPA ID No. License number as allotted by IRC d) Name Enter the full name of the policyholder 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 b) Date of commencement of first insurance without break c) Company name Enter the full name of the insurance company Name of the organisation in full	
d) Name Enter the full name of the policyholder 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 b) Date of commencement of first insurance without break c) Company name Enter the full name of the insurance company Name of the organisation in full	
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 b) Date of commencement of first insurance without break c) Company name Enter the full name of the insurance company Name of the organisation in full	ne
a) Currently covered by any other Mediclaim	
a) Currently covered by any other Mediclaim Indicate whether currently covered by another Tick Yes or No Mediclaim/Health Insurance b) Date of commencement of first insurance Enter the date of commencement of first insurance without break c) Company name Enter the full name of the insurance company Name of the organisation in full	
/Health Insurance? Mediclaim/Health Insurance b) Date of commencement of first insurance Enter the date of commencement of first insurance without break c) Company name Enter the full name of the insurance company Name of the organisation in full	
without break c) Company name Enter the full name of the insurance company Name of the organisation in full	
Dellas Na	
Policy No. Enter the policy number As allotted by the insurance comp	any
Sum insured Enter the total sum insured as per the policy In rupees	
d) Have you been hospitalised in the last	
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 Nam	ıe
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	
e) Relationship to primary Insured Indicate relationship of patient with the policyholder Tick the right option. If others, ple specify	ase
f) Occupation Indicate occupation of the patient Tick the right option. If others, please specify	ase
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	
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	

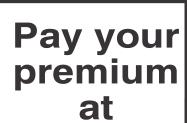
GUIDANCE	FOR FILLING CLAIM FORM - PART A (To be filled in by	y the Insured)
DATA ELEMENT	DESCRIPTION	FORMAT
	SECTION E DETAILS OF CLAIM	
a) Details of treatment expenses	Enter the amount claimed as treatment expenses	In rupees (Do not enter paise values)
b) Claim for domiciliary hospitalisation	Indicate 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

SEC	FION G DETAILS OF PRIMARY INSUREDS BANK ACC	DUNT
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.





reliancelife.com

Debit Card | Credit Card | Net Banking Bill Desk | Bill Junction

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

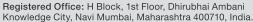




Mktg/Premium Payment-Sticker/V1/April 2015.

Reliance Life Insurance Company Limited



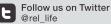
















Reimbursement Claim Form

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 b	e fille	ed in l	BLO(CK L	ETTI	ERS)
DETAILS OF THE	10SPI	TAL																												
Name of the hospi	tal																													
Hospital ID			Ī										Тур	e of	hos	pital		Net	work		Nor	n-net	wor	k (If	non	-netv	vork,	fill S	ectio	on E)
Name of the treating	ng do	ctor																												
Qualification																Reg	gistr	ation	ı No	. wit	h st	ate d	code		1	1				
Phone No.																1											1	1		
DETAILS OF THE	PATIEN	NT AD	MIT	ΓED																										
Name of the patier	t	F		R	S	Т																				L	Α	S	Т	
IP registration No.													Ger	nder		Male	е		Fem	ale		Age	-		Yea	ars			Mor	nths
Date of birth	D	IVI	IVI	Υ	Е	Α	R				Da	te of	adn	nissi	on	D	D	IVI	IVI	Υ	Е	Α	R			Time	IVI	IVI	Н	Н
Date of discharge	D	D	IVI	IVI	Υ	Е	Α	R	Ti	me	IVI	IVI	Н	Н	Т	уре	of a	dmis	sion		Em	erge	ncy		Pla	ınned	ı	Day	Car	е
Maternity	If Ma	terni	ty, d	ate o	f deli	very	D	D	M	M	Υ	Е	Α	R	Gr	avida	a Sta	atus							_			1 -		
Status at the time	of dis	char	ge		Disc	harg	ge to	hom	ie		Disc	charg	je to	anot	ther	hosp	oital		Dec	ease	ed		_							
DETAILS OF THE	AILME	NT DI	AGN	OSED	(PRII	MARY	/)																							
	IC	CD 1	0 qu	otes						Desc	rip	tion						CI	D 10	PCS	3						Desc	cript	ion	
i. Primary diagn	osis												i	i Pro	cedu	ure 1										1				
ii Additional diag	gnosis	s											T _i	ii Pro	ced	ure 2)									1				
iii Co-morbiditie	s												i	iii Pro	oceo	lure 3	3								1	1				
iv Morbidities													 	iv De	tails	of p	roce	dure							1	1				
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Present ailment is			atio	٦		1		Yes				es, s		y det	tails))	1	1			1	1	_	7	٦	٦	1	1	1	
Pre-authorisation of				Yes		No			autho	Г		No.											<u></u>		<u> </u>	<u> </u>	<u> </u>	<u> </u>		
If authorisation by	netwo	ork h	nosp	ital r	ot o	btaiı	ned,	give	reas	ons																				
Hospitalisation due	to in	jury		Yes		No	If ye	es, gi	ve ca	use		Self	-infli	cted		Roa	d tra	affic a	accic	lent		Suk	ostar	nce a	ıbuse	e/Alc	ohol	cons	sump	otion
If injury due to sub	stanc	e ab	use	/alco	hol d	cons	ump	tion	. Test	t cor	ndu	cted	to e	stab	lish	this		Yes		No	(If Y	es, a	attac	h re	ports	()			1	
If Medico legal	Yes	3	No	Re	port	ed t	o po	lice		Yes		No	FIR	No.									<u> </u>		<u> </u>	<u> </u>	<u> </u>			
If not reported to p	olice,	, give	e rea	sons	8																						<u></u>			
CLAIM DOCUMEN	TS SU	BMIT	TED-	CHEC	K LIS	T										1														
Claim Form D	uly Si	gnec	t													Inv	estiç	gatio	n re	port	s									
Original pre-a	uthori	isati	on re	eque	st											СТ	/MR	/USF	1/HP	E In	ves	tigat	ion	repo	rts					Š
Copy of pre-a	uthori	isatio	on a	ppro	val le	etter										Do	ctors	s refe	eren	ce s	lip f	or in	vest	igat	ion					
Copy of photo	ID ca	ard o	of pa	tient	veri	fied	by h	ospi	tal							EC	G													
Hospital disch	arge	sum	mar	у												Pha	arma	acy b	ills											,
Operation the	atre n	otes	5													ML	C re	port	and	poli	ce F	FIR								Ę
Hospital main	bills															Ori	gina	l dea	ith s	umn	nary	froi	n ho	spit	al w	here	app	licab	le	
Hospital break	-up b	oills														Anv	oth	ner. p	leas	e sn	ecit	īv								

DE.																															=	
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Regist	rati	ion	No.																	P.	AN C	ard N	o									
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			211L K	Jeus	'					,III LIC	s av	aılat	ole a	t the	hos	spita	IOT	1	es	No	ICU	Ye	:S									
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Signature of Hospital Authority (with Hospital stamp)

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

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DATA ELEMENT	DECODIDATION	FORMAT
DATA ELEMENT	DESCRIPTION	FORMAT
	ECTION C DETAILS OF AILMENT DIAGONISED (PRIMA	RY)
) 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
o) 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

Indicate which supporting documents are submitted

	SECTION E DETAILS IN CASE OF NON NETWORK HOS	PITAL
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.

Reliance Nippon Life Insurance Company Limited. IRDAI Registration No: 121. Registered Office: H Block, 1st Floor, Dhirubhai Ambani Knowledge City, Navi Mumbai, Maharashtra 400710. For more information or any grievance, 1. Call us between 9am to 6pm, Monday to our Toll Free Number 1800 102 1010 or 2. Visit us at www.reliancenipponlife.com or 3. Email us at: rulife.customerservice@relianceada.com. Trade logo displayed above belongs to Anil Dhirubhai Ambani Ventures Private Limited & Nippon Life Insurance Company and used by Reliance Nippon Life Insurance Company Limited under license.

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