

# Need to claim? We won't play the claim game!

## **Zuno Health Insurance**

### Claim form - A

#### Instructions:

- 1. This form has to be filled in BLOCK letters by the Insured / Policy Holder.
- 2. The filling up and submission of this Form does not make us liable to accept the Claim.

2. The filling up and submission of this Form does not make us hable to accept the Claim.			
Section A – Details of the primary insured / policyholder			
a) Policy No.: b) Sl. No ./ Certificate No:			
c) Company/ TPA ID No.:			
d) Name: e) Address:			
City: State: Pin code:			
Phone No.: Email ID:			
Section B – Some details of your other/past insurance			
a) Are you currently covered by any other mediclaim/ health insurance: Yes No			
b) Date of start of the first insurance without break:			
c) If yes, company name: Policy number: Sum insured (INR):			
d) Have you been hospitalized in the last four years since the beginning of the policy? Yes no			
Date: DDMMYYYYY Diagnosis:			
e) Were you previously covered by any other mediclaim / health insurance? Yes No			
f) If yes, company name:			
Section C – Details of hospitalized insured person / policy holder			
a) Name:			
b) Gender: Male Female Third gender c) Age: Years Months d) Date of birth: DDMMYYYYY			
e) Relationship with primarily insured: Self Spouse Child Father Mother Other (Please Specify)			
f) Occupation: Service Self-employed Homemaker Student Retired Other (Please Specify)			
g) Address (if different from above): City: State:			
Pin code: i) Email ID:			
Section D – details of hospitalization			
a) Name of hospital where admitted:			
b) Room category occupied: Day care Single occupancy Twin sharing 3 or more beds per room			
c) Hospitalization due to: Injury Illness Maternity			
d) Date of Injury / date disease first detected /date of delivery:			
e) Date of admission: DDMMYYYYY  Time: HHMM			
f) Date of discharged: DDMMYYYYY Time: HHMM			
g) If injury, give cause: Self inflicted Road traffic accident Substance abuse /alcohol consumption			
h) If medico legal: (i)Yes No (ii) Reported to Police: Yes No iii) MLC report & police FIR attached: Yes No			
i) System of medicine:			



Section E – details of claim				
a) Details of the treatment expenses cla	imed			
(i) Pre-hospitalization expenses: ₹		(ii) Hospitalization expenses:	₹	
(iii) Post-hospitalization expenses:	₹	(iv) Health-check-up cost:	₹	
(v) Ambulance charges:	₹	(vi) Others (code)::	₹	
		Total:	₹	
(vii) Pre-hospitalization period:day	/S	(viii) Post-hospitalization period:	days	
b) Claim for domiciliary hospitalization:	Yes No (If Yes, provid	le details in annexure)		
c) Details of lump sum / cash benefit cla	imed:			
(i) Hospital daily cash:		(ii) Surgical cash: Rs.	₹	
(iii) Critical illness benefit:	₹	(iv) Convalescence:	₹	
(v) Pre/Post hospitalization lump sum be	enefit: ₹	(vi) Others:	₹	
		Total:	₹	
Duly signed claim Form Copy of the claim intimation, if any Hospital main bill Hospital break-up bill Hospital discharge summary Hospital bill payment receipt Pharmacy bill  Section F – details of bills enclosed		<ul> <li>Operation theatre notes</li> <li>ECG</li> <li>Doctor's request for investigation</li> <li>Investigation reports (Including CT/MRI / USG / HPE)</li> <li>Doctor's prescriptions</li> <li>Others</li> </ul>		
SI.No. Bill No. Date	Issued by	Towards	Amount (₹)	
1 (DD/MM/YYYY)	133464 59	Hospital main bill	7 tilloune (ty	
2 (DD/MM/YYYY)		Pre-hospitalization bills: Nos		
3 (DD/MM/YYYY)		Post-hospitalization Bills:Nos		
4 (DD/MM/YYYY)	Pharmacy bills			
5 (DD/MM/YYYY)				
6 (DD/MM/YYYY)				
7 (DD/MM/YYYY)				
8 (DD/MM/YYYY)				
9 (DD/MM/YYYY)				
10 (DD/MM/YYYY)				
Section G -details of primarily insured's I  a) PAN:  c) Bank name and branch:  d) Cheque/DD payable details:		Account No.:		



#### Section H - 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 with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent & authorize 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 hospitalization claim, if any.

Date: DDMMYYYYY Place:	Signature of the Insured

Guidance for filling claim form – part A		(to be filled 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	As allotted by the organization	
	certificate number of social health		
	insurance scheme		
c) Company TPA ID no.	Enter the TPA ID No.	License number as allotted by IRDAI	
		and printed in TPA documents	
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	Indicate whether currently covered by	Tick Yes or No	
mediclaim/health insurance?	another Mediclaim / Health Insurance		
b) Date of commencement of first insurance	Enter the date of commencement of first	Use dd-mm-yy format	
without break	insurance		
c) Company name	Enter the full name of the insurance	Name of the organization in full	
	company		
Policy no.	Enter the policy number	As allotted by the insurance company	
Sum insured	Enter the total sum insured as per the	In rupees	
	policy		
d) Have you been hospitalized in the last	Indicate whether hospitalized in the last	Tick Yes or No	
four years since Inception of the contract?	four years		
Date	Enter the date of hospitalization	Use mm-yy format	
Diagnosis	Enter the diagnosis details	Open Text	
e) Previously covered by any other	Indicate whether previously covered by	Tick Yes or No	
mediclaim/health insurance?	another Mediclaim / Health Insurance		
f) Company name	Enter the full name of the insurance	Name of the organization in full	
	company		
Section c - details of insured person hospital	ized		
a) Name	Enter the 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 and months	
d) Date of birth	Enter Date of Birth of patient	Use dd-mm-yy format	
e) Relationship to primary insured	Indicate relationship of patient with	Tick the right option. If others, please	
	policyholder	specify.	
f) Occupation	Indicate occupation of 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 patient	Include STD code with telephone number	
i) E-mail id			



Section d - details of hospitalization  a) Name of hospital where admitted	Enter the name of hospital	Name of hospital in full
b) Room category occupied	Indicate the room category occupied  Tick the right option	
c) Hospitalization due to	Indicate reason of hospitalization	Tick the right option
e) Date of injury/date disease first detected/	Enter the relevant date	Use dd-mm-yy format
date of delivery		
d) 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 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 and Police FIR attached	Tick Yes or No
j) System of medicine	Enter the system of medicine followed in treating the patient	Open Text
Section e - details of claim	0 1	
a) Details of treatment expenses	Enter the amount claimed as treatment expenses	In rupees (Do not enter paise values)
b) Claim for domiciliary hospitalization	Indicate whether claim is for domiciliary hospitalization	Tick Yes or No
C) Details of lump sum/ cash benefit claimed		In rupees (Do not enter paise values)
D) Claim documents submitted check list   Indicate which supporting document submitted		Tick the right option
Section f - details of bills enclosed		
Indicate which bills are enclosed with the am	ounts in rupees	
Section g - details in case of non-network ho	spital	
A) PAN	Enter the permanent account number	As allotted by the Income Tax department
B) account number	Enter the bank account number	As allotted by the bank
C) Bank name and 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/ organization 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		





## **Zuno Health Insurance**

### Claim form - B

#### Instructions:

- To be filled in BLOCK letters by the Insured.
   The issue of this form is not to be taken as an admission of liability.

Section A – details of hospital				
a) Name of hospital:	b) Hospital ID:			
c) Type of hospital: Network				
d) Name of treating doctor:	e) Qualification	:		
f) Registration No. with state code:	g) Phone No.:			
Section B – details of the patient a	dmitted			
a) Name of the patient:	b) IP registration	on No.:		
c) Gender: Male Female	Third Gender d) Age: Y Y M M	e) Date of birth: DDMMYYYY		
f) Date of admission: DDMMY	g) Time: HH MM h) Dat	te of discharge: DDMMYYYY		
i) Time: H H M M j) Type o	of admission: Emergency Planned Day Care	Maternity		
k) If maternity, (i) Date of delivery:	DDMMYYYY ii) Gravida status:			
l) Status at time of discharge: Disc	harge to home Discharge to another hospital	Deceased		
m) Total claimed amount:				
Section C – details of ailment diagr	nosed (primary)			
a)	ICD 10 codes	Description		
(i) Primary diagnosis:				
(ii) Additional diagnosis:				
(iii) Co-morbidities:				
(iv) Co-morbidities:				
b)	ICD 10 codes	Description		
(i) Procedure 1:				
(ii) Procedure 2:				
(iii) Procedure 3:				
(iv) Details of procedure:				
c) Pre-authorization obtained: Yes No d) Pre-authorization No.:				
e) If authorization by network hosp	oital not obtained, give reason:			
f) Hospitalization due to injury: Yes No				
i) If Yes, give cause: Self-inflicted		e/alcohol consumption		
ii) If injury due to substance abuse	/alcohol consumption, test conducted to establish t	this: Yes 🔲 No 📗		
(If Yes, attach reports)				
iii) If medico legal: Yes No	iv) Reported to police: Y	′es No		
(v) FIR No.:	(vi) If not reported, give reason:			



Section D – claim documents submitted	– checklist		
Claim form duly signed		Investigation reports	
Original pre-authorization request		CT/MR/USG/HPE inv	
Copy of the Pre-authorization approx	val letter	Doctor's reference sli	
Copy of photo ID card of patient ver		ECG	p 101 600.8uc.o
Hospital discharge summary	inea by nospital	Pharmacy bills	
Operation theatre notes		MLC report & police	
Hospital main bill			ary from hospital where applicable
Hospital break-up bill		Any other, please spe	cify:
Section E – additional details in case of n	on-network hospital		(only fill in case of non-network hospital)
a) Address of hospital:			
City:State	e:		Pin code:
b) Phone No:		c) Registration No. with st	tate code:
d) Hospital PAN:		e) Number of inpatient be	
f) Facilities available in the hospital: (i) O		(ii) ICU: Yes No	
Other:	1. 103	(11) 100. 103	
Other.			
Section F – declaration by the hospital			(please read very carefully)
We hereby declare that the information			9
If we have made any false or untrue state	ement, suppression o	or concealment of any mat	erial fact, our right to claim under this
claim shall be forfeited.			
Date: DDMMYYYY			Cimpatuma Q Carl after
Place:			Signature & Seal of the Hospital Authority
			Trospital Authority
Guidance for filling claim form – part B			(to be filled by the insured)
Data element	Description		Format
Section a - details of hospital  a) Name of hospital	Enter the name of	hospital	Name of hospital in full
b) Hospital ID		f hospital enter the TPA	As allocated by the TPA
5, 1165p.tda. 12	ID No	. Heepital eliter the first	
c) Type of hospital		n network or non-net-	Tick the right option
d) Name of treating doctor	work hospital	the treating doctor	Name of doctor in full
e) Qualification		tions of the treating	Abbreviations of educational qualifica-
c) quantication	doctor	cions of the treating	tions
f) Registration No. with state code	Enter the registrat	ion number of the	As allocated by the medical council of
	doctor along with t	he state code	India
g) Phone No.	Enter the phone nu	umber of doctor	Include STD code with telephone
			number
Section b - details of the patient admitted a) Name of Patient		hasnital	Name of bossital in full
b) IP Registration No.	Enter the name of Enter insurance pro	·	Name of hospital in full  As allotted by the insurance provider
o, ii Registration 140.	number	ovider registration	7.3 anotice by the mountaine provider
c) Gender	Indicate gender of	the patient	Tick male or female or third gender
d) Age	Enter age of the pa	itient	Number of years and months
e) Date of birth	Enter date of birth		Use dd-mm-yy format



f) Date of admission	Enter date of admission	Use dd-mm-yy format
g) Time	Enter time of admission	Use hh:mm format
h) Date of discharge	Enter date of discharge	Use dd-mm-yy format
i) Time	Enter time of discharge	Use hh:mm format
j) Type of admission	Indicate type of admission of patient	Tick the right option
k) If maternity		
Date of delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format
Gravida status	Enter Gravida status if maternity	Use standard format
l) Baby's date of admission	Enter date of admission	Use dd-mm-yy format
m) Baby's date of discharge	Enter date of discharge	Use dd-mm-yy format
n) Status at time of discharge	Indicate status of patient at time of	Tick the right option
ny status at time of discharge	discharge	Tiek the right option
o) Total claimed amount	Indicate the total claimed amount	In rupees (Do not enter paise values)
Section C - details of ailment diagnosed		
a) ICD 10 code		
Primary diagnosis	Enter the ICD 10 code and description of	Standard format and open text
1 milary diagnosis	the primary diagnosis	Staridard format and open text
Additional diagnosis	Enter the ICD 10 code and description of	Standard format and open text
Additional diagnosis	the additional diagnosis	Standard format and open text
Co-morbidities	Enter the ICD 10 code and description of	Standard format and open text
Co-morbialties		Standard format and open text
h) ICD 10 DCS	the co-morbidities	
b) ICD 10 PCS	Fortunate ICD 10 DCC	Charadan de la
Procedure 1	Enter the ICD 10 PCS and description of	Standard format and open text
	the first procedure	
Procedure 2	Enter the ICD 10 PCS and description of	Standard format and open text
	the second procedure	
Procedure 3	Enter the ICD 10 PCS and description of	Standard format and open text
	the third procedure	
Details of procedure	Enter the details of the procedure	Open text
c) Pre-authorization obtained	Indicate whether pre-authorization	Tick yes or no
	obtained	
d) Pre-authorization No.	Enter pre-authorization number	As allotted by TPA
e) If authorization by network hospital	Enter reason for not obtaining	Open text
not obtained, reason	pre-authorization number	·
f) Hospitalization due to injury	Indicate if hospitalization is due to injury	Tick yes or no
Cause	Indicate cause of injury	Tick the right option
If injury due to substance abuse	Indicate whether test conducted	Tick yes or no
/alcohol consumption, test conducted	marcate whether test conducted	Their yes of the
to establish this.		
Medico legal	Indicate whether injury is medico legal	Tick yes or no
Reported to police	Indicate whether police report was filed	Tick yes or no
If reported, FIR No.	Enter first information report number	As issued by police authorities
If not reported to police, give reason	Enter reason for not reporting to police	Open Text
Section D - claim documents submitted		
Indicate which supporting documents ar		
Section E - details in case of non-networ		
a) Address.	Enter the full postal address	Include street, city and pin code
b) Phone No.	Enter the phone number of hospital	Include STD code with telephone number
c) Registration No. with state code	Enter the registration number of the	As allocated by the medical council o
c) registration No. with state code		-
d) Hassital DAN	doctor along with the state Code	India
d) Hospital PAN	Enter the permanent account number	As allotted by the income tax depart
		ment
e) Number of Inpatient beds	Enter the number of inpatient beds	Digits
f) Facilities available in the hospital		Tick the right option. If others, pleas
		specify
Section F - declaration by the hospital		

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