RELIANCE GENERAL INSURANCE

Tech+ ♥ = Live Smart

Claim No.: _____

REQUEST FOR CASHLESS HOSPITALISATION FOR HEALTH INSURANCE POLICY - PART C - CLAIM FORM

(To be filled in BLOCK LETTERS)

Name of Hospital		Hospital ID	
Hospital email ID		ROHINI ID	

DETAIL OF THE THIRD PARTY ADMINISTRATOR			
1) Name of TPA Insurance Company			
2) Phone Number		3) Fax Number	

TO BE FILLED BY INSURED/PATIENT			
a) Name of the patient			
b) Gender	☐ Male ☐ Female ☐ Third Gender		
c) Age	_____ Years _____ Months	d) Date of birth	D D / M M / Y Y Y Y
e) Contact number		f) Contact number of attending relative	
g) Insured Card ID number		h) Policy number/Name of Corporate	
i) Employee ID			
j) Currently do you have any other Mediclaim /health insurance			☐ Yes ☐ No
i. Insurer Company Name			
ii. Give Details			
k) Do you have a family Physician if yes name	☐ Yes ☐ No		
l) Contact number, if any		m) Current Address of insured patient	
n) Occupation of Insured patient			

TO BE FILLED BY TREATING DOCTOR/HOSPITAL			
a) Name of the treating Doctor		b) Contact number	
c) Nature of Illness/Disease with presenting complaint			
d) Relevant Critical Findings			
e) i) Duration of the present ailment	_____ Days	ii) Date of First consultation	D D / M M / Y Y Y Y
iii) Past history of present ailment, if any			
f) Provisional diagnosis		g) ICD l0 code	
h) Proposed line of treatment			
☐ i) Medical Management ☐ ii) Surgical Management ☐ iii) Intensive care ☐ iv) Investigation ☐ v) Non-allopathic treatment			

i) If investigation/or Medical Management, provide details			
i. ☐ IV ☐ ORAL ☐ OTHER			
ii. Route of Drug Administration			
iii. If surgical, name of surgery			
iv. ICD l0 PCS code			
j) If other treatment, provide details			
k) How did injury occur			
l) In case of accident			
i. Is it RTA	☐ Yes ☐ No	ii. Date of Injury	D D / M M / Y Y Y Y
iii. Reported to Police	☐ Yes ☐ No	iv. FIR No	☐ Yes ☐ No
v. Injury /Disease caused due to substance abuse/ alcohol consumption	☐ Yes ☐ No	vi. Test conducted to establish this (if yes, attach report)	☐ Yes ☐ No
m) In case of Maternity	☐ G ☐ P ☐ L ☐ A		
i. Expected date of Delivery			

DETAILS OF PATIENT ADMITTED			
a) Date of admission	D D / M M / Y Y Y Y	b) Time of admission	H H / M M AM/PM
c) Is this an emergency/planned hospitalization event		☐ Emergency ☐ Planned	

Mandatory Past History of any chronic illness If yes (since month/year)

S. No.	Documents		S. No.	Documents	
1	Diabetes	M M / Y Y Y Y	6	Asthma/COPD/Bronchitis	M M / Y Y Y Y
2	Heart disease	M M / Y Y Y Y	7	Cancer	M M / Y Y Y Y
3	Hypertension	M M / Y Y Y Y	8	Alcohol/Drug abuse	M M / Y Y Y Y
4	Hyperlipidemias	M M / Y Y Y Y	9	Any HIV/ or STD Related ailment	M M / Y Y Y Y
5	Osteoarthritis	M M / Y Y Y Y	10	Any other ailment, give details	M M / Y Y Y Y

d) Expected number of Days/stay in hospital	_____ Days
e) Days in ICU	_____ Days
f) Room Type	
g) Per day room rent+nursing and service charges+ patients diet	
h) Expected cost of investigation + diagnostic	
i) ICU charges	
j) OT charges	
k) Professional fees Surgeon + Anesthetist Fees + consultation Charges	
l) Medicines + Consumables + Cost of Implants (if applicable please specify)	
m) Other hospital expenses if any	
n) All-inclusive package charges if any applicable	
o) Sum Total expected cost of hospitalization	

PEP DECLARATION:

Are you a Politically Exposed Person (PEP)?	☐ Yes ☐ No
If yes, please mention the position held	
Is any of your close relation or family member a PEP?	☐ Yes ☐ No
If yes, please mention the name and relation and the position held by such close relative/family member.	

I hereby declare that in future if me, any of my close relatives or any of my family member attains a position of PEP then I shall confirm the same to Reliance General Insurance Co. Ltd as a mandate. I understand that this is a crucial information under the PMLA Rules and AML/ CFT Guidelines and shall confirm that the answers given by me is true. In case the company comes to know that this is a misrepresentation and concealment of information then the policy shall be put on hold for scrutiny by the company and I shall be solely responsible for the same.

Note :

"Politically Exposed Persons" (PEPs) shall have the meaning assigned to it under sub clause (db) of clause (1) of Rule 2 of the Prevention of Money Laundering (Maintenance of Records) Rules, 2005."

(db) "Politically Exposed Persons" (PEPs) are individuals who have been entrusted with prominent public functions by a foreign country, including the heads of States or Governments, senior politicians, senior government or judicial or military officers, senior executives of state-owned corporations and important political party officials".

AML Guidelines

1. I/We hereby confirm that all premiums have been/will be paid from bonafide sources and no premiums have been /will be paid out of proceeds of crime related to any of the offense listed in Prevention of Money Laundering Act,2002.
2. I Understand that the Company has the right to call for document to established sources of funds.
3. The Insurance Company has right to cancel the insurance contract in case I am/have been found guilty by competent court of law under any of the statutes, directly or indirectly governing the prevention of money laundering in India.

Place: _____

Date: _____

_____

Signature of Proposer

GENERAL DECLARATION:

I understand that as per the new AML/CFT Guidelines issued Reliance General Insurance Co. Ltd will be verifying my details pertaining to KYC and PAN provided at the time of proposal.

I further, do hereby agree and consent that in the case of the event of a mismatch of information provided by me in the proposal form, identification proof, and address proof at the time of issuance of the policy. I request Reliance General Insurance Company Limited to issue the policy with the details appearing as per my proposal form. I will be solely responsible for any consequences arising out of the difference in detail given by me during the verification of supporting documents provided by me at the time of issuance of the policy or otherwise.

DECLARATION (PLEASE READ VERY CAREFULLY)

We confirm having read understood and agreed to the declarations on the reverse of this form

a. Name of the treating doctor			
b. Qualification		c. Registration number with State code	

DECLARATION BY THE PATIENT / REPRESENTATIVE

a. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Insurer/T.P.A after the discharge. I agree to sign on the Final Bill & the Discharge Summary, before my discharge.

b. Payment to hospital is governed by the terms and conditions of the policy. In case the Insurer / TPA is not liable to settle the hospital bill, I undertake to settle the bill as per the terms and conditions of the policy.

c. All non-medical expenses and expenses not relevant to current hospitalization and the amounts over & above the limit authorized by the Insurer/T.P.A not governed by the terms and conditions of the policy will be paid by me.

d. I hereby declare to abide by the terms and conditions of the policy and if at any time the facts disclosed by me are found to be false or incorrect I forfeit my claim and agree to indemnify the Insurer / T.P.A

e. I agree and understand that T.P.A is in no way warranting the service of the hospital & that the Insurer / TPA is in no way guaranteeing that the services provided by the hospital will be of a particular quality or standard.

f. I hereby warrant the truth of the forgoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppression or concealment with respect to the claim, my right to claim reimbursement of the said expenses shall be absolutely forfeited.

g. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer/ TPA.

h. I/We authorize Insurance Company/TPA to contact me/us through mobile/email for any update on this claim

a) Patient's / Insured's Name	
b) Contact Number	
c) E-mail Id (optional)	

Date: _____ _____

Place: _____ Patient's / Insured's Signature

HOSPITAL DECLARATION

1. We have no objection to any authorized TPA / Insurance Company official verifying documents pertaining to hospitalization.
2. All valid original documents duly countersigned by the insured/patient as per the checklist below will be sent to TPA/ Insurance Company within 7 days of the patient's discharge.
3. We agree that TPA / Insurance Company will not be Liable to make the payment in the event of any discrepancy between the facts in this form and discharge summary or other documents.
4. The patient declaration has been signed by the patient or by his representative in our presence.
5. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications.
6. We will abide by the terms and conditions agreed in the MOU.
7. We confirm that no additional amount would be collected from the insured in excess of Agreed Package Rates except costs towards nonadmissible amounts (including additional charges due to opting higher room rent than eligibility choosing separate line of treatment which is not envisaged/ considered in package).
8. We confirm that no recoveries would be made from the deposit amount collected from the Insured except for costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility/ choosing separate line of treatment which is not envisaged/considered in package).
9. In the event of unauthorized recovery of any additional amount from the Insured in excess of Agreed Package Rates, the authorized TPA/ Insurance Company reserves the right to recover the same from us (the Network Provider) and,/or take necessary action, as provided under the MoU or applicable laws.
10. Any change in Diagnosis/Treatment plan should be intimated before discharge of patient.
11. If clinical details provided are insufficient, Insurer/TPA may delay the authorization or denial for cashless access.
12. As per IRDAI any claimed amount above 1 lac, Pan card of the Insured/Policy holder/Proposer is mandatory and below 1 lac, Photo identity proof is mandatory.

_____ _____

Hospital Seal Doctor Signature

RCare Address:

Rcare Health: Reliance General Insurance, No.1-89/3/B/40 to 42/ks/301, 3rd floor, Krishe Block, Krishe Sapphire, Madhapur, Hyderabad - 500081. Email: rgicl.rcarehealth@relianceada.com.