



# WEST BENGAL GRAMIN BANK

CIRCULAR NO: HR/245/2025-26

Date: 15.09.2025

**All Branches / Offices  
All Departments at Head Office**

**Re: Exercising of option by serving Officers/Employees (Top-up facility) & Retirees (Officers/Employees) for Group Medical Insurance Scheme (GMP) along with Top-up facility**

**Ref: Circular No. HR/215/2025-26 dated 26.08.2025**

Bank vide its Circular No. HR/215/2025-26 dated 26.08.2025 has stated that the Group Medical Insurance Scheme (GMP) w.e.f. 29.08.2025 for its serving Officers/Employees as well for retirees who retired during 1<sup>st</sup> August, 2024 to 31<sup>st</sup> July, 2025 and opted to get themselves included in the GMP by paying the requisite premium amount.

Accordingly, Bank has now in receipt of final negotiated rate of Top-up Policy from NICL as given hereinunder:

(Amount in ₹)				
Sl. No	Amount	Rate	GST@18%	Gross rate payable
1	1,00,000.00	9163.00	1649.00	10812.00
2	2,00,000.00	14565.00	2622.00	17187.00
3	3,00,000.00	19875.00	3578.00	23453.00
4	4,00,000.00	24774.00	4459.00	29233.00
5	5,00,000.00	32206.00	5797.00	38003.00

**Note:**

- i. Top-up policy shall commence from 01.10.2025 for all categories.
- ii. Top-up Policy will cover all the inclusions as per the Base Policy except for domiciliary treatment (Ref: Circular No.: HR/215/2025-26 dated 26.08.2025)
- iii. In-service officers/employees & retirees of eUBKGB shall be provided with an option to enroll themselves in Top-up policy by paying prorata premium on expiry of their existing policies.
- iv. Top-up policy shall be made available by NICL subject to minimum 10% participation by the intending optees from all categories together.

**Action Point: Retirees of eBGVB/ePBGB (who are currently enrolled under GMP)**

The captioned retirees shall be included in main policy on prorata basis for synchronization of policy dates. The rates shall be as under:

**Table III (With Domiciliary)**

(Amount in ₹)				
Basic Cover	Category	Prorata Premium (329 days) incl. GST @18%	Effective Date	Expiry Date
5,25,000.00	Self	34,621.00	04.10.2025	28.08.2026
	Self + Spouse	36,780.00		

	Self+ spouse-mentally/physically dependent children	42,447.00	04.10.2025	28.08.2026
4,00,000.00	Self	26,400.00		
	Self + Spouse	28,341.00		
	Self+ spouse-mentally/physically dependent children	32,708.00		

**Table IV (Without Domiciliary)**

(Amount in ₹)

Basic Cover	Category	Prorata Premium (329 days) incl. GST @18%	Effective Date	Expiry Date
5,25,000.00	Self	33,577.00	04.10.2025	28.08.2026
	Self + Spouse	34,945.00		
	Self+ spouse-mentally/physically dependent children	39,364.00		
4,00,000.00	Self	25,485.00		
	Self + Spouse	26,832.00		
	Self+ spouse-mentally/physically dependent children	30,015.00		

**Note:**

- i. Ex-Officers can opt for basic cover of ₹ 5,25,000.00 and ex-employees (including PTS) for ₹ 4,00,000.00 respectively.
- ii. Extent of coverage for domiciliary treatment for retirees is restricted to 10% of basic cover, if he/she opt for domiciliary coverage.
- iii. Retirees (eBGVB & ePBGB) shall need to pay prorata premium of 329 days only for synchronization with the in-service employees policy.
- iv. If retiree is having a living spouse, he/she cannot opt for single premium.
- v. In case of inclusion of dependent mentally/physically children, proper document need to be submitted in this regard (Family income threshold is ₹ 18000/month).
- vi. Corporate buffer & additional coverage for critical illness is not applicable for retirees.
- vii. Retirees of eUBKGB shall be given the option to get enroll themselves on expiry of their existing policy.
- viii. Retirees who have retired prior to August, 2025 but had not opted for GMP but intends to opt now, shall require to exercise his/her option for inclusion from 4<sup>th</sup> October, 2025 onwards in due course.
- ix. As of now, GST is applicable for group policies. In case of any further direction received from regulatory authorities before inclusion/commencement of policy (01.10.2025 & 04.10.2025 for Top-up & GMP of retirees respectively), the same shall be made effective and GST amount shall be refunded, if any,

**Time period for exercising option:**

Willing and eligible Existing Officers/Employees and retirees, who intends to opt for the Top-up/GMP may apply through Bank's website [www.wbgb.co.in](http://www.wbgb.co.in) (process enclosed) as per following timeline:

<b>Application period:</b>	<b>15<sup>th</sup>, September 2025 to 21<sup>st</sup>, September 2025</b>
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Premium shall be debited on **22.09.2025** from respective the accounts of optees for remitting the same to the Insurance Company. **Please not that no request for extension of date shall be entertained in this regard.**

For operational convenience, NACL has subdivided the main master policy as under:

<b>Policy Type</b>	<b>Policy No</b>
Existing Employees	150100502510007222
Retiree (With domiciliary)	150100502510007366
Retiree (Without domiciliary)	150100502510007367

**Link for downloading health Cards:**

<http://223.31.103.204/HeritageHealthTPA/HOME/EcardDownload.aspx>

**Whatsapp Chatbot No: 90888 93333**

Following document are enclosed for reference:

1. Schematic representation of application process for enrolment in GMP/Top-up by existing employees/Retirees
2. details regarding cashless/reimbursement/intimation/escalation matrix
3. Checklist for RO/HO/CO while receiving claim document
4. IRDAI standard claim form

This Circular must be brought to the notice of all concerned for necessary action.



GENERAL MANAGER (HR)

# Schematic representation of application process for enrolment in GMP/Top-up by existing employees/Retirees



URL for application: <https://groupmedicalinsurance.wbgb.co.in/>

## 1. Home Page

ওয়েস্ট বেঙ্গল গ্রামীণ ব্যাঙ্ক  
WEST BENGAL GRAMIN BANK

WBGB Medical Insurance Scheme

Apply For Medical Insurance

Existing Employee

Retired Employee

Existing employee please click here

Retired employee please click here

chic infotech

## 2. Existing employee page 1

ওয়েস্ট বেঙ্গল গ্রামীণ ব্যাঙ্ক  
WEST BENGAL GRAMIN BANK

WBGB Medical Insurance Scheme

Existing Employee

Employee ID \*

21747

Salary Account Number \*

Next

Please put your WBGB Employee No

Please put your Salary A/C no & click next

### 3. Existing employee page 2

#### Existing Employee Details

Employee Name *	Employee Date of Birth *
<input type="text" value="ARNAB KUMAR DAS"/>	<input type="text" value=""/>
Email ID	Additional Top-up *
<input type="text" value="arnabdas.wgbg@gmail.com"/>	<input type="text" value="4 Lakh"/>
Remark	Premium Ammount
<input type="text" value=""/>	<input type="text" value="29233.00"/>

Enter your email id here

Choose top-up amount from drop-down

### 4. Existing employee Acknowledgement

#### Acknowledgement

Acknowledgement No : WBGBEX1509202552258

Dear ARNAB KUMAR DAS,

Your submission has been recorded successfully and will be processed by WBGB Medical Insurance Team.

Top-up Amount : 400000

Total Premium Amount : 29233

Submission Date : 15/09/2025 18:03

Thanking you

## 5. Pensioner Page 1

**Retired Employee**

**PPO Number \***

**Pension Account Number \***

Next

**For e-BGVB pensioner** put first 5 digit of PPO No. ignore "0" zero on left side  
e.g. for PPO No. 00001 put 1,  
for PPO No. 00012 put 12,  
for PPO No. 00123 put 123,  
for PPO No. 01234 put 1234

**For e-PBGB pensioner** put full PPO No. as it is  
e.g. PBGB(F)123 put PBGB(F)123,  
PBGB321 put PBGB321

## 6. Pensioner Page 2

**Retired Employee**

**PPO Number \***

**Pension Account Number \***

**Name \***

**Date Of Birth \***

**Post \***

**Basic Coverage\***

**Type Of Coverage \***

**Insurance Coverage \***

**Spouse Details:**

**Spouse Name \***

**Spouse DOB \***

**Dependent Details:**

**Dependent 1 Name \***

**Dependent 1 DOB \***

**Coverage Premium Amount**

**Monthly Income \***

**Top-Up Amount \***

**Top-Up Premium Amount**

**Mobile No \***

**Email ID**

**Pension Paying Branch \***

**Pension Paying Region Name \***

**Total Premium Amount**

**Remark**

Submit

**Please select appropriate option from above drop down & fill up the necessary data, put remarks if there is any incorrect data observed.**

## 7. Pensioner Acknowledgement Page



### Acknowledgement

Acknowledgement No: **WBGBRET15092570574**

Dear **TUSHAR BARAN PAL**,

Your submission has been recorded successfully and will be processed by WBGB Medical Insurance Team.

Basic Coverage: **525000**

Type Of Coverage: **Domiciliary**

Insurance Coverage: **Self+Spouse**

Cover Premium: **36780**

Additional Top-up: **400000**

Premium Amount: **29233**

Total Coverage Premium Amount: **66,013.00**

Submission Date: **15/09/2025 18:38**

Thanking you

[Print](#)

[Home](#)

## Details regarding cashless/reimbursement/intimation/escalation matrix

### **A. CLAIM PROCESS**

The members covered under the policy can claim benefits either through Cashless or Reimbursement.

#### **1. Cashless**

##### **Steps for availing the cashless facility**

- Please check the network list for cashless hospitals in the given link. Request you to always refer to the link below to check for the most updated list of empaneled hospitals as the list is static and network list keep on changing without any notice or connect with TPA/Broker for any assistance. [Home Page - WelCome to Heritage](#) (CTRL click).
- The member needs to apply for the cashless in the insurance help desk of hospital by submitting the health cards and govt. photo ID proof.
- On receipt of cashless request, the initial approval will be done within 1-2 hours on the day of admission and may take 3-4 hours on the day of discharge for final approval.
- For planned hospitalization it is advisable to apply for cashless 2 to 3 days prior to admission, the same process needs to be followed.

\*\*\* In case of any delay in receiving a response from the processing team, you are requested to get in touch with Broker (Edme Insurance Broker) for assistance.

#### **2. Reimbursement**

If an insured is hospitalized in any hospital / nursing home (within India) as defined in the policy and pays the treatment expenses at the time of discharge, he / she needs to file a claim with TPA for the amount due under the policy.

##### **Steps for reimbursement process:**

**Step 1: Claim Intimation:** Claim intimation is mandatory within 24 hrs from the date of admission Please intimate the claim within 24 hrs of claim through following mail id:

To : [heritage\\_health@bajoria.in](mailto:heritage_health@bajoria.in) ; [debapriya.roy@bajoria.in](mailto:debapriya.roy@bajoria.in)

CC : [sushmita.lodh@edmeinsurance.com](mailto:sushmita.lodh@edmeinsurance.com) ; [samrat.dutta@edmeinsurance.com](mailto:samrat.dutta@edmeinsurance.com)

Please note that as per policy T&C claim Intimation is mandatory. Details required for claim intimation are as follows:

- Corporate Name:
- Policy Number:
- Employee Code:
- Employee Name:
- Patient's Name:
- Expected Date of admission:
- Hospital name:
- Diagnosis:
- Estimate claim amount:

**Step 2: Blacklisted / Excluded hospitals:** In case of members getting hospitalized in a non-network hospital kindly ask the member to check the below site for **Blacklisted or Excluded**

**hospitals.** Claims will not be entertained or will be repudiated by the insurer if treatments taken at these blacklisted hospitals.

Link for blacklisted hospitals: [Home Page - WelCome to Heritage](#)

**Step 3: Reimbursement claim submission:** The original claim documents needs to be submitted to TPA within 30 days from the date of discharge. It is advisable to retain photocopies of the entire set of claim documents for future reference.

### **Claim and Query Submission**

- ✓ The hospitalization and pre-hospitalization claim to be submitted within 30 days from the date of discharge
- ✓ Intimation number to be mentioned on claim form
- ✓ Post hospitalization claim to be submitted within 7 days of completion of post hospitalization treatment or by 67th day of discharge
- ✓ Query submission to be submitted within 7 – 15 days of the receipt of the requirement.
- ✓ On receipt of claim documents, TPA takes 3-4 working days to take the decision

### **Reimbursement Document Checklist:**

- ❖ The claim needs to submit to the processing team within 30 days from date of discharge. Post hospitalization claim should be submitted within 7 days from completion of post 60 limits/completion of treatment whichever is earlier.
- ❖ Claim Form of the Insurance Company
  - a. Need to mention Employee no , employee Name and Patient name on Claim Form.
  - b. Claim form part A & C need to be Signed by Patient / employee / insured Person.
  - c. Claim form part B to be stamped and signed by the treating doctor & hospital.
- ❖ Original Final Hospital Bill with break up.
- ❖ Final hospital Payment Receipt .
  - a. Pre-printed software generated with sign and stamp
- ❖ If Medicine, IV fluid and Consumables charges are included in hospital bill then please ask hospital to provide in break up.
  - a. Item / Dosage wise break up
  - b. Quantity / Cost wise break up
  - c. Above details should be on Letter head of hospital with sign & stamp of authority.
- ❖ Original Discharge Summary / Card.
  - a. Patient Name, Gender and Age
  - b. DOA – DOD with Time
  - c. Symptoms with vitals
  - d. Final Diagnosis
  - e. Investigation done during hospitalisation
  - f. Treatment given during hospitalisation
  - g. Advice on discharge with medicine dosage / follow up and next consultation date
- ❖ Death Summary / Death Certificate -
  - a. Patient Name, Gender and Age
  - b. DOA – DOD with Time
  - c. Symptoms with vitals
  - d. Final Diagnosis
  - e. Investigation done during hospitalisation
  - f. Treatment given during hospitalisation
  - g. Cause of death along with time
  - h. Copy of death certificate issued by hospital

- ❖ Indoor Case Papers (Attested by hospital authority)
  - a. Daily treatment & Monitoring sheet with all patient records .
- ❖ All Original Investigation reports and Bills.
  - a. Investigations :- Pathological, MRI, CT Scan , X rays.
  - b. Original Bills & Receipts for investigations done outside hospital
  - c. Prescriptions recommending undergoing tests
  - d. Original Reports
  - e. In case of fracture X-ray films
  - f. Pre & post operative
- ❖ Original Doctors Prescription and medicines bills.
  - a. Original Medicine bills
  - b. Invoice of Implant and surgical appliance
  - c. Prescription of Medicine, Implant and surgical appliance
  - d. Pre & post hospitalisation bills
- ❖ In Accident cases
  - a. Details incident History ( how, When and where the injury has occurred)
  - b. X-ray film along with report.
  - c. MLC / FIR copy (if MLC / FIR not done, required declaration from treating doctor)
- ❖ In Cataract / Surgery claim wherein implant are used.
  - a. Sticker of lens / Stent /Implant used
  - b. Invoice of Implant / stent used
- ❖ In Maternity Cases
  - a. Obstetric history of patient on discharge cards In GPAL format (G-Gravida, P-Pregnancy, A- Abortion, L-Live Children).
- ❖ Claiming for balance amount (Contribution claims )
  - a. Settlement letter / Certificate from earlier TPA/ Insurance Company.
  - b. Complete set of Documents attested from earlier TPA Insurance Company.
- ❖ Copy of Hospital Registration Certificate
  - a. If Registration is not there then declaration from hospital stating no's of beds in the hospital, 24hrs Nursing staff, Fully Equipped Operation Theater & Qualified Doctors in the hospital.
- ❖ Proof of identity with photo, address proof required for Claims of 1 Lac and above- (Identity proof - Passport, PAN Card, Voter's Identity Card, Driving License)
- ❖ General Guidelines-
  - a. Claim Submission should be within 30 days from the date of discharge.
  - b. Post claim should be submitted within 07 days from completion of post 60 days limit/completion of treatment whichever is earlier.
  - c. Copy of set of all submitted documents including bills should be kept with employee.

### **3. Contact details & Escalation Matrix:**

#### **Contact Details for claim intimation:**

To: [heritage\\_health@bajoria.in](mailto:heritage_health@bajoria.in) ; [debapriya.roy@bajoria.in](mailto:debapriya.roy@bajoria.in)

CC: [sushmita.lodh@edmeinsurance.com](mailto:sushmita.lodh@edmeinsurance.com) ; [samrat.dutta@edmeinsurance.com](mailto:samrat.dutta@edmeinsurance.com)

Claim / Cashless Support for In service employee/Retirees			
Level	Name	Contact Number	Email ID
Primary SPOC	Soumi Chakraborty	6292321731	
Escalation 1	Anirban Chatterjee	9874586357	
Escalation 2	Surid Chatterjee	6293692660	<a href="mailto:wbgb@bajoria.in">wbgb@bajoria.in</a>
Escalation 3	Joydeep	6293694749	<a href="mailto:wbgb@bajoria.in">wbgb@bajoria.in</a>
Escalation 4	Debapriya Roy	6292318285	<a href="mailto:debapriya.roy@bajoria.in">debapriya.roy@bajoria.in</a>
Escalation 5	Sougata Bhattacharya	6292250010	<a href="mailto:sougata@bajoria.in">sougata@bajoria.in</a>
Escalation 6	Sushmita Lodh	9088103187	<a href="mailto:sushmita.lodh@edmeinsurance.com">sushmita.lodh@edmeinsurance.com</a>

## Checklist for RO/HO/CO while receiving claim document

### Basic Mandatory documents for submitting claims under Reimbursement:

The Documents may be submitted as per the checklist mentioned below:

		YES/NO/NA
1	Duly filled original claim Form Part -A (for Insured) & Part -B (from Hospital), with Claimant Signature mentioning exact Claim Amount, Contact details, e-mail Id etc. Reason for delay may be given additionally only if the claim documents are being submitted 30 days after the date of discharge.	
2	Copy of cancelled cheque / copy of front page of passbook & photocopy of Govt. Recognized photo id proof.	
3	Original advice for admission to hospital / reference letter for admission and first prescription with clinical notes, in original	
4	Original Discharge Summary / Card / Certificate with Date & Time and details of treatment duly signed and stamped by hospital. (In case of Day Care procedure provide Day care discharge summary)	
5	All original investigation reports including Pre & Post Hospitalization, all the prescriptions, money receipt/cash memo, Investigation reports.	
6	Original numbered final hospital bill with money receipts.	
7	In case of Implant - sticker & tax Invoice with money receipt in original.	
8	In case treatment taken in non-empaneled hospital then detailed bifurcated bills having details such as room rent, surgery, medicine, investigation, consultation etc.	
9	Copy of claim Intimation (mail copy/ web intimation )	
10	In accidental cases self-statement/FIR/Medico legal report.	
11	Original X-ray report with film (Compulsory for fracture cases).	
12	Details of therapeutic diet related to ailments from treating doctor. (In Ayurvedic Treatment, if any)	

- In cases where claim has already been settled under any other health insurance policy, submission of TPA verified documents along with settlement letter showing details of allowed and disallowed Items from the earlier claim will be mandatory to initiate claim under GMP Policy.

Verified by: -	
<b>Bank Official:</b> Name -	<b>TPA Representative:</b> (RO/HO: _____) Name -

<b>Signature &amp; Stamp:</b>	<b>Signature &amp; Stamp:</b>
<b>Date -</b>	<b>Date -</b>

**Basic Mandatory documents for submitting claims under Domiciliary treatment:**

The Documents may be submitted as per the checklist mentioned below:

**YES/NO/NA**

1	Duly filled & signed claim form	
2*	Treating doctor's prescription, original bills for medicines and reports if any.	
3	Diagnosis and Doctor's registration number should be mentioned in the submitted prescription.	
4	Self-declaration for Injury related cases.	
5	GST No., Batch No, Expiry date of medicine should be mentioned medicine bill.	
6	For Physiotherapy bills: Registration no. of Physiotherapist, Doctor prescription, detailed break up of bill along with Therapy activity chart.	

**Original treating doctor prescription is required for first claim. However, in exceptional cases claims can also be submitted with copy of prescription/ investigation reports duly verified by bank officials (with designation stamp). Further, it may be noted that the prescription submitted is valid for three months only.**

<b>Verified by: -</b>	
<b>Bank Official:</b> Name -	<b>TPA Representative:</b> (RO/HO: _____) Name -
<b>Signature &amp; Stamp:</b>	<b>Signature &amp; Stamp:</b>
<b>Date -</b>	<b>Date -</b>



**DECLARATION BY THE INSURED:**

I hereby declare that the information furnished in the 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    Place:

Signature of the Insured

SECTION H

GUIDANCE FOR FILLING CLAIM FORM - PART A (To be filled in by the insured)		
DATA ELEMENT	DESCRIPTION	FORMAT
<b>SECTION A - DETAILS OF PRIMARY INSURED</b>		
a) Policy No.	Enter the policy number	As allotted by the Insurance Company
b) Sl. No/ Certificate No.	Enter the social Insurance number or the certificate number of social health insurance scheme	As allotted by the organization
c) Company TPA ID No.	Enter the TPA ID No.	License number as allotted by IRDA 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
<b>SECTION B -DETAILS OF INSURANCE HISTORY</b>		
a) Currently covered by any other Mediciam / Health Insurance?	Indicate whether currently covered by another Mediciam / 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 organization 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 Hospitalized in the last four years since Inception of the contract?	Indicate whether hospitalized in the last four years	Tick Yes or No
Date	Enter the date of Hospitalization	Use mm-yy format
Diagnosis	Enter the diagnosis details	Open Text
e) Previously covered by any other Mediciam / Health Insurance?	Indicate whether previously covered by another mediciam / Health Insurance	Tick Yes or No
f) Company Name	Enter the full name of the Insurance Company	Name of the organization in full
<b>SECTION C -DETAILS OF INSURED PERSON HOSPITALIZED</b>		
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 policyholder	Tick the right option, if others, please 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
1) E-mail ID	Enter e-mail address of patient	Complete e-mail address
<b>SECTION D - DETAILS OF HOSPITALIZATION</b>		
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
d) Date of injury/Date Disease 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 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
<b>SECTION E - DETAILS OF CLAIM</b>		
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	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
<b>SECTION F - DETAILS OF BILLS ENCLOSED</b>		
Indicate which bills are enclosed with the amount in rupees		
<b>SECTION G - DETAILS OF PRIMARY INSURED's BANK ACCOUNT</b>		
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
c) Cheque/ DD payable details	Enter the name of the beneficiary the cheque / DD should be made out to	Name of the individual / organization in full
c) IFSC Code	Enter the IFSC code of the Bank branch	IFSC code of the Bank branch in full
<b>SECTION H - DECLARATION BY THE INSURED</b>		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.		

**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 preauthorization request form in lieu of PART A

(To be Filled in block letters)

**DETAILS OF HOSPITAL**

a) Name of the hospital:

a) Hospital ID:  c) Type of Hospital: Network :  Non Network :  (if non network fill section E)

c) Name of the treating doctor:

e) Qualification:  f) Registration No. with State Code:  g) Phone No.

**DETAILS OF THE PATIENT ADMITTED**

a) Name of the Patient:

b) IP Registration Number:  c) Gender: Male  Female  d) Age: Years  Months  e) Date of birth:

f) Date of Admission:  g) Time:  h) Date of Discharge:  i) Time:

j) Type of Admission: Emergency  Planned  Day Care  Maternity  k) If Maternity  i) Date of Delivery:  ii) Gravida Status:

l) Status at time of discharge: Discharge to home  Discharge to another hospital  Deceased  m) Total claimed amount

**DETAILS OF AILMENT DIAGNOSED (PRIMARY)**

a) ICD 10 Codes	Description	b) ICD 10 PCS	Description
i. Primary Diagnosis: <input type="text"/>	<input type="text"/>	i. Procedure 1: <input type="text"/>	<input type="text"/>
ii. Additional Diagnosis: <input type="text"/>	<input type="text"/>	ii. Procedure 2: <input type="text"/>	<input type="text"/>
iii. Co-morbidities: <input type="text"/>	<input type="text"/>	iii. Procedure 3: <input type="text"/>	<input type="text"/>
iv. Co-morbidities: <input type="text"/>	<input type="text"/>	iv. Details of Procedure: <input type="text"/>	<input type="text"/>

c) Pre-authorization obtained:  Yes  No d) Pre-authorization Number:

e) If authorization by network hospital not obtained, give reason:

f) Hospitalization due to injury:  Yes  No I. If Yes, give cause Self-inflicted  Road Traffic Accident  Substance abuse / alcohol consumption

ii) If injury due to substance abuse / alcohol consumption, Test conducted to establish this:  Yes  No (If Yes, attach reports) iii. If Medico legal:  Yes  No iv. Reported to Police  Yes  No

v. FIR No.  vi. If not reported to police give reason:

**CLAIM DOCUMENTS SUBMITTED - CHECK LIST**

- |                                                                                |                                                                                |
|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| <input type="checkbox"/> Claim Form duly signed                                | <input type="checkbox"/> Investigation reports                                 |
| <input type="checkbox"/> Original Pre-authorization request                    | <input type="checkbox"/> CT/MR/USG/HPE investigation reports                   |
| <input type="checkbox"/> Copy of the Pre-authorization approval letter         | <input type="checkbox"/> Doctor's reference slip for investigation             |
| <input type="checkbox"/> Copy of Photo ID Card of patient Verified by hospital | <input type="checkbox"/> ECG                                                   |
| <input type="checkbox"/> Hospital Discharge summary                            | <input type="checkbox"/> Pharmacy bills                                        |
| <input type="checkbox"/> Operation Theatre Notes                               | <input type="checkbox"/> MLC reports & Police FIR                              |
| <input type="checkbox"/> Hospital main bill                                    | <input type="checkbox"/> Original death summary from hospital where applicable |
| <input type="checkbox"/> Hospital break-up bill                                | <input type="checkbox"/> Any other, please specify                             |

**DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)**

a) Address of the Hospital

City:  State:

Pin Code:  b) Phone No.  c) Registration No. with State Code:

d) Hospital PAN:  e) Number of inpatient beds  f) Facilities available in the hospital i. OT  Yes  No ii. ICU  Yes  No

iii. Others:

**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.

Date:

Place:  Signature and Seal of the Hospital Authority:

SECTION A  
SECTION B  
SECTION C  
SECTION D  
SECTION E  
SECTION F

GUIDANCE FOR FILLING CLAIM FORM - PART B (To be filled in by the hospital)		
DATA ELEMENT	DESCRIPTION	FORMAT
<b>SECTION A - DETAILS OF HOSPITAL</b>		
a) Name of the hospital:	Enter the name of hospital	Name of the hospital in full
b) Hospital ID	Enter ID number of hospital	As allocated by the TPA
c) Type of Hospital	Indicate whether in network or non network hospital	Tick the right option
c) Name of treating doctor	Enter the name of the treating doctor	Name of doctor in full
e) Qualification	Enter the qualification of the treating doctor	Abbreviations of educational qualifications
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 doctor	Include STD code with telephone number
<b>SECTION B - DETAILS OF THE PATIENT ADMITTED</b>		
a) Name of Patient	Enter the name of patient	Name of patient in full
b) IP registration Number	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 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		
i. Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format
ii. Gravida Status	Enter Gravida status if maternity	Use standard format
l) Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
M) Total claimed amount	Indicate the total claimed amount	In rupees (Do not enter paise values)
<b>SECTION C - DETAILS OF AILMENT DIAGNOSED (PRIMARY)</b>		
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 Code and description of the first procedure	Standard Format and Open text
Procedure 2	Enter the ICD 10 Code and description of the second procedure	Standard Format and Open text
Procedure 3	Enter the ICD 10 Code and description of the third procedure	Standard Format and Open text
Details of Procedure	Enter the details of the procedure	Open text
c) Pre-authorization obtained	Indicate whether pre-authorization obtained	Tick Yes or No
d) Pre-authorization Number	Enter pre-authorization number	As allotted by TPA
e) If authorization by network hospital not obtained, give reason	Enter reason for not obtaining pre-authorization number	Open text
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/alcohol consumption test conducted to establish this	Indicate whether test conducted	Tick Yes or No
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
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
<b>SECTION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST</b>		
Indicate which supporting documents are submitted		
<b>SECTION E - DETAILS IN CASE OF NON NETWORK HOSPITAL</b>		
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 Hospital obtained from local body like City Corporation / Municipality	As allocated by the City Corporation / Municipality
d) Hospital PAN	Enter the permanent account number	As allocated by the Income Tax Department
e) Number of Inpatient beds	Enter the number of inpatient beds	Digits
f) Facilities available in the hospital	Indicate facilities available in the hospital	Tick the right option. If others, please specify
<b>SECTION F - DECLARATION BY THE HOSPITAL</b>		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign. and stamp		