

**NOTE: IMMEDIATE INTIMATION TO MEDSAVE WITHIN  
24 HOURS IN CASE OF HOSPITALISATION / FILE  
SUBMISSION 7 DAYS AFTER DISCHARGE**

## **SMS / E-MAIL / LETTER**

**HELP DESK CONTACT NO**

1800 1111 42 – TOLL FREE NO WEB SIDE - [www.medsave.in](http://www.medsave.in)

9322646395 - VINOD DHEMBARE - (Email id – [mtnlmumbai@medsave.in](mailto:mtnlmumbai@medsave.in) )

9869691919 – LALITA -- [ Email id – [lalita@medsave.in](mailto:lalita@medsave.in) ]

DESK NO - 24373667 - LALITA

OFFICE NO : 022-24373667 / 022-24374277 [ LALITA / VINOD ]

**ADDRESS:**

*TO, MR VINOD DHEMBARE  
MED SAVE HEALTH CARE TPA,  
TELEPHONE HOUSE,  
1ST FLOOR, MTNL ROAD,  
PRABHADEVI, DADAR (WEST),  
MUMBAI 400028*

### **IMMEDIATE INTIMATION FORMATE**

STAFF NO	
PATIENT NAME	
HOSPITAL NAME AND ADDRESS	
DATE OF ADMISSION	
MTNL EMP / PATIENT MOBILE NO	
DIAGNOSIS	

**REIMBURSEMENT CLAIM REQUIRED DOCUMENT**

1. ADMINISTRATION FORWARDING LETTER WITH AGM SIGNATURE AND STAMP
2. MEDSAVE CLAIM FORM
3. NEFT FORM WITH ATTACHED BANK DETAILS (CHEQUE OR PASSBOOK XEROX)
4. KYC [ PAN CARD / AADHAR CARD / VOTER CARDS ] ANY ONE DOCUMENT
5. DISCHARGE SUMMARY IN ORIGINAL [HOSPITAL DISCHARGE CARDE, FINAL HOSPITAL BILL STAMP IN HOSPITAL AND SIGN IN DR ]
6. FINAL BILL WITH PAYMENT RECEIPT IN ORIGINAL WITH BREAKUP
7. CONSULTATION RECEIPT WITH DR. PRESCRIPTION
8. MEDICINE BILL WITH DR. PRESCRIPTION
9. ALL ORIGINAL INVESTIGATION RELATED WITH DISEASE
10. ALL HOSPITAL PAPER SIGNATURE IN PATIENT
11. INDOOR CASE PAPER IN ATTESTED IN HOSPITAL

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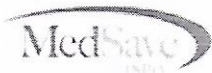
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4



# CLAIM FORM - PART A

TO BE FILLED IN BY THE INSURED

(To be filled in block letter)

The issue of this form is not to be taken as an admission of liability

## DETAILS OF PRIMARY INSURED

a) Policy No :  b) SI. No/certificate No :

c) Company / TPA ID No :

d) Name :

e) Address :

City :  State :

Pin Code :  Phone No :  Email ID :

SECTION A

## DETAILS OF INSURANCE HISTORY

a) Currently covered by any other Medidclaim / Health Insurance :  Yes  No

b) Date of commencement of first insurance without break :  (copy of policies to be attached)

c) If Company Name :  Policy No :

Sum Insured (Rs.) :

d) Have you been hospitalized in the last 4 year?  Yes  No Date :  Diagnosis :

e) Previously covered by any other Medidclaim / Health Insurance :  Yes  No f) If Yes, Company Name :

SECTION B

## DETAILS OF INSURED PERSON HOSPITALIZED

a) Name :

b) Gender :  Male  Female c) Age : Year  Months  d) Date of Birth

e) Relationship to Primary Insured :  Self  Spouse  Child  Father  Mother  Other (Please specify)

f) Occupation :  Service  Self Employed  Homemaker  Student  Retired  Other (Please specify)

e) Address (if different from Above) :

City :  State :

Pin Code :  Phone No :  Email ID :

SECTION C

## DETAIL 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 :  f) Time :  g) Date Of Discharge :  h) Time :

i) If Injury Give Cause :  Self Inflicted  Road Traffic Accident  Substance / Alcohol Consumption i) If Medico legal :  Yes  No

ii) Reported To Police :  Yes  No iii) MLC Report & Police FIR Attached :  Yes  No j) System of Medicine :

SECTION D

## DETAIL OF CLAIM

a) Details of The Treatment Expenses Claimed

i. Pre-hospitalization Expenses : Rs. <input type="text"/>	ii. Hospitalization Expenses : Rs. <input type="text"/>
iii. Post-hospitalization Expenses : Rs. <input type="text"/>	iv. Health-Check up Cost : Rs. <input type="text"/>
v. Ambulance charges : Rs. <input type="text"/>	vi. Other (code) : <input type="text"/> Rs. <input type="text"/>
vii. Pre-hospitalisation period : days <input type="text"/>	<b>Total</b> Rs. <input type="text"/>
	viii. Post-hospitalization Period : days <input type="text"/>

b) Claim for Domiciliary Hospitalization :  Yes  No (If yes, provide details in annexure)

c) Details Of Lump sum / Cash Benefit Claimed:

i. Hospital Daily Cash : Rs. <input type="text"/>	ii. Surgical Cash : Rs. <input type="text"/>
ii. Critical Illness Benefit : Rs. <input type="text"/>	iv. Convalescence : Rs. <input type="text"/>
v. Pre/Post Hospitalization Lump Sum Benefit : Rs. <input type="text"/>	vi. Other : Rs. <input type="text"/>
	<b>Total</b> Rs. <input type="text"/>

SECTION E



4a

**Claim Documents Submitted - Check List**

- Claim Form Duly Signed
- Copy of the claim Intimation
- Hospital Main Bill
- Hospital Break-up Bill
- Hospital Bill Payment Receipt
- Hospital Discharge Summary
- Pharmacy Bill
- Operation Theater Notes
- ECG
- Doctor's Request For Investigation
- Investigation Report (Including CT / MRI/ USG / HPE)
- Other

SECTION E

**DETAILS OF BILL ENCLOSED**

Sl. No	Bill No	Date		Issued by	Towards	Amount (RS)				
1.				y y		Hospital Main Bill				
2.				y y		Pre-hospitalization: _____ Nos				
3.				y y		Pre-hospitalization: _____ Nos				
4.				y y		Pharmacy Bills				
5.				y y						
6.				y y						
7.				y y						
8.				y y						
9.				y y						
10.				y y						

SECTION F

**DETAILS PRIMARY INSURED'S ACCOUNT**

a) Pan :  b) Account Number:

c) Bank Name and Branch:

d) Cheque/ DD Payable details:  e) IFSC Code:

SECTION G

**DECLARATION BY THE INSURED**

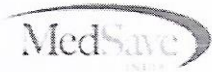
I hereby declare that the information furnished in this claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact, my right to claim reimbursement shall be forfeited. I also consent & authorize TPA/ 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.

SECTION H

Date :  y y Place :  Signature of the insured

- ANTI-MONEY LAUNDERING REQUIREMENT (For claim more than or equal to Rs. 1 Lakh - One Document each from (1) and (2))**
- Proposer's Identification (a) Passport (b) PAN Card (c) Voter's ID Card (d) Driving License (e) AADHAR Card
  - Proposer's Address (a) Current Telephone /Mobile Bill (b) Current Bank Passbook (c) Electricity Bill (d) Ration Card (e) Valid Rent Lease Agreement





5

# CLAIM FORM - PART B

TO BE FILLED IN BY THE HOSPITAL

(To be filled in block letter)

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

## DETAILS OF HOSPITAL

a) Name of Hospital : \_\_\_\_\_

b) Hospital ID : \_\_\_\_\_ c) Type of Hospital :  Network  Non Network (If non network section E)

d) Name of the treating doctor : \_\_\_\_\_

e) Qualification : \_\_\_\_\_ f) Registration No. with State Code : \_\_\_\_\_

g) Phone No : \_\_\_\_\_

SECTION A

## DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient : \_\_\_\_\_

b) IP Registration Number : \_\_\_\_\_ c) Gender :  Male  Female d) Age : Year   Months

e) Date of Birth :       y y f) Date of Admission :       y y g) Time :

h) Date of Discharge :       y y i) Time :   j) Type of Admission :  Emergency  Planned  Day Care  Maternity

k) If Maternity : i. Date of Delivery :       y y ii. Grade of status :

l) Status at time of discharge :  Discharge to home  Discharge to another hospital  Deceased

SECTION B

## DETAIL OF AILMENT DIAGNOSED (PRIMARY)

a)	ICD 10 Codes	Description	b)	ICD 10 Codes	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) Present ailment is a complication of PED?  Yes  No i) (If Yes, Specify Details): \_\_\_\_\_

d) Pre-authorization obtained :  Yes  No e) Pre-authorization Number : \_\_\_\_\_

f) If authorization by network hospital not obtained, give reason : \_\_\_\_\_

g) Hospitalization due to Injury :  Yes  No i) (If Yes, give cause)  Self-inflicted  Road Traffic Accident  Substance abuse/ alcohol consumption

h) If injury due to substance abuse/ alcohol consumption, Test Conducted to establish this :  Yes  No (If Yes, Attach Report) iii) If Medico Legal :  Yes  No

i) FIR no : \_\_\_\_\_ vi) If not reported to police give reason: \_\_\_\_\_

SECTION C

## CLAIM DOCUMENTS SUBMITTED - CHECK LIST

<input type="checkbox"/> Claim Form Duly Signed	<input type="checkbox"/> Investigation report
<input type="checkbox"/> Original Pre-authorization request	<input type="checkbox"/> CT/MR/USG/HPE investigation report
<input type="checkbox"/> Copy of 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 Theatere notes	<input type="checkbox"/> MLC report & 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

SECTION D

(IMPORTANT : PLEASE TURN OVER)

5a

DETAILS IN CASE OF NON NETWORK HOSPITAL

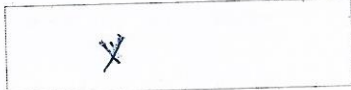
a) Address of Hospital: \_\_\_\_\_  
 \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_  
 Pin Code: \_\_\_\_\_ b) Phone No: \_\_\_\_\_ c) Registration No: \_\_\_\_\_  
 d) PAN \_\_\_\_\_ e) Number of Inpatient beds: \_\_\_\_\_ f) Facilities available in the hospital : i) OT :  Yes  No ii) ICU :  Yes  No  
 iii) Other: \_\_\_\_\_

SECTION E

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 & 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: \_\_\_\_\_ y y Place: \_\_\_\_\_ Signature of the insured 

SECTION F

DECLARATION BY THE HOSPITAL

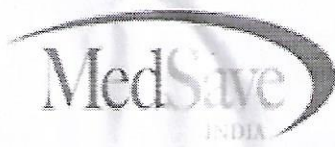
(PLEASE READ VERY CAREFULLY)

We hereby declare that the information furnished in this Claim Form is true & correct to the best of our my 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. The signature of the insured is taken on this form after Claim Form B is fully filled up by us.

Date: \_\_\_\_\_ y y Place: \_\_\_\_\_ Signature and Seal of the hospital Authority 

SECTION G





**Payments through Electronic Mode/NEFT for MTNL**

POLICY No. / MEDICAL ID CARD NO :

INSURED / EMPLOYEE NAME :

EMPLOYEE CODE / STAFF NO :

ADDRESS OF INSURED / EMPLOYEE :

EMAIL ID FOR COMMUNICATIONS :

CONTACT NAME & NUMBER :

**Bank NEFT Details**

PAYEE NAME AS PER BANK ACCOUNT :

BANK ACCOUNT NUMBER :

TYPE OF ACCOUNT :

NAME OF THE BANK :

NAME OF THE BRANCH :

ADDRESS OF THE BRANCH :

IFSC CODE OF THE BRANCH :

We undertake to inform any change to the above information immediately to the Company. We are also enclosing a copy of Cheque for the above Bank Account for further verification of the above data.

**Stamp & Signature of Authorized Person**

**Note:**

- 1. We shall make payment directly to your above said bank account and shall not be responsible for any wrong payment made due to mistake in particulars submitted by hospital / Insured.
  - 2. Copy of a cancelled Cheque leaf is to be attached along with this application
- N. B.: Name of the hospital/Insured must be printed on copy of Cheque. In absence of printed Cheque please enclose copy of bank confirmation letter along with copy of Cheque.*