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

9322646395 - VINOD DHEMBARE - (Email id – mtnlmumbai@medsave.in)

9869691919 – LALITA - - [Email id – 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 SINGATURE 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 SING 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

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

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REIMBURSEMENT CLAIM REQUIRED DOCUMENT

CATRACTE

1. ADMINISTRATION FORWARDING LETTER WITH AGM SINGATURE AND STAMP
2. MEDSAVE CLAIM FORM
3. NEFT FORM WITH ATTACHED BANK DETAILS (CHEQUE OR PASSBOOK XEROX)
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7. LENS INVOICE BILL
8. A SCAN REPORT IN ORIGINAL
9. CONSULTATION RECEIPT WITH DR. PRESCRIPTION
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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) Sl. No/certificate No :

c) Company / TPA ID No :

d) Name :

e) Address :

City : State :

Pin Code : Phone No : Email ID :

DETAILS OF INSURANCE HISTORY

a) Currently covered by any other Mediclaim / 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 Mediclaim / Health Insurance : ☐ Yes ☐ No f) If Yes, Company Name :

DETAILS OF INSURED PERSON HOSPITALIZED

a) Name :

b) Gender : ☐ Male ☐ Female c) Age : Year y y Months d) Date of Brith y y

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 :

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 : y y

e) Date of Admission : y y f) Time : g) Date Of Discharge : y y h) Time :

i) If Injury Give Cause : ☐ Self Inflicted ☐ Road TrafficAccident ☐ 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 :

DETAIL OF CLAIM

a) Details of The Treatment Expenses Claimed

i. Pre-hospitalization Expenses : Rs.

ii. Hospitalization Expenses : Rs.

iii. Post-hospitalization Expenses : Rs.

iv. Health-Check up Cost : Rs.

v. Ambulance charges : Rs.

vi. Other (code) : Rs.

Total **Rs.**

vii. Pre-hospitalisation period : days

viii. Post-hospitalization Period : days y y

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.

ii. Surgical Cash : Rs.

ii. Critical Illness Benefit : Rs.

iv. Convalescence : Rs.

v. Pre/Post Hospitalization Lump Sum Benefit : Rs.

vi. Other : Rs.

Total **Rs.**

SECTION A

SECTION B

SECTION C

SECTION D

SECTION E

(IMPORTANT: PLEASE TURNOVER)

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))

1. Proposer's Identification (a) Passport (b) PAN Card (c) Voter's ID Card (d) Driving License (e) AADHAR Card
2. Proposer's Address (a) Current Telephone /Mobile Bill (b) Current Bank Passbook (c) Electricity Bill (d) Ration Card (e) Valid Rent Lease Agreement

MedSave

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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

SECTION A

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 :

DETAILS OF THE PATIENT ADMITTED

SECTION B

a) Name of the Patient :

b) IP Registration Number : c) Gender : ☐ Male ☐ Female d) Age : Year y y 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 :

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

DETAIL OF AILMENT DIAGNOSED (PRIMARY)

SECTION C

a)	ICD 10 Codes	Description	b)	ICD 10 Codes	Description
i) Primary Diagnosis :			i) Procedure 1 :		
ii) Additional Diagnosis :			ii) Procedure 2 :		
iii) Co-morbidities :			iii) Procedure 3 :		
iv) Co-morbidities :			iv) Details of Procedure :		

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

ii) 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

v) FIR no : vi) If not reported to police give reason:

CLAIM DOCUMENTS SUBMITTED - CHECK LIST

SECTION D

- ☐ Claim From Duly Singed
- ☐ Original Pre-authorization request
- ☐ Copy of Pre-authorization Approval latter
- ☐ Copy of photo ID card of patient verified by hospital
- ☐ Hospital Dischargesummary
- ☐ Operation Theaternotes
- ☐ Hospital main bill
- ☐ Hospital break-up bill
- ☐ Investigation report
- ☐ CT/MR/USG/HPE investigation report
- ☐ Doctor's reference slip for investigation
- ☐ ECG
- ☐ Pharmacy bills
- ☐ MLC report & Police FIR
- ☐ Original death summary from hospital where applicable
- ☐ Any other, please specify

(IMPORTANT : PLEASE TURN OVER)

5a

DETAILS IN CASE OF NON NETWORK HOSPITAL

SECTION E

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 :

DECLARATION BY THE INSURED

SECTION F

(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

DECLARATION BY THE HOSPITAL

SECTION G

(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

MedSave INDIA

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 N E F T 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.