STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED

Regd. & Corporate Office: 1, New Tank Street, Valluvar Kottam High Road, Nungambakkam, Chennai - 600 034.
Corporate Office - Claims Dept. : KRM Center, 6th Floor, No 2 Harrington Road, Chetpet, Chennai - 600 031.
Toll free Phone No: 1800 425 2255 Toll free Fax No: 1800 425 5522
CIN : U66010TN2005PLC056649 Email:info@starhealth.in Website: www.starhealth.in IRDAI Regn. No: 129

STAR Personal & Caring | Health Insurance
The Health Insurance Specialist

CLAIM FORM - PART - A

TO BE FILLED IN BY THE INSURED The issue of this Form is not to be taken as an admission of liability

Claim No. ____________

(To be filled in block letters)

SECTION A

DETAILS OF PRIMARY INSURED:

a) Policy No: ____________ b) Sl. No/ Certificate No: ____________

c) Company/ TPA ID No: ____________

d) Name : ____________

e) Address : ____________

City: ____________ State: ____________

SECTION B

DETAILS OF INSURANCE HISTORY:

a) Currently covered by any other Mediclaim / Health Insurance: Yes ☐ No ☐ b) Date of commencement of first Insurance without break: D D M M Y Y (Copies of Policies to be attached)

c) If yes, company name: ____________ Policy No. ____________

Sum Insured (Rs.) ____________ d) Have you been hospitalized in the last 4 years? Yes No Date: ___/___/___ Diagnosis: ____________

e) Previously covered by any other Mediclaim / Health insurance : Yes ☐ No ☐ f) If yes, Company Name ____________

SECTION C

DETAILS OF INSURED PERSON HOSPITALIZED:

a) Name: ____________

b) Gender: Male ☐ Female ☐ c) Age: years Y Y months M M 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) ____________

g) Address (if different from above): ____________

City: ____________ State: ____________

Pin Code: ____________ Phone No: ____________ Email ID : ____________

SECTION D

DETAILS OF HOSPITALIZATION:

a) Name of Hospital where Admitted: ____________ No. of IP Beds: ____________

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 Abuse / 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 E

DETAILS 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. Others (code): Rs. ____________
Total **Rs.** ____________
vii. Pre-hospitalization period: days ____________
viii. Post-hospitalization period: days ____________

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. ____________
iii. Critical Illness Benefit: Rs. ____________
iv. Convalescence: Rs. ____________
v. Pre/Post hospitalization Lump sum benefit: Rs. ____________
vi. Others: ☐☐☐ Rs. ____________
Total **Rs.** ____________

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 Theatre Notes
- ☐ Doctor's request for investigation
- ☐ ECG
- ☐ Investigation Reports (Including CT / MRI / USG / HPE)
- ☐ Doctor's Prescriptions
- ☐ Others

SECTION F

DETAILS OF BILLS ENCLOSED:

Sl. No	Bill No	Date	Issued by	Towards	Amount (Rs)
1.		D D M M Y Y		Hospital Main Bill	
2.		D D M M Y Y		Pre-hospitalization Bills:____________Nos	
3.		D D M M Y Y		Post-hospitalization Bills:____________Nos	
4.		D D M M Y Y		Pharmacy Bills	
5.		D D M M Y Y			
6.		D D M M Y Y			
7.		D D M M Y Y			
8.		D D M M Y Y			
9.		D D M M Y Y			
10		D D M M Y Y			

SECTION G

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT:

a) PAN: ☐☐☐☐☐☐☐☐☐☐ b) Bank Account Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

c) Bank Name and Branch: ____________

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

(IMPORTANT: PLEASE TURN OVER)

Size 210.00mm x 297.00mm

STAR Health Insurance
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SECTION H

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.

Date: D D M M Y Y   Place: Signature of the Insured

GUIDANCE FOR FILLING CLAIM FORM – PART A (To be filled in 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)	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
		SECTION B - DETAILS OF INSURANCE HISTORY	
a)	Currently covered by any other Mediclaim / Health Insurance?	Indicate whether currently covered by another Mediclaim / 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 4 years	Indicate whether hospitalized in the last 4 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 Mediclaim/ Health Insurance?	Indicate whether previously covered by another Mediclaim / Health Insurance	Tick Yes or No
f)	Company Name	Enter the full name of the insurance company	Name of the organization in full
		SECTION C - DETAILS OF INSURED PERSON HOSPITALIZED	
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
i)	E-mail ID	Enter e-mail address of patient	Complete e-mail address
		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
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
		SECTION E - DETAILS OF CLAIM	
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
		SECTION F - DETAILS OF BILLS ENCLOSED	
Indicate which bills are enclosed with the amounts in rupees			
		SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT	
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 in 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	
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.			

STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED

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CIN : U66010TN2005PLC056649 Email:info@starhealth.in Website: www.starhealth.in IRDAI Regn. No: 129

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)

SECTION A

DETAILS OF HOSPITAL

a) Name of the hospital: ____________________

b) Hospital ID: ____________ Star's Hospital ID: ____________ c) Type of Hospital: Network ☐ Non Network ☐ (If non network fill section E)

d) Name of the treating doctor: ____________ e) Qualification: ____________

f) Registration No. with State Code: ____________ g) Phone No. ____________ h) Email ID: ____________

SECTION B

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient: ____________________

b) IP Registration Number: ____________ c) Gender: Male ☐ Female ☐ d) Age: Years [Y][Y] Months [M][M] e) Date of birth: ____ / ____ / ____

f) Date of Admission: ____ / ____ / ____ g) Time: ____ : ____ h) Date of Discharge: ____ / ____ / ____ i) Time: [H][H] : [M][M]

j) Type of Admission: Emergency ☐ Planned ☐ Day Care ☐ Maternity ☐ k) If Maternity i. Date of Delivery: [D][D] [M][M] [Y][Y] ii. Gravida Status: ☐☐☐

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

SECTION C

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a)	ICD 10 Codes	Description	b)	ICD 10 PCS	Description
i. Primary Diagnosis:	☐☐☐☐☐☐☐		i. Procedure 1:	☐☐☐☐☐☐☐	
ii Additional Diagnosis:	☐☐☐☐☐☐☐		ii. Procedure 2:	☐☐☐☐☐☐☐	
iii. Co-morbidities:	☐☐☐☐☐☐☐		iii. Procedure 3:	☐☐☐☐☐☐☐	
iv. Co-morbidities:	☐☐☐☐☐☐☐				
v. Duration of Illness:			iv. Details of Procedure:		
vi. Past Medical History:					

c) Present ailment is a complication of PED? Yes ☐ No ☐ (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 reports) iii. If Medico legal: Yes ☐ No ☐ iv. Reported to Police: Yes ☐ No ☐

v. FIR no. ☐☐☐☐☐☐☐☐☐☐ vi. If not reported to police give reason: ____________

SECTION D

CLAIM DOCUMENTS SUBMITTED - CHECK LIST

- ☐ Claim Form duly signed
- ☐ Original Pre-authorization request
- ☐ Copy of the Pre-authorization approval letter
- ☐ Copy of photo ID card of patient verified by hospital
- ☐ Hospital Discharge summary
- ☐ Operation Theatre notes
- ☐ Hospital main bill
- ☐ Hospital break-up bill
- ☐ Investigation reports
- ☐ CT/MRI/USG/HPE investigation reports
- ☐ Doctor's reference slip for investigation
- ☐ ECG
- ☐ Pharmacy bills
- ☐ MLC report & Police FIR
- ☐ Original death summary from hospital where applicable
- ☐ Any other, please specify

SECTION E

ADDITIONAL 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.: ____________

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

iii. Others : ____________

SECTION F

DECLARATION BY THE HOSPITAL

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. The signature of the insured is taken on this form after Claim Form B is fully filled up by us.

Date: [D][D] [M][M] [Y][Y]

Place: ____________

Signature and Seal of the Hospital Authority:

(IMPORTANT: PLEASE TURN OVER)

Not to be Faxed / Scanned

GUIDANCE FOR FILLING CLAIM FORM – PART B (To be filled in by the hospital)			
	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	Enter ID number of hospital	As allocated by the TPA
c)	Type of Hospital	Indicate whether In network or non network nospital	Tick the right option
d)	Name of treating doctor	Enter the name of the treating doctor	Name of doctor in full
e)	Qualification	Enter the qualifications 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
	SECTION B – DETAILS OF THE PATIENT ADMITTED		
a)	Name of Patient	Enter the name of hospital	Name of hospital 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 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)	Type of Admission	Indicate type of admission of patient	Tick the right option
j)	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
k)	Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
	SECTION C – DETAILS OF AILMENT DIAGNOSED (PRIMARY)		
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 PCS and description of the first procedure	Standard Format and Open text
	Procedure 2	Enter the ICD 10 PCS and description of the second procedure	Standard Format and Open text
	Procedure 3	Enter the ICD 10 PCS and description of the third procedure	Standard Format and Open text
	Details of Procedure	Enter the details of the procedure	Open text
c)	Present Ailment is a Complication of PED	Indicate whether present ailment is a complication of some pre-existing disease	Tick Yes or No
d)	Pre-authorization obtained	Indicate whether pre-authorization obtained	Tick Yes or No
e)	Pre-authorization Number	Enter pre-authorization number	As allotted by TPA
f)	If authorization by network hospital not obtained, give reason	Enter reason for not obtaining pre-authorization number	Open text
g)	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
	SECTION D – CLAIM DOCUMENTS SUBMITTED-CHECK LIST		
	Indicate which supporting documents are submitted		
	SECTION E – DETAILS IN CASE OF NON NETWORK HOSPITAL		
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.	Enter the registration number of patient	As allocated by the Hospital
d)	PAN	Enter the permanent account number	As allotted 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
	SECTION F - DECLARATION BY THE HOSPITAL		
	Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign and stamp		

SPC: 10.07.15 -1LK- PO : 037

Star Health And Allied Insurance Company Limited

Regd and Corporate Office : 1, New Tank Street, Valluvar Kottam High Road, Nungambakkam
Chennai – 600 034. Phone – 044 – 28288800, TeleFax – 28260062
Corporate Claims Department, 6th Floor, KRM Centre, No. 2, Harrington Road, Chetpet,
Chennai – 600 031 Phone – 044 – 4347 8337 , www.starhealth.in

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To: (Name of the Hospital & Address) Date:

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Dear Sirs,

Re: AUTHORISATION TO STAR HEALTH AND ALLIED INSURANCE CO. LTD.,

I have undergone treatment for……………………………………………………………………………………

from……………………………………………to………………………………………………… in your hospital.

I hereby authorize M/s Star Health and Allied Insurance Company Ltd., who is my Health Insurer to seek any medical information/records from you or from the Medical Practitioners who have attended on me in connection with the above ailment and the treatment given.

In case they seek any such information/records kindly oblige.

Thanking you,

Yours faithfully,

(Signature of the Claimant)

Address of the Insured:

____

____

____

Patient Admission No: