



**CLAIM FORM FOR HEALTH INSURANCE POLICIES  
OTHER THAN TRAVEL AND PERSONAL ACCIDENT**

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

(Guidance for filling claim form - Part A is available on our website: www.royalsundaram.in)

**PART A**

**DETAILS OF PRIMARY INSURED (PROPOSER)**

(TO BE FILLED IN BY THE INSURED)

<b>MOST IMPORTANT</b>	a) Policy No.		b) Sl. No./ Certificate No.	
	c) Membership No./ TPA ID No.			
	d) Name			
	e) Address			
	City		State	
	Pin Code		Land Line (with STD Code)	
	Mobile No.		Email ID	
	Alternate Email ID			

PLEASE PROVIDE ACTIVE EMAIL ID ONLY AS CLAIMS CORRESPONDENCE WILL BE DONE TO THIS EMAIL ID.

SECTION A

**DETAILS OF INSURANCE HISTORY**

a) Currently covered by any other Medclaim/Health Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No								
b) If yes, Company Name									
Policy No.									
c) Date of commencement of first Insurance without break	<table border="1"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y		
d) Sum Insured (Rs.)									
e) Have you been hospitalized in the last four years since inception of the contract?	<input type="checkbox"/> Yes <input type="checkbox"/> No								
f) Date	<table border="1"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y		
g) Diagnosis									

SECTION B

**DETAILS OF INSURED PERSON HOSPITALIZED**

a) Name																		
b) Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	c) Age	<table border="1"> <tr> <td>Y</td><td>Y</td> </tr> </table> Years	Y	Y	<table border="1"> <tr> <td>M</td><td>M</td> </tr> </table> Months	M	M	d) Date of Birth	<table border="1"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y
Y	Y																	
M	M																	
D	D	M	M	Y	Y	Y	Y											
e) Relationship to Primary insured	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Other (Please Specify) _____																	
f) Occupation	<input type="checkbox"/> Doctor <input type="checkbox"/> Service <input type="checkbox"/> Self Employed <input type="checkbox"/> Homemaker <input type="checkbox"/> Student <input type="checkbox"/> Retired <input type="checkbox"/> Other (Please Specify) _____																	
g) Address (if different from above)																		
City		State																
Pin Code		Land Line (with STD Code)																

SECTION C

**DETAILS OF HOSPITALIZATION**

a) Name & Address of Hospital where Admitted																															
City		State																													
Pin Code		Land Mark																													
b) Room Category occupied	<input type="checkbox"/> Day care <input type="checkbox"/> Single occupancy <input type="checkbox"/> 3 or more beds per room <input type="checkbox"/> Any other category, Pls specify _____																														
c) Hospitalization due to	<input type="checkbox"/> Injury <input type="checkbox"/> Illness <input type="checkbox"/> Maternity	d) Date of Injury/Date Disease first detected	<table border="1"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y																				
D	D	M	M	Y	Y	Y	Y																								
e) Date of Admission	<table border="1"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table> Time	D	D	M	M	Y	Y	Y	Y	<table border="1"> <tr> <td>H</td><td>H</td> </tr> </table> :	H	H	<table border="1"> <tr> <td>M</td><td>M</td> </tr> </table>	M	M	f) Date of Discharge	<table border="1"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table> Time	D	D	M	M	Y	Y	Y	Y	<table border="1"> <tr> <td>H</td><td>H</td> </tr> </table> :	H	H	<table border="1"> <tr> <td>M</td><td>M</td> </tr> </table>	M	M
D	D	M	M	Y	Y	Y	Y																								
H	H																														
M	M																														
D	D	M	M	Y	Y	Y	Y																								
H	H																														
M	M																														
g) In case of maternity, 1 Date of Delivery	<table border="1"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y	2 Gravida Status																					
D	D	M	M	Y	Y	Y	Y																								
h) If Injury, give cause	<input type="checkbox"/> Self inflicted <input type="checkbox"/> Road Traffic Accident <input type="checkbox"/> Substance Abuse/Alcohol Consumption																														
	1. If Medico legal <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Reported to police <input type="checkbox"/> Yes <input type="checkbox"/> No 3. MLC Report & Police FIR attached <input type="checkbox"/> Yes <input type="checkbox"/> No																														
i) System of Medicine																															

SECTION D

**DETAILS OF CLAIM**

**a) Details of the treatment expenses claimed**

1. Pre-hospitalization Expenses	Rs.	<input type="text"/>	2. Hospitalization Expenses	Rs.	<input type="text"/>
3. Post-hospitalization Expenses	Rs.	<input type="text"/>	4. Health-Check up Cost	Rs.	<input type="text"/>
5. Ambulance Charges	Rs.	<input type="text"/>	6. Others	Rs.	<input type="text"/>
			<b>Total (1 to 6)</b>	Rs.	<input type="text"/>

**b) Claim for Domiciliary Hospitalization**  Yes  No (If yes, please provide summary of bills in separate sheet)

**c) Details of Lump sum / cash benefit claimed:**

1. Hospital Daily Cash	Rs.	<input type="text"/>	2. Surgical Cash	Rs.	<input type="text"/>
3. Critical Illness Benefit	Rs.	<input type="text"/>	4. Convalescence	Rs.	<input type="text"/>
5. Pre/Post hospitalization Lump sum benefit:	Rs.	<input type="text"/>	6. Others_____	Rs.	<input type="text"/>
			<b>Total (1 to 6)</b>	Rs.	<input type="text"/>

**Claim Documents to be submitted - Check List**

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Claim Form Duly signed  | <input type="checkbox"/> Copy of the claim intimation, if any  | <input type="checkbox"/> Hospital Main Bill                  | <input type="checkbox"/> Hospital Break-up Bill             |
| <input type="checkbox"/> Hospital Bill Payment Receipt   | <input type="checkbox"/> Hospital Discharge Summary  | <input type="checkbox"/> Pharmacy Bill                       | <input type="checkbox"/> Doctor's request for investigation |
| <input type="checkbox"/> Investigation Reports (Including CT/MRI/USG/HPE/ECG)  | <input type="checkbox"/> Doctor's prescription for medicines purchased outside the hospital                | <input type="checkbox"/> Hospital advance and final receipts |   |
| <input type="checkbox"/> Test report and prescription relating to first consultation for the illness                           | <input type="checkbox"/> Hospital advance and final receipts   |  |   |
| <input type="checkbox"/> FIR/MLC in case of accident injury and English translation of the same if it is in any other language |  |  |   |
| <input type="checkbox"/> KYC document (Address proof, ID proof only for claims exceeding Rs. 1 Lakh)                           | <input type="checkbox"/> Cancelled Cheque leaf of the bank account held in the name of the primary insured |  |   |

**DETAILS OF BILLS ENCLOSED**

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

Note : Please attach separate sheet if necessary

**PLEASE PROVIDE YOUR BANK DETAILS:** (Please attach cancelled cheque leaf of bank account in the name of primary insured without fail)

a) PAN	<input type="text"/>	b) Account Number	<input type="text"/>
c) Bank Name and Branch	<input type="text"/>		
d) IFSC Code	<input type="text"/>		

**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 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	<input type="text"/>	Place	<input type="text"/>	Signature of the Primary Insured	<input type="text"/>
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# 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  
(Guidance for filling claim form- Part B is available on our website: www.royalsundaram.in)



**Royal Sundaram**  
General Insurance

### DETAILS OF HOSPITAL

a) Name of the hospital

b) Hospital ID   
(For Office use only)

c) Type of Hospital  Network  Non Network (If non network fill section D)

d) Name of the treating Doctor

e) Qualification

f) Registration No. with State Code

g) Phone

SECTION A

### DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient:

b) IP Registration Number

c) Gender  Male  Female c) Age   Years   Months

d) Date of Birth

f) Type of Admission  Emergency  Planned  Day Care  Maternity

g) Date of Admission         Time   :

h) Date of Discharge         Time   :

i) If Maternity  
1. Date of Delivery         2. Gravida Status \_\_\_\_\_

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

SECTION B

### DETAILS OF AILMENT DIAGNOSED

a)	ICD 10 Codes	Description	Duration
1. Primary Diagnosis	<input type="text"/>	_____	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
2. Additional Diagnosis	<input type="text"/>	_____	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
3. Co-morbidities	<input type="text"/>	_____	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
4. Co-morbidities	<input type="text"/>	_____	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	ICD 10 PCS Codes		
1. Procedure(1)	<input type="text"/>	_____	
2. Procedure(2)	<input type="text"/>	_____	
3. Procedure(3)	<input type="text"/>	_____	
4. Details of any other Procedure	<input type="text"/>	_____	

b) Hospitalization due to Injury  Yes  No If Yes, give cause

1.  Self-inflicted  Road Traffic Accident  Substance abuse/alcohol consumption

2. If Injury due to Substance abuse/alcohol consumption, Test Conducted to establish this:  Yes  No  
If Yes, details of tests conducted \_\_\_\_\_

3. If Medico legal  Yes  No 4. Reported to Police  Yes  No 5. FIR No.

6. If not reported to police, give reason \_\_\_\_\_

SECTION C

c) When did the patient start suffering with the complaint? \_\_\_\_\_ Date of first consultation (prior to hospitalisation) 

D	D	M	M	Y	Y	Y	Y
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d) Please give previous medical history of the patient

e) Is the patient suffering from any of the following diseases. If "yes" Please mention the duration below.

	Say Yes/No	Duration in Year	Duration in Month
1. Bronchial Asthma			
2. Chronic Obstructive Pulmonary disease			
3. Hypertension			
4. Diabetes			
5. Heart ailment			
6. Osteoarthritis			
7. Cerebro vascular attack			
8. Seizure disorder			
9. Renal/Kidney Disorder			
10. Any other			

f) Is the ailment a complication of a pre-existing disease or condition? 



  
If Yes , please give details

g) History of alcoholism  Yes  No  
If yes : No of years \_\_\_\_\_  
Quantity consumed per day \_\_\_\_\_

h) History of Smoking/ Tobacco chewing  Yes  No  
If yes : No of years \_\_\_\_\_  
Units consumed per day \_\_\_\_\_

**ADDITIONAL DETAILS IN CASE OF NON-NETWORK HOSPITAL**

a) Address of the Hospital

b) Hospital Registration No

c) Hospital Registered with 



  
City 



 State

d) Hospital PAN 



 e) Number of Inpatient beds

f) Facilities available in the hospital: 1. OT  Yes  No 2. ICU  Yes  No 3. Doctor/Round the clock Nurses  Yes  No  
4. Others \_\_\_\_\_

SECTION D

**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, insured's right to claim under this policy shall be forfeited.

Date 

D	D	M	M	Y	Y	Y	Y
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 Place 



 Signature and Seal of the Hospital Authority

SECTION E



**Authorization Letter (Mandatory)**

**Date:**

**From:**

**To:**

The Manager/ Medical Superintendent,  
Medical Records

Dear Sir

Reg : Authorization Letter.

Name of the Patient:\_\_\_\_\_

IP Number\_\_\_\_\_ (First admission) in \_\_\_\_\_Hospital

IP Number\_\_\_\_\_ (Second admission) in \_\_\_\_\_Hospital

IP Number\_\_\_\_\_ (Third admission) in \_\_\_\_\_Hospital

I consent and authorize M/s Royal Sundaram Alliance Insurance Company and their Authorized Service Providers to seek medical information from your hospital and share copies of indoor case sheets and such other relevant medical records and / or meet the Medical Practitioner who has at any time attended on the patient for the hospitalization dated ..... to .....

Thanking you,

Yours sincerely,

Signature of the Proposer

Signature of the Patient