## CLAIM FORM - PART A' to 'CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT - PART A

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

(To be Filled in block letters)

DETAILS OF PRIMARY INSURED:	
a) Policy No.:b) Sl. No/ Certificate no.	
c) Company/ TPA ID No:	
d) Name:	
e) Address:	
Pin Code Phone No: 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: D D M M	YYYY
c) If yes, company name:	
Sum insured (Rs.)	Date: M M Y Y
Diagnosis: e) Previously covered by any other Me	
f) If yes, company name:	
DETAILS OF INSURED PERSON HOSPITALIZED: :	
b) Gender         Male         Female         c) Age years         Y         Y         Months         M         d) Date of Birth         D         D         M         M         Y         Y         Y	Y
e) Relationship to Primary insured: Self Spouse Child Father Other Other (Please Specify)	ı ي
f) Occupation Service Self Employed Home Maker Student Other (Please Specify)	
g) Address (if diffrent from above) :	
DETAILS OF HOSPITALIZATION: :	
a) Name of Hospital where Admited:	
b) Room Category occupied: Day care Single occupancy Twin sharing 3 or more beds per room	
c) Hospitalization due to: Injury IIIness Maternity d) Date of injury / Date Disease first detected /Date of Delivery:	M M Y Y Y Y
	M M Y Y Y Y Y h) Time: H H : M H
ii) Reported to Police iii. MLC Report & Police FIR attached Yes No j) System of Medicine:	
DETAILS OF CLAIM:	
a) Details of the Treatment expenses claimed	aim Documents Submitted - Check List:
I. Pre -hospitalization expenses Rs.	Claim form duly signed
iii. Post-hospitalization expenses Rs.	Copy of the claim intimation, if any
v. Ambulance Charges:         Rs.         Image: Control of the state of the stat	Hospital Main Bill
	Hospital Break-up Bill
vii. Pre -hospitalization period: days days viii. Post -hospitalization period: days	Hospital Bill Payment Receipt Hospital Discharge Summary Pharmacy Bill
b) Claim for Domiciliary Hospitalization: Yes No (If yes, provide details in annexure)	Hospital Discharge Summary Pharmacy Bill
c) Details of Lump sum / cash benefit claimed:	Operation Theater Notes
i. Hospital Daily cash: Rs. Rs. IIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	ECG
i. Hospital Daily cash:       Rs.       ii. Surgical Cash:       Rs.       III.       III.         iii. Critical Illness benefit:       Rs.       III.       III.       III.       III.       III.	Doctor's request for investigation
iii. Critical Illness benefit: Rs	Doctor's request for investigation Investigation Reports (Including CT / MRI / USG / HPE)
iii. Critical Illness benefit: Rs.	Doctor's request for investigation Investigation Reports (Including CT / MRI / USG / HPE) Doctor's Prescriptions
iii. Critical Illness benefit:       Rs.       Image: State of the spitalization Lump sum benefit:       Rs.       Image: State of the spitalization Lump sum benefit:       Rs.       Image: State of the spitalization Lump sum benefit:       Rs.       Image: State of the spitalization Lump sum benefit:       Rs.       Image: State of the spitalization Lump sum benefit:       Rs.       Image: State of the spitalization Lump sum benefit:       Rs.       Image: State of the spitalization Lump sum benefit:       Rs.       Image: State of the spitalization Lump sum benefit:       Rs.       Image: State of the spitalization Lump sum benefit:       Rs.       Image: State of the spitalization Lump sum benefit:       Rs.       Image: State of the spitalization Lump sum benefit:       Rs.       Image: State of the spitalization Lump sum benefit:       Rs.       Image: State of the spitalization Lump sum benefit:       Rs.       Image: State of the spitalization Lump sum benefit:       Rs.       Image: State of the spitalization Lump sum benefit:       Rs.       Image: State of the spitalization Lump sum benefit:       Rs.       Image: State of the spitalization Lump sum benefit:       Rs.       Image: State of the spitalization Lump sum benefit:       Rs.       Image: State of the spitalization Lump sum benefit:       Rs.       Image: State of the spitalization Lump sum benefit:       Rs.       Image: State of the spitalization Lump sum benefit:       Rs.       Image: State of the spitalization Lump sum benefit:       Rs.       Image: State of the spitalization Lump sum benefit:	Doctor's request for investigation Investigation Reports (Including CT / MRI / USG / HPE)
iii. Critical Illness benefit:       Rs.       iv. Convalescence:	Doctor's request for investigation Investigation Reports (Including CT / MRI / USG / HPE) Doctor's Prescriptions
iii. Critical Illness benefit:       Rs.       iv. Convalescence:	Doctor's request for investigation     Investigation Reports (Including CT     / MRI / USG / HPE)     Doctor's Prescriptions     Others      Amount (Rs)
iii. Critical Illness benefit:       Rs.       iv. Convalescence:	Doctor's request for investigation     Investigation Reports (Including CT     / MRI / USG / HPE)     Doctor's Prescriptions     Others      Amount (Rs)
iii. Critical Illness benefit:       Rs.       iv. Convalescence:       Rs.         v. Pre/Post hospitalization Lump sum benefit:       Rs.       iv. Convalescence:       Rs.         DETAILS OF BILLS ENCLOSED:       Total       Rs.       iv. Convariance         SI. No       Bill No.       Date       Issued by       Towards         1.       D       D       M       Y       Hospital main Bill         2.       D       D       M       Y       Pre-hospitalization Bills:       Nos         3.       D       D       M       Y       Pharmacy Bills       Nos	Doctor's request for investigation     Investigation Reports (Including CT     / MRI / USG / HPE)     Doctor's Prescriptions     Others      Amount (Rs)
iii. Critical Illness benefit:       Rs.       iv. Convalescence:       Rs.         v. Pre/Post hospitalization Lump sum benefit: Rs.       iv. Convalescence:       Rs.       iv. Convalescence:         Total       Rs.       Image: Conversion of the state of the stat	Doctor's request for investigation     Investigation Reports (Including CT     / MRI / USG / HPE)     Doctor's Prescriptions     Others      Amount (Rs)
iii. Critical Illness benefit:       Rs.       iv. Convalescence:       Rs.         v. Pre/Post hospitalization Lump sum benefit:       Rs.       iv. Convalescence:       Rs.         DETAILS OF BILLS ENCLOSED:       Total       Rs.       iv. Convariance         SI. No       Bill No.       Date       Issued by       Towards         1.       D       D       M       Y       Hospital main Bill         2.       D       D       M       Y       Pre-hospitalization Bills:       Nos         3.       D       D       M       Y       Pharmacy Bills       Nos	Doctor's request for investigation     Investigation Reports (Including CT     /MRI / USG / HPE)     Doctor's Prescriptions     Others      Amount (Rs)
iii. Critical Illness benefit:       Rs.       iv. Convalescence:       Rs.         v. Pre/Post hospitalization Lump sum benefit:       Rs.       iv. Convalescence:       Rs.         DETAILS OF BILLS ENCLOSED:       It.       D       D       M       M       Y         I.       D       D       M       M       Y       Hospital main Bill         I.       D       D       M       M       Y       Pre-hospitalization Bills:       Nos         3.       D       D       M       M       Y       Post-hospitalization Bills:       Nos         4.       D       D       M       M       Y       Pharmacy Bills       Sos         5.       D       D       M       Y       Hospitalization Bills:       Nos         6.       D       D       M       Y       Hospitalization Bills:       Nos         7.       D       D       M       Y       Hospitalization Bills:       Nos	Doctor's request for investigation     Investigation Reports (Including CT     /MRI / USG / HPE)     Doctor's Prescriptions     Others      Amount (Rs)
iii. Critical Illness benefit:       Rs.       iv. Convalescence:       Rs.         v. Pre/Post hospitalization Lump sum benefit:       Rs.       iv. Convalescence:       Rs.         DETAILS OF BILLS ENCLOSED:       Total       Rs.       iv. Convaluescence:       Rs.         D       D       M       M       Y       Hospital main Bill         2.       D       D       M       M       Y         3.       D       D       M       M       Y         4.       D       D       M       M       Y         5.       D       D       M       Y       Pharmacy Bills:       Nos         4.       D       D       M       Y       Y       Image: State Stat	Doctor's request for investigation     Investigation Reports (Including CT     / MRI / USG / HPE)     Doctor's Prescriptions     Others      Amount (Rs)
iii. Critical Illness benefit:       Rs.       iv. Convalescence:       Rs.         v. Pre/Post hospitalization Lump sum benefit:       Rs.       iv. Convalescence:       Rs.         DETAILS OF BILLS ENCLOSED:       Itotal       Rs.       Itotal         SI. No       Bill No.       Date       Issued by       Towards         1.       D       M       M       Y         2.       D       D       M       Y         3.       D       D       M       Y         4.       D       D       M       Y         5.       D       D       M       Y         6.       D       D       M       Y         7.       D       D       M       Y         8.       D       D       M       Y         9.       D       D       M       Y         9.       D       D       M       Y         10.       D       M       Y       Itotal	Doctor's request for investigation     Investigation Reports (Including CT     / MRI / USG / HPE)     Doctor's Prescriptions     Others      Amount (Rs)
iii. Critical Illness benefit:       Rs.       iv. Convalescence:       Rs.         v. Pre/Post hospitalization Lump sum benefit: Rs.       iv. Convalescence:       Rs.       iv. Convalescence:         DETAILS OF BILLS ENCLOSED:             Sl. No       Bill No.       Date       Issued by       Towards         1.       D       D       M       M       Y         2.       D       D       M       M       Y         3.       D       D       M       Y       Pre-hospitalization Bills:       Nos         3.       D       D       M       Y       Y       Pre-hospitalization Bills:       Nos         4.       D       D       M       Y       Y       Pharmacy Bills       Nos         5.       D       D       M       Y       Y       Pharmacy Bills       Nos         6.       D       D       M       Y       Y       Image: Similar Simi	
iii. Critical Illness benefit:       Rs.       iv. Convalescence:       Rs.	
iii. Critical Illness benefit:       Rs.       iv. Convalescence:       Rs.         v. Pre/Post hospitalization Lump sum benefit: Rs.       iv. Convalescence:       Rs.       iv. Convalescence:         DETAILS OF BILLS ENCLOSED:             Sl. No       Bill No.       Date       Issued by       Towards         1.       D       D       M       M       Y         2.       D       D       M       M       Y         3.       D       D       M       Y       Pre-hospitalization Bills:       Nos         3.       D       D       M       Y       Y       Pre-hospitalization Bills:       Nos         4.       D       D       M       Y       Y       Pharmacy Bills       Nos         5.       D       D       M       Y       Y       Pharmacy Bills       Nos         6.       D       D       M       Y       Y       Image: Similar Simi	Doctor's request for investigation Investigation Reports (Including CT / MRI / USG / HPE) Doctor's Prescriptions Others

## 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 concealent of any material fact with respect to questions asked in relation to this claim, my right to claim reimbrusement 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	DD	MM	ΥΥΥΥ	Place:
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Signature of 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)	SI. No/ Certificate No.	Enter the social Insurance number or the certificate number of	As allotted by the oraganization
,		social health insurance scheme Enter the TPA ID No.	Licence number as allotted by IRDA and printe
c)	Company TPA ID No.		in TPA documents.
(t	Name	Enter the full name of the policyholder	Surname, First name, Middle name
e)	Address	Enter the full postal address SECTION B -DETAILS OF INSURANCE HISTORY	Include Street, City and Pin code
a)	Currently covered by any other Mediclaim / Health	Indicate whether currently covered by another Mediclaim /	1
	Insurance?	Health Insurance	Tick Yes or No
)	Date of commencement of first Insurance without break	Enter the date of commencement of first Insurance	Use dd-mm-yy-forrmat
;)	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
I)	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 Mediclaim / Health	Indicate whether previously covered by another mediclaim /	Tick Yes or No
	Insurance? Company Name	Health Insurance Enter the full name of the Insurance Company	Name of the organization in full
)		TION C -DETAILS OF INSURED PERSON HOSPITALIZED	Name of the organization in full
			Sumana First same Middle same
) 	Name	Enter the full name of the patient	Surname, First name, Middle name Tick Male or Female
)	Gender	Indicate Gender of the patient	
)	Age Date of Birth	Enter age of the patient	Number of years and months
)		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
	Occupation	indicate occupation of patient	Tick the right option. If others, please specify.
I)	Address	Enter the full postal address	Include Street, City and Pin code
)	Phone No	Enter the phone number of patient	Include STD code with telephone number
)	E-mail ID	Enter e-mail address of patient	Complete e-mail address
	Name of Leastel where educited	SECTION D - DETAILS OF HOSPITALIZATION	Name of hereited in fail
i)	Name of Hospital where admited	Enter the name of hospital	Name of hospital in full Tick the right option
) 	Room category occupied	indicate the room category occupied	Tick the right option
;)  )	Hospitalization due to Date of injury/Date Disease first detected / Date of	indicate reason of hospitalization	
·,	Delivery	Enter the relevant date	Use dd-mm-yy format
e)	Date of admission	Enter date of admission	Use dd-mm-yy format
)	Time	Enter time of admission	Use hh-mm- format
)	Date of discharge	Enter date of discharge	Use dd-mm-yy format
)	Time	Enter time of discharge	Use hh-mm- format
)	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
)	System of Medicene	Enter the system of medicine followed in treating the patient	Open Text
		SECTION E - DETAILS OF CLAIM	
ı)	Details of Treatment Expences	Enter the amount claimed as treatment expences	In rupees (Do not enter paise values)
	Claim for Domiciliary Hospitalization	indicate whether claim is for domiciliary hospitalization	Tick Yes or No
<i>.</i>	Details of Lump sum/ Cash benifit claimed	Enter the amount claimed as lump sum / cash benefit	In rupees (Do not enter paise values)
;)			Tick the right option
)	Claim documents Submitted-Check List	indicate which supporting documents are submitted	
;) 1)	Claim documents Submitted-Check List	SECTION F - DETAILS OF BILLS ENCLOSED	
;)  )	Claim documents Submitted-Check List cate which bills are enclosed with the amount in rupees	SECTION F - DETAILS OF BILLS ENCLOSED	
;) I) ndi	Claim documents Submitted-Check List cate which bills are enclosed with the amount in rupees	SECTION F - DETAILS OF BILLS ENCLOSED	1
) d) ndi	Claim documents Submitted-Check List cate which bills are enclosed with the amount in rupees SECTIO PAN	SECTION F - DETAILS OF BILLS ENCLOSED ON G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT Enter the permanent account number	As allotted by the Income Tax Department
5) 5) d) ndi a) 5)	Claim documents Submitted-Check List cate which bills are enclosed with the amount in rupees SECTIC PAN Account Number	SECTION F - DETAILS OF BILLS ENCLOSED ON G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT Enter the permanent account number Enter the Bank account number	As allotted by the Income Tax Department As allotted by the Bank
) d) ndi	Claim documents Submitted-Check List cate which bills are enclosed with the amount in rupees SECTIO PAN	SECTION F - DETAILS OF BILLS ENCLOSED         ON G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT         Enter the permanent account number         Enter the Bank account number         Enter the Bank name along with the branch	As allotted by the Income Tax Department
2) 1) ndi a) 2)	Claim documents Submitted-Check List cate which bills are enclosed with the amount in rupees SECTIC PAN Account Number	SECTION F - DETAILS OF BILLS ENCLOSED ON G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT Enter the permanent account number Enter the Bank account number	As allotted by the Income Tax Department As allotted by the Bank
;) 1) ndi i) ;)	Claim documents Submitted-Check List cate which bills are enclosed with the amount in rupees SECTIC PAN Account Number Bank Name and Branch	SECTION F - DETAILS OF BILLS ENCLOSED         ON G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT         Enter the permanent account number         Enter the Bank account number         Enter the Bank account number         Enter the Bank name along with the branch         Enter the name of the beneficiary the cheque / DD should be	As allotted by the Income Tax Department As allotted by the Bank Name of the Bank in full

CLAIM FORM TO BE FILLED IN B	
The issue of this Form is not to be Please include the original preauthoriz	taken as an admission of liability (To be Filled in block letters)
DETAILS OF HOSPITAL	
a) Name of the hospital:	
a) Hospital ID:	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:	d) Age: Years $\begin{tabular}{cccccccccccccccccccccccccccccccccccc$
f) Date of Admission: D D M M Y Y g) Time: H H M M	h) Date of Discharge: D D M M Y Y i) Time: H H M M
j) Type of Admission: Emergency Planned Day Care Maternity k) If Mater	nity i) Date of Delivery: D D M M Y Y ii) Gravida Status: .
I) 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	i. Procedure 1:
ii. Additional Diagnosis:	ii. Procedure 2:
iii. Co-morbidities:	iii. Procedure 3:
iv. Co-morbidities:	iv. Details of Procedure:
c) Pre-authorization obtained: e) If authorization by network hospital not obtained, give reason: f) Hospitalization due to injury: Yes No I. If Yes, give cause Self-inflicted	umber:     Image:
ii) If injury due to substance abuse / alcohol consumption, Test conducted to establish this:	f Yes, attach reports) iii. If Medico legal: Yes No iv. Reported to Police Yes No
v. FIR No.	
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 break-up bill	<ul> <li>Investigation reports</li> <li>CT/MR/USG/HPE investigation reports</li> <li>Doctor's reference slip for investigation</li> <li>ECG</li> <li>Pharmacy bills</li> <li>MLC reports &amp; Police FIR</li> <li>Original death summary from hospital where applicable</li> <li>Any other, please specify</li> </ul>
ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF	- NON-NETWORK HOSPITAL)
a) Address of the Hospital	
City:	State:
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: D D M M Y Y	
Place: Signature and Seal of the Hos	pital Autonity:

Signature	and	Seal	of	the	Hos	pital	Autho	rity:

	GUIDANCE FOR FI	LLING CLAIM FORM - PART B (To be filled in by the hos	spital)			
DA	TA ELEMENT	DESCRIPTION	FORMAT			
		SECTION A - DETAILS OF HOSPITAL				
a) Name of the hospita	al:	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 do	ctor	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	n 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			
	SEC	TION B - DETAILS OF THE PATIENT ADMITTED				
a) Name of Patient		Enter the name of patient	Name of patient in full			
b) IP registration Num	ber	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		a Meridian and a second second second				
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			
I) Status at time of disc	charge	Indicate status of patient at time of discharge	Tick the right option			
M) Total claimed amou	•	Indicate the total claimed amount	In rupees (Do not enter paise values)			
		I C - DETAILS OF AILMENT DIAGNOSED (PRIMARY)				
a) ICD 10 Code	6201101					
.,		Enter the ICD 10 Code and description of the primary diagnosis				
Primary Diagnosis			Standard Format and Open text			
Additional Diagnosi	S	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 of	otained	Indicate whether pre-authorization obtained	Tick Yes or No			
d) Pre-authorization N	umber	Enter pre-authorization number	As allotted by TPA			
e) If authorization by n	etwork 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 substa	nce abuse/alcohol consumption test		Tick Yes or No			
conducted to establish	h this	Indicate whether test conducted				
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 authrities			
If not reported to polic		Enter reason for not reporting to police	Open text			
		TION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST	<u> </u>			
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. wit	th 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 Inpatien	it beds	Enter the number of inpatient beds	Digits			
f) Facilities available in		Indicate facilities available in the hospital	Tick the right option. If others, please specify			
		SECTION F - DECLARATION BY THE HOSPITAL				
Read declaration carefully	y and mention date (in dd:mm:yy format),					