यूनियन बैंक ऑफ इंडिया
भारत सरकार का उपक्रम

Union Bank of India
A Government of India Undertaking

Employee Benefits Division, Human Resources Department, Central Office Mumbai- 400021

STAFF CIRCULAR NO. 101239 -2025 Date: 19.11.2025

To: **All Branches/ Offices**

Subject: Information on various guidelines & procedures along-with contact details of 'Heritage Health Insurance TPA Pvt. Ltd.'; Group Medical Insurance Policy for Retired Employees/Family Pensioners, Policy Tenure - 01.11.2025 to 31.10.2026

1. The Group Medical Insurance policy for Retired employees/ Family Pensioners has been renewed for a period of one year i.e. from 01.11.2025 up to 31.10.2026.

2. National Insurance Company Limited has informed that they have allotted the services of 'Heritage Health Insurance TPA Pvt. Ltd.' as third-party administrator, for the policy year 2025-26. The details regarding the same have already been circulated vide Staff Circular 101125-2025 dated 31.10.2025.

3. Heritage Health Insurance TPA has shared details regarding claim intimation, claim submission, claim forms and contact details of representatives of 'Heritage Health Insurance TPA Pvt. Ltd.' Team, as mentioned below and annexed herewith.

In terms of the guidelines, details pertaining to 'claim intimation & claim submission', for the policy year 2025-26, are provided below:

➢ **Claim Intimation:**

Notification of claim in case of Cashless facility	**TPA must be informed:**
In event of planned hospitalization	At least 72 (seventy-two) hours prior to the insured person's admission to network provider/ PPN Hospital
In event of emergency hospitalization	Within 24 (twenty-four) hours of the insured person's admission to the network provider/ PPN Hospital

Notification of claim in case of Reimbursement	**TPA must be informed:**
In event of planned hospitalization/emergency hospitalization	Within 48 (forty-eight) hours of the insured person's admission to the network provider/ PPN Hospital

Various methods of "claim intimation" are mentioned below:

a) **Email** - Claim intimation can be done by sending a detailed mail on **hhibaintimation@bajoria.in**

- The mail, in all cases, must contain details like employee no, employee name, patient name, relationship with the employee, hospital name, treating doctor name, hospital address, date of admission in hospital, estimated expenses etc.

b) **Phone** - 6292264916 (for Intimation Only)

c) **Intimation through Website and Mobile Application**

Upon intimation, a 'claim intimation number' is generated/ provided to the insured. For all the reimbursement hospitalization/ IPD claims, this claim intimation no. is to be mandatorily mentioned on the claim form.

- **Claim Submission:** In case of reimbursement claim, all original hard copy claim documents should be mandatorily submitted within 30 days of date of treatment/ discharge to the TPA. The location-wise addresses/ details provided by 'Heritage Health Insurance TPA Pvt. Ltd.' for submission of 'claim documents' are provided herewith as **Annexure-I** to this circular. Retired employees/Family Pensioners are requested to refer to the Annexure and submit the claim documents accordingly on the basis of their locations.

- **Claim Forms & Claim Documents Check-list:** Claim form for IPD (Hospitalization) reimbursement claims, and check-list for claim documents, as shared by Heritage Health Insurance TPA Pvt. Ltd. are attached herewith as **Annexure II & Annexure III** respectively.

- In case the insured person/ insured person's representative fails to intimate/ notify the claim to the TPA or fails to submit/ file the claim within the prescribed time limit, '<u>delay intimation and/or submission condonation letter</u>' is to be submitted to the TPA.

- The contact details/communication of representatives of 'Heritage Health Insurance TPA' team are provided below for ready reference:

  - **(24 x 7) Helpline:** 033-40145200 / 033-40557600
  - **(24 x 7) Toll Free No.:** 18001024547
  - **E-mail ID for any complaint:** heritage.complaint@bajoria.in

Helpdesk Availability: From 10 A.M. To 6 P.M. (Monday to Saturday)			
S. No	**Concerned Person**	**Contact No.**	**Email**
1	Sairaj Gaonkar	6292321737	sgaonkar@bajoria.in
2	Shubham Medhekar	6292321735	smedhekar@bajoria.in

Nodal Officer Availability: From 10 A.M. To 6 P.M. (Monday to Saturday)			
Concerned Person	**Contact No.**	**Email**	**Location**
Abantika Paul	6293696107	ibaclaims4@bajoria.in	Kolkata
Chandan Singh	9199863707	chandan.singh@bajoria.in	Bihar & Jharkhand
Mukesh Mallick	7978413557	mukeshm@bajoria.in	Orissa
Vinoth	8072992511	heritagechennai.iba@bajoria.in	Chennai
Vikash Kumar Singh	8527410585	vkumar@bajoria.in	New Delhi
Anil Yadav	9820547808	ayadav@bajoria.in	Mumbai
Manoj Shukla	9406768199	mshukla@bajoria.in	MP & Chhattisgarh

Escalation matrix Availability: From 10 A.M. To 6 P.M. (Monday to Saturday)				
Department	**Escalation Level**	**Concerned Person**	**Contact No.**	**Email**
Enrolment / E-card	I	Alok Sahoo	9831265100	alok.sahoo@bajoria.in
	II	Saikat Bag	8101054462	heritageenrollment@bajoria.in
	III	Shraddha Mukherjee	9748125245	srmukherjee@bajoria.in
Cashless Facility	I	Somi Chakraborty	6292321731	cashlesskolkata@heritagehealthtpa.co.in
	II	Anirban Chatterjee	6292321732	cashlesskolkata@heritagehealthtpa.co.in
	III	Angshuman Chatterjee	8777016621	angshuman.chatterjee@bajoria.in
Reimbursement	I	Abantika Paul	6293696107	ibaclaims4@bajoria.in
	II	Sonali Das	6292331722	ibaclaims2@bajoria.in

- **HERITAGE TPA Mobile App "Heritage Health Member App"**, which can be downloaded from Play store (Android Phones) & App Store (IOS Phones) for checking Card Status, Claim Status, List of Network hospitals, Policy details, forms for downloading, E card download, claim intimation etc.

- **HERITAGE TPA Website "www.heritagehealthtpa.com"** helps customers to access the following information: Employee login, claim details, E-Card download, Claim Intimation, Policy details etc.

- **Default Login credentials in TPA website and mobile application: -**
  Username: UBIN_Emp ID
  Password: UBIN@Emp ID

- **WhatsApp BOT:** - Real-time chatbot service through dedicated WhatsApp number- **9088893333** for accessing services like Claim Status View, E-Card Download, Policy Details, Network Hospital List Download.

Grievances/ complaints, if any, related to IBA Group Medical Insurance Policy may be raised/ addressed on the following e-mail IDs:

a) **For Grievances related to Group Medical Insurance Policy, employees may contact National Insurance Company at**
   E-mail ID: iba.grievance@nic.co.in

b) **For any complaints in processing of claims including any issues with TPA**
   E-mail ID: iba.claims@nic.co.in

The policy document, to be issued by 'National Insurance Co Ltd', pertaining to policy year 2025-26, would be shared/ communicated in due course of time.

Contact Details: For any kind of query, regarding 'Group Medical Insurance Policy for Retired Employees/Family Pensioners for the policy period 2025-26, team members may be contacted on the following numbers:

Union Bank of India, Central Office, Mumbai -

Landline Nos	:	022 - 22896255/ 22896383
IP Nos	:	116252/ 116253/ 116264/ 116263/ 116254
E-mail ID	:	staffmediclaim@unionbankofindia.bank.in

All concerned are requested to take a careful note of the above.

(S.C. Teli)
Chief General Manager

List of Annexures:
Annexure I : Location-wise address of TPA
Annexure II : Claim Form Part A & B
Annexure III: Checklist for Reimbursement Under IBA GMP

HERITAGE HEALTH INSURANCE TPA PVT. LTD.

LocationWiseOfficeAddressforSubmissionofClaimDocuments:

SLNO	Location	Address	OfficeContactno
1	**KOLKATA**	NICCOHOUSE,5thFloor,2HareStreet,Kolkata-700001	Ph.-(033) 40145100
2	**MUMBAI**	CHAMPIONBUILDING,GROUNDFLOOR,15,PARSI PANCHAYAT ROAD,Andheri(East) PIN - 400069	Ph.- (022) 61273891/3892/3893
3	**HYDERABAD**	SriSivaRamaTowers,3-6-288/3,FlatNo 502, 4thFloor,Hyderguda,(AboveHDFCBank,HydergudaBranch) Hyderabad – 500029	Ph.-(040) 23244264
4	**VIZAG**	DN. 50-84-9, Madhura Nagar, Seethammapeta, Vishakhapatnam, PIN - 530016	Ph.- (0891) 2713917
5	**CHENNAI**	102 &103,1stFloor, PrinceCentre|No. 709-710, MountRoad, Thousand Lights, Chennai – 600006	Ph.-(044) 28290400/ 2829 0430
6	**DELHI**	411-413,4thFloorLaxmiDeepBuilding,LaxminagarDistrictCentre, Laxminagar New Delhi - 110092	Ph.-(011) 43009540/41/42/43/44
7	**AHMEDABAD**	203-206,SecondFloor, Sakar-II,B/hSanyashAshram,AshramRd,OppositeEllisbridge, Ahmedabad - 380009	Ph.- (079)4027 2801-04
8	**SURAT**	601,6thFLOOR,MERIDIANTOWER,B/sAPPLEHOSPITAL, UDHNA DARWAJA, SURAT - 395002	Ph.-(0261) 400 0046/4031544-46
9	**BARODA**	202,SquarePlaza,B/hNationalPlaza, 31-VishwasColony,Alkapuri,Vadodara–390007	Ph.- (0265) 3509691, 3516744
10	**INDORE**	39, Mezzanine floor,BanshiTradeCentre,581-M.G. Road, Indore- 452001	Ph.-(0731) 4001370 / 72
11	**BANGALORE**	657,BadamiArcade,2ndFloor,AboveStateBankof,2ndMain,7th Block, BSK 3rd Stage, Bangalore - 560085	Ph.- 080-26423736,080-26423746
12	**BHUBANESWAR**	OCHCComplex,1stFloor,NearRamMandir,Janpath,UNIT-III, Kharavela Nagar, Bhubaneswar - 751001, Orissa,	Ph.-(0674) 2393107
13	**PATNA**	RoomNo210,2NDFloor,HariNarayanComplex,ExhibitionRoad, Patna, Bihar - 800001	Ph.-+91-9199863707
14	**GUWAHATI**	MANIRAMDEWANLANE(NEARULUBARIFLYOVER)HOUSE NO-2,2NDFLOOR,G.SROAD,ULUBARIGuwahati,Assam,PIN: 781007	Ph.- 0361-2450007

15	**COIMBATORE**	No.3/121,DPFStreet,Pappanaickenpalayam,Coimbatore,TamilNadu-641037	Ph.-(0422)-4337117, 2247117
16	**JAIPUR**	OfficeNo.-413-416,4thFloor,jaipurTextileMarketBuilding,PlotNo.- B2 MalviyaNagar,jaipur,Rajasthan-302017	Ph.- 0141-2944765
17	**COCHIN**	No. 61/890, B1, 4th Floor VallamattomEstate,MGRoad,Ernakulam-682015	Ph.-0484-3545259
18	**LUCKNOW**	2ndfloor,90IshwariDayalHataAryaSamajMandirRoad;Ganesh Gang; Lucknow- 226018	Ph.–(0522)424-8870
19	**RANCHI**	1stFloor,ShakambariBhawan,AboveSBIATM,RanchiRailwayStation Road, Landmark: ChutiaPoliceStation,Ranchi - 834001	Ph.-(091)8051060367
20	**DURGAPUR**	6/1VivekanandaRoad, A-Zone(NearDurgapurHouse)Durgapur- 713204	Ph.-(+91)9434147391
21	**THRISSUR**	AmbikaArcade,No.25/651/11,1st Floor,MGRoad, Thrissur - 680001	Ph.-0487-2321198
22	**PUNE**	Officeno.6;K.K.Market6thfloorG-wing, PuneSataraRoad. Dhankawadi,Pune,Maharashtra.PIN- 411043	Ph.-08421787005
23	**SILIGURI**	1stFloor, NazrulSarani,Ashrampara,Hakimpa rasiliguri,westBengal, Pin-734001	Ph.-8972860739
24	**CHANDIGARH**	SCO-102,FirstFloor,Sector-40Chandigarh, Near DPS(Delhi Public School),Pin-160036	Ph.-9877774693
25	**NASHIK**	Office No. 312, 3rd Floor, SardaSankul, Survey No. 6403/2+ D 1/2 & CTS No. 623A-1 and 623 A-2, M G Road, Nashik	NA
26	**JODHPUR**	Office No. 207, 2nd Floor, AmritKalash, BachrajjikaBagh, Rajasthan, Jodhpur- 342003	NA
27	**Vijayawada**	D N.40-27-75, 2nd Floor, Pinnameneni Polyclinic Road, Opp. Gayatri Nagar, NTR District, Vijayawada-520008(AP)	NA
28	**Madurai**	Plot No. 22, 1st Floor, Netaji Nagar, Y.Othakadai, Madurai-625107	NA
29	**Valsad**	303, 3rd Floor, Trade Center, Beside Madina Palace, Station Road, Valsad-396001	NA

HERITAGE HEALTH

CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT - PART A
TO BE FILLED IN BY THE INSURED
The issue of this Form is not to be taken as an admission of liability

IRDAI License No. 008

DETAILS OF PRIMARY INSURED: (To be filled in block letters)

SECTION A

a) Policy No: b) Sl. No./Certificate No:
c) Company/TPA ID No:
d) Name : SURNAME FIRST NAME MIDDLE NAME
e) Address :
City : State :
Pin Code : Phone No : Email ID :

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
c) If yes, company name : Policy No.
Sum Insured (Rs.) d) Have you been hospitalized in the last four years since inception of the contract ? Yes No Date: M M Y Y
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 : SURNAME FIRST NAME MIDDLE NAME
b) Gender: Male Female c) Age : Years Y Y Months M M d) Date of Birth : D D M M 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)
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 :
b) Room Category occupied : Day care Single occupancy Twin sharing 3 or more beds per room
c) Hospitatization due to : Injury Illness Maternity d) Date of injury/Date Disease first detected/Date of Delivery D D M M Y Y
e) Date of Addmission : D D M M Y Y f) Time : H H M M g) Date of Discharge : D D M M Y Y h) Time : H H M M
i) If injury give cause : Self inflicted Road Traffic Accident Substance Abude /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 Hospitlaization
vi. Others : Rs.
Lump sum benefit Rs.
Total Rs.

Claim Documents Submitted - Check List :

- Claim Form Duly signed
- Copy of the claim intimation, if any
- Hospital Main Bill
- Hospital Break-up Bill
- Hospital Bill Payment Receipt
- Hospital Discharge Summary
- Pharmacy Bill
- Operation Theatre Notes
- ECG
- Doctor's request for investigation
- 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 Bill: Nos.	
3		D D M M Y Y		Post-hospitalization Bill: 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) Account Number :
c) Bank Name and Branch :
d) Cheque/DD Payable details : e) IFSC Code:

(IMPORTANT:PLEASE TURN OVER)

DECLARATION BY THE INSURED:

SECTION H

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 & authorise 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) SI. No./Certificate No.	Enter the social insurance number of 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 Medicliam / 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 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	User 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 in 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 bank name along with the branch	Name of the bank in full
d) Cheque/DD payable details	Enter the name of 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.		

HERITAGE HEALTH

IRDAI License No. 008

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 : c) Type of Hospital : Network ☐ Non Network ☐ (if non network fill section E)

d) Name of the treating doctor : SURNAME FIRST NAME MIDDLE NAME

e) Qualification : f) Registration No. with State Code: g) Phone No.

SECTION B

DETAILS OF THE PATIENT ADMITTED

a) Name of the patient : SURNAME FIRST NAME MIDDLE NAME

b) IP Registration Number : c) Gender : Male ☐ Female ☐ d) Age: Years YY Months MM e) Date of Birth: DD MM YY

f) Date of Admission : DD MM YY g) Time: HH MM h) Date of Discharge: DD MM YY i) Time HH MM

j) Type of Admission : Emergency ☐ Planned ☐ Day Care ☐ Maternity ☐ k) if Maternity i) Date of Delivery: DD MM YY ii) Gravida Status:

l) Status at time of discharge : Discharge to home ☐ Discharge to another hospital ☐ Deceased ☐ m) Total claimed amount

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			iv. Details of Procedure		

c) Pre-authorization obtained : ☐ Yes ☐ No d) Pre-authorization Number :

e) If authorization by network hospital not obtained, give reason:

f) 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 reports & 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. with State Code:

d) Hospital 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 (PLEASE READ VERY CAREFULLY)

We hereby declare that the information furnished this Claim Form is true & correct to the best of our knowledge & 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 forfieted

Date : DD MM YY

Place :

Signature and Seal of the Hospital Authority :

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 hospital	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 patient	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 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		
Date of Delivery	Enter Date of Delivery if maternity	User dd-mm-yy format
Gravida Status	Enter Gravida status if maternity	Use standard format
l) Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
m) Total claimed amount	Indicate the total claimed amount	In rupees (Do not enter paise values)
SECTION C - DETAILS OF THE 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-morbidites	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) Pre-authorization obtained	Indicate whether pre-authorization obtained	Tick Yes or No
d) Pre-authorization Number	Enter pre-authorization number	As allotted by TPA
e) If authorization by network 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 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. with State Code	Enter the registration number of the doctor along with the state code	As allocated by the Medical Council of India
d) Hospital 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		

IBA GMI Policy Check List

Basic Mandatory documents for submitting claims under Reimbursement:

- The Documents may be submitted as per the checklist mentioned below –

		YES/NO/NA
1	Duly filled original claim Form Part -A (for Insured) & Part -B (from Hospital), with Claimant Signature mentioning exact Claim Amount, Contact details, e-mail Id etc. Reason for delay may be given additionally only if the claim documents are being submitted 30 days after the date of discharge.	
2	Copy of cancelled cheque / copy of front page of passbook & photocopy of gov. Recognized photo id proof.	
3	Original advice for admission to hospital / reference letter for admission and first prescription with clinical notes, in original	
4	Original Discharge Summary / Card / Certificate with Date & Time and details of treatment duly signed and stamped by hospital. (In case of Day Care procedure provide Day care discharge summary)	
5	All original investigation reports including Pre & Post Hospitalization, all the prescriptions, money receipt/cash memo, Investigation reports.	
6	Original numbered final hospital bill with money receipts.	
7	In case of Implant - sticker & tax Invoice with money receipt in original.	
8	In case treatment taken in non-empaneled hospital then detailed bifurcated bills having details such as room rent, surgery, medicine, investigation, consultation etc.	
9	Copy of claim Intimation (mail copy/ web intimation)	
10	In accidental cases self-statement/FIR/Medico legal report.	
11	Original X-ray report with film (Compulsory for fracture cases).	
12	Details of therapeutic diet related to ailments from treating doctor. (In Ayurvedic Treatment, if any)	

- In cases where claim has already been settled under any other health insurance policy, submission of TPA verified documents along with settlement letter showing details of allowed and disallowed Items from the earlier claim will be mandatory to initiate claim under IBA GMI Policy.