प्रधान कार्यालय: मणिपाल 576 104 (कर्नाटक)
Head Office: Manipal-576104(Karnataka)
संगठन एवं पद्धति प्रभाग
ORGANISATION & METHODS DIVISION

Circular No.112-2017-BC-PD-24-SWD

Date: 16-03-2017

PERMANENT UTILITY

IBA GROUP HEALTH INSURANCE POLICY FOR EMPLOYEES - SIMPLIFIED DOMICILIARY TREATMENT CLAIM FORM

Kind attention is drawn to our Circular Nos. 461-2015-BC dated 11-11-2015 and 066-2017-BC dated 10-02-2017 regarding guidelines for submission of Domiciliary Treatment claims under IBA Group Mediclaim Insurance Policy for employees. Now we have been informed by UIICO Ltd. the Insurer that they have simplified the Domiciliary Claim Form, format of which is attached as **Annexure**. **All the employees are requested to submit Domiciliary Treatment Claims if any, in the revised format only**. Further please note that UIICo. Ltd has informed that the procedure guidelines / conditions for domiciliary treatment claims and the procedure guidelines/ conditions and formats for hospitalization claims remain the same.

Clarification required, if any, on this circular may be sought from **STAFF WELFARE DIVISION, PERSONNEL DEPARTMENT** at Head Office, Manipal, through respective R.O. as per extant guidelines.

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Check word

(GOPINATH T IYER)
GENERAL MANAGER (P)

DOMICILIARY CLAIM FORM
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)

A) DETAILS OF THE PRIMARY INSURED:

i)	Policy No.	**5 0 0 1 0 0 2 8 1 6 P 1 0 9 9 7 7 9 0 4**
ii)	SL No./Certificate No. (N A)	
iii)	Company/TPA ID No.	
iv)	Name of Insured	
v)	Address of the Insured	
vi)	Phone No. (Mandatory)	
vii)	E-mail ID: (Mandatory)	

B) DETAILS OF CLAIMANT

i)	Name	
ii)	Gender	
iii)	Age years Months : DOB	
iv)	Relations to Primary Insured	
v)	Occupation	
vi)	Address (if different from above)	

C) DETAILS OF OP TREATMENT:

i)	Nature of illness	
ii)	Name of Doctor & Hospital	
iii)	Qualification of Medical Practitioner	
iv)	Address & Registration No of Doctor & Hospital	
v)	Period of Treatment taken.	
vi)	Total amount Claimed	
vii)	OP Treatment	

D) DETAILS OF INSURANCE HISTORY: (NOT APPLICABLE)

i)	Currently covered by any other Mediclaim / Health Insurance :	
ii)	Date of Commencement of first Insurance without Break :	
iii)	IF yes, Company name :	
iv)	Policy No.:	
v)	Sum Insured (₹ :)	NA
vi)	Have you been hospitalized in the last four years since inception of the contract?	
vii)	IF yes Date & Diagnosis	
viii)	Previously covered by any other Mediclaim /Health insurance	
ix)	If yes, company name :	

E) DETAILS OF HOSPITALIZATION: (NOT APPLICABLE):

i)	Name of Hospital Where Admitted :	
ii)	Room Category occupied :	
iii)	Hospitalization due to : Injury/Illness/Maternity	
iv)	Date of Injury/ Date Disease first detected /Date of Delivery :	
v)	Date of Admission :	
vi)	Time of Admission :	NA
vii)	Date of Discharge:	
viii)	Time of Discharge :	
ix)	If injury give cause :	
x)	Substance abuse /Alcohol Consumption :	NA
xi)	If medico legal :	
xii)	Reported to Police :	
xiii)	MLC Report	
xiv)	System of Medicine :	

F) DETAILS OF OP TREATMENT: (Not applicable):

i) Pre- hospitalization expenses ii) Hospitalization expenses iii) Post hospitalization expenses
iv) Health- Check up cost v) Ambulance

G) DETAILS OF DOCUMEITS SUBMITTED (whichever applicable tick mark √)

i) Hospital Main Bill (NOT APPLICABLE)
ii) Hospital Break –up bill (NOT APPLICABLE)
iii) Hospital Bill payment Receipt (NOT APPLICABLE)
iv) Hospital Discharge Summary (NOT APPLICABLE)
v) Original claim form duly singed
vi) Pharmacy Bill
vii) Prescription & certificate of illness – **original / photocopy duly attested** (Please tick the relevant field). If photocopy given reasons for the same.
viii) Original bills of consultation fees.
ix) Original bills of medicines purchased
x) Original bills of Lab test done
xi) Reports of the Lab test.
xii) Others.

SCHEDULE OF EXPENSES INCURRED AND BEING CLAIMED BY THE CLAIMANT

SL. No.	Receipt		Nature of Expenditure	Amt. claimed (₹)	Amt. Payable (₹)
	No.	Date			
	TOTAL				

H) DETAILS OF PRIMARY INSURED'S BANK ACCOUNT DETAILS:

i)	Name of the Account holder :	
ii)	PAN No. :	
iii)	Branch Name :	
iv)	Full Bank Account No. (14 digits)	
v)	IFSC code (11 Digits)	
vi)	Cheque / DD No.	

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 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:
Place: **Signature of the Insured**

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