Su-Swastha Yojna

A Government of Sikkim Initiative

REIMBURSEMENT CLAIM FORM - 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) Su-Swastha ID No. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

b) Name Mr./Mrs./Ms. First Name* Middle Name Last Name*

c) Address

Line 1 Line 2

Line 3 City Village/City/Town

District State Pin Code ☐☐☐☐☐☐

Contact No. ☐☐☐☐☐☐☐☐☐☐ Email Id

DETAILS OF INSURANCE HISTORY

a) Currently covered by any other Mediclaim/Health Insurance ☐Yes ☐No

b) If Yes, Company Name Policy No. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Sum Insured (Rs.) ☐☐☐☐☐☐

c) Have you been Hospitalized in the last Four years since inception of the contract ☐Yes ☐No

Date of Hospitalization M M Y Y Diagnosis

d) Previously covered by any other Mediclaim/Health Insurance ☐Yes ☐No

e) If Yes, Company Name

DETAILS OF INSURED PERSON HOSPITALIZED

a) Name Mr./Mrs./Ms. First Name* Middle Name Last Name*

b) Gender ☐Male ☐Female ☐Other c) Age Y Y M M d) Date of Birth D D M M Y Y Y Y

e) Relationship to Primary Insured ☐Self ☐Spouse ☐Child ☐Father ☐Mother ☐Other (Please Specify)

f) Occupation ☐Service ☐Self Employed ☐Home Maker ☐Student ☐Retired ☐Other (Please Specify)

g) Address (If different from above)

Line 1 Line 2

Line 3 City Village/City/Town

District State Pin Code ☐☐☐☐☐☐

Contact No. ☐☐☐☐☐☐☐☐☐☐ Email Id

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) Hospitalization due to ☐Injury ☐Illness ☐Maternity d) Date of Injury/Disease first detected/Delivery D D M M Y Y Y Y

e) Date of Admission D D M M Y Y Y Y f) Time H H M M

g) Date of Discharge D D M M Y Y Y Y h) Time H H M M

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

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DETAILS OF CLAIM

a) Details of Treatment Expenses Claimed

i) Pre-Hospitalization Expenses Rs.

ii) Hospitalization Expenses Rs.

iii) Post-Hospitalization Expenses Rs.

iv) Health Checkup Cost Rs.

v) Ambulance Charges Rs.

vi) Others (code) Rs.

Total Rs.

Claim Documents Submitted - Checklist

- ☐ 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 Theater Notes
- ☐ ECG
- ☐ Doctor's Request for Investigation
- ☐ Investigation Reports (including CT/ MRI/USG/HPE)
- ☐ Doctor's Prescription
- ☐ Others

DETAILS OF BILLS ENCLOSED

Sl. No.	Bill No.	Date	Issued By	Towards	Amount (Rs.)
1		DD MM YYYY		Hospital Main Bill	
2		DD MM YYYY		Pre-Hospital Bill Nos.	
3		DD MM YYYY		Post-Hospitalization Bill Nos.	
4		DD MM YYYY		Pharmacy Bill	
5		DD MM YYYY			
6		DD MM YYYY			
7		DD MM YYYY			
8		DD MM YYYY			
9		DD MM YYYY			
10		DD MM YYYY			

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

a) PAN No. b) Account No.

c) Bank Name & Branch

d) Cheque/DD Payable Details e) IFSC Code

DECLARATION BY INSURED

I hereby declare that the information furnished in the claim form is due & 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 and authorize Su Swastha Yojna to seek neccessary medical information/documents from any Hospital/Medical Practitioner who has attended on the person against whome 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 DD MM YYYY

Place

Signature

Signature of Employee

Su-Swastha Yojna

A Government of Sikkim Initiative

REIMBURSEMENT CLAIM FORM - PART B

TO BE FILLED 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

Su-Swastha Yojna
Department of Health & Family Welfare
Government of Sikkim

DETAILS OF THE HOSPITAL

a) Name Of Hospital

b) Hospital Id ☐☐☐☐☐☐☐☐☐☐ c) Type of Hospital ☐ Network ☐ Non-Network If Non-Network fill relevant section

d) Name of Treating Doctor First Name* Middle Name Last Name*

Qualifications Registration No. with State Code ☐☐☐☐☐☐☐☐

Phone No. ☐☐☐☐☐☐☐☐☐☐

DETAILS OF PATIENT ADMITTED

a) Name of the Patient First Name* Middle Name Last Name*

b) IP Registration No. ☐☐☐☐☐☐☐☐☐☐

c) Gender ☐ Male ☐ Female ☐ Other d) Age Y Y M M e) Date of Birth D D M M Y Y Y Y

f) Date of Admission D D M M Y Y Y Y g) Time H H M M

h) Date of Discharge D D M M Y Y Y Y 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 Y Y ii) Gravida Status ☐☐☐

l) Status at time of Discharge ☐ Discharge to home ☐ Discharge to another Hospital ☐ Deceased

m) Total Claim Amount Rs. ☐☐☐☐☐☐☐☐

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 the Police ☐ Yes ☐ No v) FIR No. ☐☐☐☐☐☐☐☐☐☐

vi) If Not reported to Police, give reason

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REIMBURSEMENT CLAIM FORM - PART B

TO BE FILLED BY THE HOSPITAL

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TO BE FILLED IN BLOCK LETTERS

CLAIM DOCUMENTS SUBMITTED - CHECKLIST

- ☐ 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/MR/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

ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL
(ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)

a) Address of the Hospital

Line 1 _____ Line 2 _____

Line 3 _____ City Village/City/Town

District _____ State _____ Pin Code ☐☐☐☐☐☐

b) Phone No. ☐☐☐☐☐☐☐☐☐☐ c) Registration No. with State Code ☐☐☐☐☐☐☐☐☐☐

d) Hospital PAN No. ☐☐☐☐☐☐☐☐☐☐ e) No. of Patient Beds ☐☐☐

f) Facilities available in the Hospital i) OT ☐Yes ☐No i) ICU ☐Yes ☐No

iii) Others _____

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 Y Y

Place _____

Signature

Signature & Seal of the Hospital Authority