ICICI Lombard Health Care Claim Form - Hospitalisation

(Issuance of this form is not to be taken as an admission of liability)

ICICI Lombard Nibhaye Vaade

ICICI Lombard Health Care

Do You Know

★ To receive update on your claim status, provide your mobile no. & E-mail ID

★ Track your claim status at: www.icicilombard.com→Claims→Health Claims→Services→Track your claims

TO BE FILLED IN CAPITAL LETTERS ONLY

Part - A (To be filled by Insured)

Name of Policy Holder:

Current Policy Number:

Card No./UHID:

Aadhaar No. of Policy Holder: PAN No. of Policy Holder:

Claimant Details

Name of Insured:

Current Residential Address:

City and State:

Pin Code: Mobile No.: Landline No.:

E-mail:

Part - B (Claim Details)

Date of Admission: D D / M M / Y Y Y Y	Time: H H M M
Date of Discharge: D D / M M / Y Y Y Y	Time: H H M M
Number of days of Hospitalization:	
Amount Claimed per day of Hospitalization (₹):	
Total Claimed Amount (₹):	

To be filled in case of Accidental Hospitalization

Nature of Injury: Industrial ☐ Domestic ☐ RTA ☐

If Injury type is Industrial/Domestic: Please provide Incident history

If Injury type is RTA: Please submit MLC / FIR copy

Date of Injury: D D / M M / Y Y Y Y Time of Injury: H H M M Place of Injury:

Details of the amount claimed	Bill number	Bill date	Bills attached	Amount
Room rent		D D M M Y Y	Y N	₹
Doctors consultation/ Visit charges		D D M M Y Y	Y N	₹
Investigation charges (Includes Radiology and Pathology reports)		D D M M Y Y	Y N	₹
Surgeon and Asst. surgeon charges		D D M M Y Y	Y N	₹
Anesthetist charges & Operation theatre charges		D D M M Y Y	Y N	₹
Equipment charges/ Procedure charges		D D M M Y Y	Y N	₹
Cost of implant (If any)		D D M M Y Y	Y N	₹
Pharmacy charges		D D M M Y Y	Y N	₹
Taxes/ Surcharges/ Service charge		D D M M Y Y	Y N	₹
Miscellaneous/ Other charges		D D M M Y Y	Y N	₹
Discount provided by hospital (If any)		D D M M Y Y	Y N	₹
Total claimed amount (In ₹) (Total claimed amount should be equal to the amount in attached bill documents)				₹

Claim documents to be dispatched to: ICICI Lombard Healthcare, ICICI Bank Tower, Plot No. 12, Financial District, Nanakram Guda, Gachibowli, Hyderabad, TS-500032

Part - C - (Bank Details)

(All claims shall be settled in electronic mode only, as per IRDA. Please provide correct bank account details)

Name of the Policy Holder:

Bank account number of Policy Holder:

Name of the Bank:

Branch Name:

IFSC of the Bank: (should be same as per the provided cheque leaflet)

***Policy holder is the person who has paid premium for the policy.**

EFT Mandate Cancelled cheque copy (OR) ☐ Valid photo identity proof (self attested) (OR) ☐ Bank attested copy of passbook with IFSC

ENCLOSURE CHECK LIST

☐ Claim form duly filled & signed ☐ Copy of Discharge Summary ☐ EFT Mandate ☐ Aadhaar Card Copy ☐ PAN Card Copy

☐ Any other documents _____

In case of accidental hospitalisation below documents to be submitted in original.

☐ Final bill ☐ Medicine bills with Prescriptions ☐ Investigation bills supported by Prescriptions & Reports ☐ Payment Receipts

DECLARATION

I hereby agree, affirm and declare that

a) The statements / information given / stated in this claim form are true, correct and complete to the best of my knowledge and belief.
b) No material information which is relevant to the processing of the claim or which any manner has a bearing on the claim has been withheld or not disclosed.
c) If I have given/made any false or fraudulent statement/information or suppressed or concealed or in any manner failed to disclose material information, the policy shall be void and that I shall not be entitled to all/any rights to recover there under in respect of any or all claims, past, present or future.
d) The receipt of this claim form/other supporting/related documents does not constitute an agreement by the Company of the claim and the company reserve the right to process or reject or require further/additional information in respect of the claim.
e) I also consent and authorize ICICI Lombard Health Care to seek medical information from any hospital/medical practitioner who has any time attended on the insured person.
f) 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
g) I confirm that the expenses for which claim is being lodged have been incurred in respect of the insured.

Place : Date: D D / M M / Y Y Y Y

Signature of Claimant/ Policy Holder