Liberty General Insurance Limited
10th Floor, Tower A, Peninsula Business Park,
Ganpatrao Kadam Marg, Lower Parel, Mumbai – 400 013
Phone: +91 22 6700 1313 • Fax: +91 22 6700 1606
Email: care@libertyinsurance.in
IRDA registration number: 150
CIN: U66000MH2010PLC209656

Liberty Health Connect Policy Claim Form

(Standard Claim Form as prescribed by IRDA for Health Products)

Liberty Health Connect Policy
Claim Form: Part - A

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

SECTION - A: Details of Primary Insured

a) Policy Number:_____ b) SL No./Certificate No./Claim Number (If any):_____

c) Company/ TPA ID No:_____

d) Name:_____

e) Address:_____

f) City:_____ g) State:_____ h) Pin Code:_____

i) Phone No:_____ j) Email ID:_____

k) CKYC Code:_____

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: dd/mm/yy

c) If YES, -

Company Name:_____Policy Number:_____

Sum Insured:_____

d) Have you been hospitalized in the last four years since the inception of the contract? YES / NO

Date: MM/YY

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:_____

b) Gender: Male/Female c) Age: _____Years_____Months d) Date of Birth: dd/mm/yy

e) Relationship of 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:_____

h) ABHA ID:_____
If ABHA ID is not available, we urge you to visit - **https://abha.abdm.gov.in/** for creation of ABHA ID and inform the same to us once created.

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SECTION - D: Details of Hospitalization

a) Name of the Hospital where admitted_____

b) Room Category Occupied: Day care / Single Occupancy / Twin sharing / 3 or more

c) Hospitalization due to: Illness / Injury / Maternity

d) Date of Injury / Disease first detected / Date of Delivery: DD MM YYYY

e) Date of Admission: DD MM YY Time: HH MM f) Date of Discharge: DD MM YY Time: HH MM

h) If injury, give cause : Self Inflicted / Road Traffic Accident/ Substance Abuse or Alcohol Consumption

i) If Medico legal: YES/ NO j) Reported to Police: YES/ NO k) MLC report or Police FIR attached: YES / NO

l) System of Medicine _____

SECTION - E: Details of Claim

a) Details of Treatment Expenses Claimed

1. Pre Hospitalization Expenses: Rs .....
2. Hospitalization Expenses: Rs .....
3. Post Hospitalization Expenses: Rs.....
4. Health Check Up cost: Rs .....
5) Ambulance Charges: Rs .....
6. Others (Code) Rs .....

Total: Rs .....

Pre Hospitalization Period:_____days Post Hospitalization Period:_____days

b) Claim for Domiciliary Hospitalization: YES/NO
(If Yes provide details on annexure)

c) Detail of Lump Sum cash benefit claimed:

Hospital Daily Cash: Rs ..... **Surgical Cash:** Rs .....

Critical Illness: Rs .....

Convalescence: Rs ..... **Pre Post Lump Sum:** Rs .....

Vector Borne Disease Benefit: Rs .....

EMI Protector Benefit – EMIs:..... Rs .....

Other: Rs ..... **Total:** Rs .....

Claim Documents Submitted Check List -

- ❑ Claim Form Duly Filled
- ❑ Copy of the Claim Intimation, if any

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Liberty Health Connect Policy Claim Form

- ❑ 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

SECTION - F: Details of Bills Enclosed

Sl. No.	Bill No.	Date	Issued by	Towards	Amount
				Hospital Main Bill	
				Pre Hospitalization Bills Nos	
				Post Hospitalization Bills Nos	
				Pharmacy Bills	
				Total	

Please attach separate sheet for additional bills/receipt details.

SECTION - G: Details of Primary Insureds Bank Account

a) PAN No:

b) Account Number:

c) Bank Name/ Branch:

d) Payable details: Cheque/ DD/NEFT* Payable to:

e) IFSC Code:

SECTION - H: Declaration by the Insured

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 & 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.

Signature of the Insured

Date :
Place :

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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 or 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 Mediclaim / 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 4 years	Indicate whether hospitalized in the last 4 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 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

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DATA ELEMENT	DESCRIPTION	FORMAT
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 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
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 the bank name along with the branch	Name of the Bank in full
d) Cheque/ DD payable details	Enter the name of the 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.		

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Liberty Health Connect Policy Claim Form

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: Hospital Details

Name of the Hospital		Hospital ID:	
Type of Hospital	Network	Non Network	
If Non Network fill Sec. E			
Name of the treating Doctor			
Qualification	Registration No with State Code:	Phone No:	

SECTION - B: Details of the Patient Admitted

Name of the patient		IP Registration Number		
Gender	Male/ Female	Age	Date of Birth: DD/MM/YYYY	
Date of Admission		Time of Admission		
Date of Discharge		Time of Discharge		
Type of Admission	Emergency	Planned	Day-care	Maternity
If Maternity Date of delivery		Gravida Status		
Status at the time of Discharge: Discharge to Home/ Discharge to another Hospital/ Deceased Total Claimed Amount: …….				

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SECTION - C: Details of Ailment Diagnosed

Ailment Diagnosed (Primary)						
ICD 10 Code	Primary Diagnosis	Codes Description	Additional Diagnosis Description	Codes Description	Co-morbidities	Codes
Details of Procedure/s done						
ICD 10 PCS	Procedure 1	Code & Description	Procedure 2	Code & Description	Procedure 3	Code & Description

Pre authorization Obtained	YES/ NO	PRE AUTHRIZATION NUMBER	
Hospitalization due to Injury	YES/ NO	If Yes Give cause	Self-Inflicted/ Road Traffic Accident / Substance Abuse / Alcohol Consumption
Reported to police	YES/ NO	Medico Legal	YES / NO
FIR No	If not reported to police, give reasons		
If injury due to Substance Abuse/ Alcohol consumption test conducted to establish this? If YES please attach Report			YES/ NO
If authorization by network hospital not obtained, give reason			
Note: For details of Claim Documents to be submitted, please refer checklist			

Claim Document Submitted - Checklist

- ❑ Claim Form Duly signed
- ❑ Original Pre-Authorisation Request
- ❑ Copy of Pre-Authorisation Approval Letter
- ❑ Copy of Photo Id Card of Patient verified by the Hospital
- ❑ Hospital Discharge Summary
- ❑ Operation Theater Notes
- ❑ Hospital Main Bills
- ❑ Hospital Break-up Bill
- ❑ Investigation reports
- ❑ CT/MRI/USG/HPE investigation reports
- ❑ Doctor's reference slip for investigation
- ❑ ECG
- ❑ Pharmacy Bills
- ❑ MLC report & Policy FIR
- ❑ Original Death Summary from Hospital where applicable
- ❑ Any other, please specify.

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Details in case of Non-network Hospital (only fill in case of non–network hospital)

Address of the Hospital	:	_____
City	:	_____
State	:	_____
Pin Code	:	_____
Phone No	:	_____
Registration no with state code	:	_____
Hospital PAN	:	_____
No of Inpatient Beds	:	_____
Facilities in the Hospital	:	• OT - ☐ Yes ☐ No • ICU - ☐ Yes ☐ No
Others	:	_____

DECLARATION BY THE HOSPITAL

We hereby declare that the information furnished in this Claim Form is true and correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppressed or concealed any material fact, our right to claim under this Policy shall be forfeited.

SEAL & SIGNATURE
OF THE HOSPITAL AUTHORITY

Date :

Place :

UIN: LIBHLIP24108V042324