REGD. OFFICE:
BHARTI AXA GENERAL INSURANCE COMPANY LIMITED,
RMZ Infinity, B - Tower, 2nd Floor, No. 3, Old Madras Road,
Bangalore - 560016. Tel: 080-40260200.
Toll-Free Helpline: 1800-103-2292
E-mail: claims@bharti-axagi.co.in
www.bharti-axagi.co.in

bharti AXA
GENERAL INSURANCE

HEALTH INSURANCE CLAIM FORM

THE ISSUE OF THIS FORM IS NOT TO BE TAKEN AS AN ADMISSIBILITY OF LIABILITY.

Please fill this form in **Block Letters** and **Tick the Boxes** ☑ where appropriate and do not leave any column unanswered. If any detail or information is not readily available, please do not delay despatch of this report and such particulars may be sent later.

PART - I

Policy Number: _____ Claim Number: _____

Period of Insurance: D D M M Y Y Y Y to D D M M Y Y Y Y

INSURED DETAILS:

Name of the Insured _____

Address _____

_____

_____

_____ City _____

Pin code _____ State _____

Contact Nos. Mobile No. _____ Office +91 _____

Residence +91 _____ E-mail ID _____

For Group Policies:

Corporate Name _____ Employee Code _____

Contact Nos. Mobile No. _____ Office +91 _____

Residence +91 _____ E-mail ID _____

PATIENT DETAILS:

Name of the Patient: _____

Gender: ☐ Male ☐ Female

Date of Birth D D M M Y Y Y Y Relationship with the Insured _____

CLAIM DETAILS:

Type of Claim

☐ Hospitalisation ☐ Domiciliary Hospitalisation ☐ Post Hospitalisation ☐ Critical Illness

☐ Hospital Cash ☐ Others

Date of admission D D M M Y Y Y Y Date of discharge D D M M Y Y Y Y

Name of Hospital, where admitted/treated _____

Address of Hospital _____

_____

_____

Name of attending doctor/physician _____

(Please attach a report from the attending physician in attached format)

ILLNESS/DISEASE:

Nature of Disease / Illness/ Diagnosis _____

Date first noticed/symptoms of disease/illness D D M M Y Y Y Y

INJURY:

Is it arising out of accident: ☐ Yes ☐ No If yes, please complete the following:

Date of accident: D D M M Y Y Y Y

Brief narration of accident _____

Whether FIR filed? ☐ Yes ☐ No If yes, FIR No. _____
(Attach copy of the same)

Police Station _____

If no, please state reasons for not informing police:

Are you currently insured under any other health insurance policies ? ☐ Yes ☐ No
If yes, kindly complete the following table.

Sl. No.	Name & address of Insurance Company	Policy No.	From	To	Sum Insured (Rs.)

Previous claims history

Sl. No.	Name & address of Insurance Company	Nature of illness/ disease/injury	Policy No.	Date of Claim	Claim Ref. No.	Sum Insured (Rs.)

Amount of claim (Please mention & include under what head claims are lodged viz. hospitalisation, post-hospitalisation, critical illness etc. & attach separate sheet if the space is insufficient)

Sl. No.	Description	Bill No.	Date	RR	Med.	Dg.	OTC	CF	AF	Nursing	Diet	Others*	Total
	(Hospitalisation/Post-hospitalisation/Critical illness etc.)												
			Total										

RR - Room rent, Med. - Medicines, Dg. - Diagnostics, OTC - Operation Theatre Charges, CF - Consultants' Fees, AF - Anaesthetists Fees, * - Please specify

Please furnish the following list of documents:

- ☐ Discharge Summary in full
- ☐ FIR, in injury cases
- ☐ All prescription along with medical reports
- ☐ Specialist's certificate confirming the diagnosis with supporting pathological, imaging or any other reports
- ☐ All hospital/drug bills & receipts in original
- ☐ First consultation report
- ☐ Attached physician's statement duly completed by him/her
- ☐ Surgeon's certificate stating nature of operation performed with detailed operative notes

INSURED'S / PATIENT'S CONSENT FOR ACCESS TO MEDICAL RECORDS & DECLARATION

I/We hereby authorize Bharti AXA General Insurance Co. Ltd. or any other individual/agency engaged by Bharti AXA to obtain all medical records pertaining to the above patient available with any hospital/doctor. The Insurance Company or their representatives or any other authorised agency engaged by them may be allowed access & possession of medical records pertaining to the above patient. The necessary charges will be borne by the Insurance Co. or their authorised agencies.

I/We agree to provide additional information to the Company, if required. I/We the abovenamed, do hereby, to the best of my/our knowledge and belief, warrant the truth of the foregoing statement in every respect, and if I/We have made, or in any further declaration the Company may require in respect of the said accident, shall make any false or fraudulent statement, or any suppression or concealment, the policy shall be void and all rights to recover thereunder in respect of past or future claims shall be forfeited.

Date: _____ Place: _____ _____
Signature of Insured

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PART - II: ATTENDING PHYSICIAN'S STATEMENT

Name of the Patient: _____

Age | | | Years Gender: ☐ Male ☐ Female

Address _____

_____

_____

_____ City _____

Pin code _____ State _____

Illness/Disease cases:

Date when patient first reported symptoms of disease/illness : |D|D|M|M|Y|Y|Y|Y|

Diagnosis: _____

_____

_____

Date when patient might have contacted/developed disease/illness in your opinion: |D|D|M|M|Y|Y|Y|Y|

Please provide previous medical history of the patient:

_____

_____

Is the present condition attributable to congenital defect? If yes, please provide details:

_____

_____

_____

Injury cases:

Nature of the accident and details of injuries sustained:

_____

_____

_____

Are the injuries solely due to the accident or traceable to any previous injuries/disease/infirmities?

_____

_____

_____

Nature of treatment/surgery performed for present illness/disease/injury:

Was he under the influence of intoxicants or drugs at the time of accident?
If yes, please provide details of diagnosis done and alcohol content.

Are you his usual medical attendant? ☐ Yes ☐ No

If yes, please give detailsof previous treatment for any illness/disease/injury:

Date: D D M M Y Y Y Y

Doctor's Name
(preferably name & address stamp)

Registration No.

Address

Telephone No.

Date:

Doctor's Signature

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