RELIANCE GENERAL INSURANCE

reliancegeneral.co.in
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Corona Kavach Policy, Reliance General
Claim Form - Part B

(To be filled in BLOCK LETTERS)

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

SECTION A - DETAILS OF HOSPITAL

a) Name of the Hospital _____ Hospital ID _____

b) Hospital Email ID _____ ROHINI ID _____

c) Type of Hospital ☐ Network ☐ Non Network (if non network fill section E)

d) Name of the treating doctor _____

e) Qualification _____

f) Registration No with state code _____ g) Phone No _____

h) Email Id: _____

SECTION B - DETAILS OF PATIENT ADMITTED

a) Name of the patient _____

b) IP Registration Number _____

c) Gender ☐ Male ☐ Female c) Age - _____ years _____Months d) Date of birth 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) Type of admission ☐ Emergency ☐ Planned

j) Status at time of discharge ☐ Discharge to home ☐ Discharge to another hospital ☐ Deceased

k) Total claimed amount ₹_____/-

SECTION C - DETAILS OF AILMENT DIAGNOSED (PRIMARY) - Part A

S.No	ICD 10 Codes	Description
1	Primary Diagnosis	
2	Additional Diagnosis	
3	Co-morbidities	
4	Co-morbidities	

SECTION C - DETAILS OF AILMENT DIAGNOSED (PRIMARY) - Part B

S.No	ICD 10 PCS	Description
1	Procedure 1	
2	Procedure 2	
3	Procedure 3	
4	Details of procedure	

An ISO 9001:2015 Certified Company

Please courier documents to the below address:

RCare Health: Reliance General Insurance, No.1-89/3/B/40 to 42/ks/301, 3rd floor, Krishe Block, Krishe Sapphire, Madhapur, Hyderabad 500081.
Email: rgicl.rcarehealth@relianceada.com.

l) Pre - authorization obtained ☐ Yes ☐ No

m) Pre - authorization number _____

n) If authorization by network hospital not obtained, give reason _____

Covid Hospitalization Cover- Claim Document Submission Checklist

S.No	Documents	
1	☐	Duly filled and signed Claim Form
2	☐	Copy of Insured Person's passport, if available (All pages)
3	☐	Photo Identity proof of the patient (if insured person does not own a passport)
4	☐	Medical practitioner's prescription advising admission
5	☐	Original bills with itemized break-up
6	☐	Payment receipts
7	☐	Discharge summary including complete medical history of the patient along with other details.
8	☐	Investigation reports including Insured Person's test reports from Authorized diagnostic centre for COVID
9	☐	OT notes or Surgeon's certificate giving details of the operation performed, wherever applicable
10	☐	Sticker/Invoice of the Implants, wherever applicable.
11	☐	NEFT Details (to enable direct credit of claim amount in bank account) and cancelled cheque
12	☐	KYC (Identity proof with Address) of the proposer, where claim liability is above Rs 1 Lakh as per AML Guidelines
13	☐	Legal heir/succession certificate, wherever applicable

Any other relevant document required by Company for assessment of the claim.

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

a) Address of the Hospital _____

City _____ State _____ Pin Code _____

b) Phone No _____ c) Registration No with state code _____

d) Hospital PAN _____ e) Number of Inpatients bed _____

f) Facilities available in the hospital i) OT ☐ Yes ☐ No ii) ICU ☐ Yes ☐ No iii) Others _____

SECTION F - DECLARATION BY THE HOSPITAL

We hereby declare that the information furnished in the claim form is true & correct to the best of my 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 & Seal of Hospital Authority _____

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