UCOBANK RETIREES' ASSOCIATION
KARNATAKA (Regd)
(Regd as S.No: 699/97-98 Dated 20/01/1998
with the Registrar of Societies, Karnataka)
Regd Office: C/o UCO Bank, 3rd Floor, 13/22,
Kempegowda Road, Bangalore-560009
Website: urakar.com

UBRA-KAR/CIR/006/2023- 26 **Date: 25.11.2023.**

To all members of our unit.

Dear Comrades,

SUB: IBA Health Insurance Policy 2023 - 24.

We are all aware that M/S. Health Insurance is our TPA for the year 2023 - 24. Now they have furnished details regarding the downloading the E Card and forms related to submission of claim papers, in the case of hospitalisation.

There are two procedures for downloading the E Card.

I. Kindly send a mail from your registered email ID, mentioning the following particulars to

seniorcitizens@hitpa.co.in

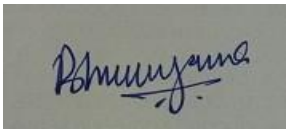
Name
PFM Number
Mobile Number
You will receive your e card by mail.

II. Go to
www.hitpa.co.in
Download-E Card IBA card-click UCO Bank
Select Policy No
Mention Emp No/ PF No
Download
Your card will appear, Please save the card.

III.Policy details:
Base Policy No. 251100502310000287
Top Up Policy No. 251100502310000290

IV. The contact person at Head Office Mediclaim Deptt. - Nodal Officer Shri Mohit Kumar Chief Manager Mob. No.9822711464
The contact person at HITPA Bangalore Office - Mr. Kumar, Mob no. +91 84483 99486

V. The check list for submission of claims and the claim forms are attached.



B.Lakshminarayana,
Hon. Secretary.

Encl: as above. All Correspondence to:B.Lakshminarayana, No.1317,11th main,5th A Cross Srinivasanagar II Phase, B.S.K. III Stage,BANGALORE – 560 050.Mob: 9845443998; Email:balana56@gmail.com

हैल्थ इन्श्योरेंस टीपीए ऑफ इन्डिया लिमिटेड
HEALTH INSURANCE TPA OF INDIA LTD.

CHECK LIST FOR SUBMISSION OF REIMBURSEMENT CLAIM

Please attach the checklist with the Claim file.

Arrange the documents in the same order as in the checklist & keep checking against the designated box when you do so. This way you can ensure that you have not missed any documents.

Name : _____ Emp. No. : _____

E-mail ID : _____ Mobile No. : _____

Policy No. : _____ HI TPA ID : _____

Checklist for documents: Please Put a ✓ mark against the box

1. Claim form duly filled & signed by the insured. ☐
2. Copy of your Member Photo ID / Photo ID Proof ☐
3. Copy of your current Policy and also last 4 years Policies (if available). ☐
4. Discharge Summary / Discharge card (Original, Photocopy for pre/post hospitalization claim) ☐
5. Hospital bills and all payment receipts (Original) For all consolidated amounts, the detailed breakup of the billed amount is required from the hospital. Advance payment made if any should be supported by a receipt. ☐
6. For medicines purchased from outside the original bill should be accompanied by a prescriptions from the doctor. ☐
7. All investigation reports. ☐
8. In case of hospitalization due to accident, medico legal certificate (MLC) from hospital. ☐
9. All Previous treatment papers related to ailment including first consultation papers. ☐
10. Cancelled Cheque (with pre-printed name) / Copy of passbook of the proposer for electronic fund transfer type. Complete Account Number duly signed by insured and Bank authority and sealed by the bank (All Fields in the form are mandatory to process). {Not required if already provided} ☐
11. Registration Certificate of the hospital or a certificate from the hospital giving infrastructure details eg Number of Beds, Availability of Doctor's & Nurse's round the clock. Operation theatre etc. ☐
12. Summary of claim made providing details of Bill no. date amount. ☐
13. Copy of claim intimation (if Any). ☐
14. KYC (Photo ID and Address Proof of the Proposer) for claim of 1 lakh and above. ☐
15. Claim intimation should be given within 24hrs of admission, if there is delay more than that kindly provide justification for the same. ☐
16. Claim documents should be submitted within 7 days from discharge/last consultation. if there is delay more than that kindly provide reason for the same. ☐
17. Sticker /Invoice of the Implant/lens used (if applicable)

Important Points to remember

Please retain a duplicate copies of all the documents submitted to us for future reference.

For any assistance with any of the above formats, please contact us at : **customerservice@hitpa.co.in** or call at :**-1800-102-3600 / 1800-180-3600**

Please retain a POD copy of the courier for tracking your consignment in case of any etc.

The above list of documents is indicative. In case of any other document requirement as specified by the insurance company our Document recovery Team will contact you on receipt of the claim documents by us. For Implants used in Cataract. Heart Valve Surgeries. CABG, Abdominal Surgeries Knee replacement surgeries, please submit the bill from the vendor for the prosthetic device used along with sticker.

हैल्थ इन्श्योरेंस टीपीए ऑफ इन्डिया लिमिटेड
HEALTH INSURANCE TPA OF INDIA LTD.

CLAIM FORM - PART A' to '
CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT - 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)

SECTION A

DETAILS OF PRIMARY INSURED:

a) Policy No.: b) Sl. No./Certificate No.

c) Company/TPA ID No.:

d) Name: SURNAME FIRST NAME MIDDLE NAME

e) Address:

City: State:

Pin Code: Phone No.: Email ID:

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: D D M M Y Y Y Y

c) If yes, company name: Policy No.

Sum Insured (Rs.) d) Have you been hospitalized in the last four years since inception of the contract? Yes No Date: M M Y Y

Diagnosis: e) Previously covered by any other Mediclaim/Health insurance: Yes No

e) If yes, company name:

SECTION C

DETAILS OF INSURED PERSON HOSPITALIZED::

a) Name: SURNAME FIRST NAME MIDDLE NAME

b) Gender Male Female c) Age years Y Y Months 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 diffrent from above) :

City: State:

Pin Code Phone No.: Email ID:

SECTION D

DETAILS OF HOSPITALIZATION::

a) Name of Hospital where Admited:

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 / Date Disease first detected /Date of Delivery: D D M M Y Y Y Y

e) Date of admission: D D M M Y Y f) Time: H H M M g) Date of Discharge: D D M M Y Y h) Time: H H M M

I) If injury give cause: Self inflicted Road Traffic Accident Substance Abuse / Alcohol Consumption i) If medical legal Yes No

ii) Reported to Police Yes No iii) MLC Report & Police FIR attached Yes No j) System of Medicine:

SECTION E

DETAILS OF CLAIM:

a) Details of the Treatment expenses claimed

I. Pre-hospitalization expenses Rs.

ii. Hospitalization expenses Rs.

iii) Post-hospitalization expenses Rs.

iv. Health-Check up cost: Rs.

v. Ambulance Charges: Rs.

vi. Others (code): Rs.

Total Rs.

vii. Pre-hospitalization parid: days

viii. Post-hospitalization period: days

b) Claim for Domiciliary Hospitalization: Yes No (if yes, provide details in annexure)

c) Details of Lump sum / cash benefit claimed:

I. Hospital Daily cash: Rs.

ii. Surgical Cash: Rs.

iii. Critical Illness benefit: Rs.

iv. Convalescence: Rs.

v. Pre/Post hospitalization Lump sum benefit: Rs.

vi. Others: Rs.

Total Rs.

Claim Documents Submitted - Check List:

- 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

SECTION F

DETAILS OF BILLS ENCLOSED:

Sl. No.	Bill No.	Date	Issued by	Towards	Amount (Rs)
1.		D D M M Y Y		Hospital mail Bill	
2.		D D M M Y Y		Pre-hospitalization Bills: Nos	
3.		D D M M Y Y		Post-hospitalization Bills: Nos	
4.		D D M M Y Y		Pharmacy Bills	
5.		D D M M Y Y			
6.		D D M M Y Y			
7.		D D M M Y Y			
8.		D D M M Y Y			
9.		D D M M Y Y			
10.		D D M M Y Y			

SECTION G

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT::

a) Pan: b) Account Number:

c) Bank Name and Branch:

d) Cheque / DD Payable details: e) IFSC Code:

(IMPORTANT: PLEASE TURN OVER)

DELARATION BY THE INSURED:

I hereby declare that the information furnished in the claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealent of any material fact with respect to questions asked in relation to this claim, my right to claim reimbrusement 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

SECTION H

Date D D M M Y Y Y Y

Signature of the Insured

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)	Sl. No/ Certificate No.	Enter the social Insurance number or the certificate number of social health insurance scheme	As allotted by the oraganization
c)	Company TPA ID No.	Enter the TPA ID No.	Licence number as allotted by IRDA and printed in TPA documents
d)	Name	Enter the full name of the policy holder	Surname, First name, Middle name
e)	Address	Enter the full postal addresse	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-forrmat
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 four years since Inception of the contract?	Indicate whether hospitalized in the last four 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 Noe
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
I)	E-mail ID	Enter e-mail address of patient	Complete e-mail address
	SECTION D - DETAILS OF HOSPITALIZATION		
a)	Name of Hospital where admited	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 Medicene	Enter the system of medicine followed in treating the patient	Open Text
	SECTION E - DETAILS OF CLAIM		
a)	Details of Treatment Expences	Enter the amount claimed as treatment expences	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 benifit 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 amount 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
c)	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
c)	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.			

हैल्थ इन्श्योरेंस टीपीए ऑफ इन्डिया लिमिटेड
HEALTH INSURANCE TPA OF INDIA LTD.

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

DETAILS OF HOSPITAL

a) Name of the hospital:

b) Hospital ID: c) Type of Hospital: Network: Non Network: (if non Network fill section E)

c) Name of the treating doctor: SURNAME FIRST NAME MIDDLE NAME

e) Qualification: f) Registration No. with State Code: g) Phone No.

SECTION B

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient: SURNAME FIRST NAME MIDDLE NAME

b) IP Registration Number: c) Gender: Male Female d) Age: Years: Y Y Months M M e) Date of birth: D D M M Y Y

f) Date of Admission: D D M M Y Y g) Time: H H M M h) Date of Discharge: D D M M 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 ii) Gravida Status:

l) Status at time of discharge: Discharge to home Discharge to another hospital Deceased m) Total claimed amount

SECTION C

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a)	ICD 10 Codes	Description	b)	ICD 10 Codes	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 police Yes No

v. FIR No. vi. If not reported to police give reason:

SECTION D

CLAIM DOCUMENTS SUBMITTED - CHECK LIST

- 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

City: State:

Pin Code: b) Phone No. c) Registration No. with State Code:

d) Hospital PAN: e) Number of impatient beds 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 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

Place:

Signature and Seal of the Hospital Authority:

GUIDANCE FOR FILLING CLAIM FORM - PART B (To be filled in by the hospital)		
DATA ELEMENT	**DESCRIPTION**	**FORMAT**
SECTION A - DETAILS OF HOSPITAL		
a) Name of the hospital:	Enter the name of hospital	Name of the hospital in full
b) Hospital ID	Enter ID number of hospital	As allocated by the TPA
c) Type of Hospital	Indicate whether in network or non network hospital	Tick the right option
c) Name of treating doctor	Enter the name of the treating doctor	Name of doctor in full
e) Qualification	Enter the qualification of the treating doctor	Abbreviations of educational qualifications
f) Registration No. with State Code	Enter the registration number of the doctor along with the state code	As allocated by the Medical Council of India
g) Phone No.	Enter the phone number of doctor	Include STD code with telephone number
SECTION B - DETAILS OF THE PATIENT ADMITTED		
a) Name of Patient	Enter the name of patient	Name of patient in full
b) IP registration Number	Enter insurance provider registration number	As allotted by the insurance provider
c) Gender	Indicate Gender of the patient	Tick Male or Female
d) Age	Enter age of the patient	Number of years and months
e) Date of Birth	Enter date of birth	Use dd-mm-yy format
f) Date of Admission	Enter date of admission	Use dd-mm-yy format
g) Time	Enter Time of admission	Use hh:mm format
h) Date of Discharge	Enter date of Discharge	Use dd-mm-yy format
I) Time	Enter time of Discharge	Use hh:mm format
j) Type of Admission	Indicate type of admission of patient	Tick the right option
k) If Maternity		
Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format
Gravida Status	Enter Gravida status if maternity	Use standard format
l) Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
M) Total claimed amount	Indicate the total claimed amount	In rupees (Do not enter paise values)
SECTION C - DETAILS OF AILMENT DIAGNOSED (PRIMARY)		
a) ICD 10 Code		
Primary Diagnosis	Enter the ICD 10 Code and description of the primary diagnosis	Standard Format and Open text
Additional Diagnosis	Enter the ICD 10 Code and description of the additional diagnosis	Standard Format and Open text
Co-morbidities	Enter the ICD 10 Code and description of the Co-morbidities	Standard Format and Open text
b) ICD 10 PCS		
Procedure 1	Enter the ICD 10 Code and description of the first procedure	Standard Format and Open text
Procedure 2	Enter the ICD 10 Code and description of the second procedure	Standard Format and Open text
Procedure 3	Enter the ICD 10 Code and description of the third procedure	Standard Format and Open text
Details of Procedure	Enter the details of the procedure	Open text
c) Pre-authorization obtained	Indicate whether pre-authorization obtained	Tick Yes or No
d) Pre-authorization Number	Enter pre-authorization number	As allotted by TPA
e) If authorization by network hospital not obtained, give reason	Enter reason for not obtaining pre-authorization number	Open text
f) Hospitalization due to injury	Indicate if hospitalization is due to injury	Tick Yes or No
Cause	Indicate cause of injury	Tick the right option
If injury due to substance abuse/alcohol consumption test conducted to establish this	Indicate whether test conducted	Tick Yes or No
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
FIR No.	Enter first information report number	As issued by police authrities
If not reported to police, give reason	Enter reason for not reporting to police	Open text
SECTION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST		
Indicate which supporting documents are submitted		
SECTION E - DETAILS IN CASE OF NON NETWORK HOSPITAL		
a) Address	Enter the full postal address	Include Street, City and Pin Code
b) Phone No.	Enter the phone number of hospital	Include STD code with telephone number
c) Registration No. with State Cod	Enter the registration number of the Hospital obtained from local body like City Corporation / Municipality	As allocated by the City Corporation / Municipality
d) Hospital PAN	Enter the permanent account number	As allocated by the Income Tax Department
e) Number of Inpatient beds	Enter the number of inpatient beds	Digits
f) Facilities available in the hospital	Indicate facilities available in the hospital	Tick the right option. If others, please specify
SECTION F - DECLARATION BY THE HOSPITAL		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign. and stamp		

हैल्थ इन्श्योरेंस टीपीए ऑफ इन्डिया लिमिटेड

HEALTH INSURANCE TPA OF INDIA LTD.

Registered and corporate office :Health Insurance TPA of India Ltd.,2nd Floor, Majestic Omnia Building, A-110, Sector 4 Noida, Uttar Pradesh - 201301.

CONSENT FORM

From:

Patient's Name and address:

Policy no:

Hospital IPD no:

To:

Hospital Name:

Madam/Sir,

I hereby authorize TPA representatives/Investigator free and unlimited access to seek medical information (Indoor case papers, reports, documents, including photocopies thereof pertaining my admission / treatment) from any hospital / medical practitioner from which or whom I have at any time sought or shall seek medical attention concerning any disease/ sickness, ailment or injury, which affects my physical or mental health.

Yours faithfully

Signature of the Patient/Insured