ICICI Lombard Health Insurance

ICICI Lombard Health Care Claim Form - Outpatient Department

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

ICICI Lombard Health Care

Do You Know

★ Non-submission of bills and receipts is the main reason for delay in claim settlements. Please provide all mandatory documents.

★ To receive updates on your claim status, do provide your WhatsApp enabled mobile number & your E-mail address.

★ You can track your claim by downloading the ILTake Care App, on WhatsApp just say 'Hi' to RIA on 7738282666 or on our Website at www.icicilombard.com, simply navigate to Claims > Health Claims.

TO BE FILLED IN CAPITAL LETTERS ONLY

Part - A

NOTE: Every insured member claiming for OPD need to fill a seperate claim form

1. **Name of Policy Holder/Proposer*/Employee:**

Current Policy Number: Card No./UHID:

PAN No. of the Proposer*/Employee:

2. Tick appropriately : **Individual/Retail** Policy ☐ **Group/Corporate** Policy ☐ , Company name: _____

(*Policy Holder. For Retail Policy proposer name required. For Corporate Policy provide employee name) Employee ID:

3. **Details of the Insured Person in respect of whom claim is made: (patient details)**

Name of Insured:

Relationship with the Policy Holder : Present completed age (In Years) : Gender M ☐ F ☐ T ☐

Occupation: Service ☐ Self Employed ☐ Homemaker ☐ Student ☐ Retired ☐ Other ☐ (Please specify)_____

Current Residential address:

City: State:

Pin Code: Mobile No.: Landline No.:

E-mail:

ABHA Number

ABHA is a 14 digit number that will uniquely identify you as a participant in India's digital healthcare ecosystem.

4. **Nature of disease / illness contracted or injury suffered** _____

5. **Date of Constitution Letter** D D / M M / Y Y Y Y

6. **Provide Name and contact details of treating Doctor:**

7. **Details of the Amount Claimed**

Bill Heads (as Applicable)	**Bill Number**	**Bill Date**	**Bills attached**	**Amount (In ₹)**
Consulting Doctor's Fees		D D M M Y Y	Y N	
Pharmacy/Medicine Charges		D D M M Y Y	Y N	
Investigation Charges		D D M M Y Y	Y N	
Others (Kindly Specify)		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)				

Part - B

In support to the above claim, I enclose following documents {Please indicate by (✓)}

☐ Bills/ Receipt/ Cash Memos in original for medicines etc. (name of patient along with date should be mentioned on it.)

☐ Most Recent Medical prescription/ Consultation papers in support of the above.

☐ Receipts and Investigation test reports in original from a Pathological Lab supported by the note from the treating doctor/ Surgeon advising such Investigation tests.

☐ Attending doctors/ Consultant's/ Specialist's bill and receipt and certificate regarding diagnosis, whichever is prescribed and thereby expenses incurred along with doctors registration number (compulsory).

Mandatory:

☐ **1. Part - C (For EFT/RTGS/NEFT)**

DECLARATION

I hereby agree, affirm and declare that

a) The statements / information given / stated by me/us in this claim form are true, correct and complete.

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) I have not submitted any other claim under Outpatient Treatment Cover (Benefit 'B') and shall not be submitting any other Outpatient Treatment Cover claim in future under the above referred Policy Certificate.

e) 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.

f) 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.

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/ Proposer

18/03/2024/0001

क्लेम फॉर्म हिन्दी के लिए कृपया हमारी वेबसाइट पर जाँच कीजिए : www.icicilombard.com

Claim documents to the dispatched to: ICICI Lombard Healthcare, Varun Tower II, 1st, 4th, 5th & 6th Floor, Begumpet, Hyderabad, Telangana, Pincode – 500016.

ICICI Lombard
Nibhaye Vaade

Part - C - NEFT Form
(For Direct Electronic Fund Transfer)

Mandatory: All claim settlements must be processed through NEFT (as per regulatory norms). Please provide your bank account details along with a copy of a cancelled cheque/passbook or a bank statement showing the payee/account holder's name and IFSC code Please provide your consent to credit ₹ 1 to your bank account mentioned in the grid below for claim processing.

C1. Patient's Name: (in respect of whom claim is made):

C2. PAN No. of the Proposer (Mandatory if claim amount is greater than 1 lakh)

C3. Card No./ UHID No.

C4. Claim Number (if allotted): **C5. Mobile/ Contact No.:**

C6. Email:

C7. As per IRDA Circular No.: IRDA/F&A/CIR/GLD/056/02/2014, Proposer's/ policy holder's bank account details are mandatory to process the claim through EFT.

Please provide below documents of proposer/ policy holder-

- ☐ Please provide a self-attested copy of a valid Identity proof of the Proposer/Policy holder (provide any of the mentioned documents in Proof of Identity under Part-D)
- ☐ Cancelled cheque copy/ Bank attested copy of Passbook with IFSC code

C8. Please provide the below details (all fields are compulsory)

- Proposer (policy holder)/ Employee name*(as per bank records):
- Proposer/ policy holder Bank account no.:
- Name of the bank:
- Branch name:
- Address of the bank:
- IFSC code no. of the bank: (should be same as per the provided cheque leaflet)

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

For Retail policy, Name & Account details of Proposer required. For Corporate policy, Employee Name & Account details required.

Terms and Conditions for Payments through RTGS/ NEFT

1. The details provided by the Proposers/ policy holder in the Mandate Form shall be considered as final and ICICI Lombard General Insurance Company Ltd. shall not be responsible for cross verification of any of the details provided therein.
2. The RTGS/ NEFT facility shall be effective for the respective Proposer(s)/ policy holder within 15 days of the receipt of the Mandate Form by ICICI Lombard General Insurance Company Ltd. and/ or within such period as may be reasonably required by ICICI Lombard General Insurance Company Ltd. to activate the RTGS/ NEFT facility.
3. The Proposer/ policy holder agrees that under the RTGS/ NEFT facility, there may be a risk of non-payment in the Proposer/ policy holder Accounts No. on the day of the credit of payments due to change in the applicable regulations pertaining to RTGS/ NEFT facility or due to any other reasons without any fault/ inaction/ failure on part of ICICI Lombard General Insurance Company or any factor beyond the control of ICICI Lombard General Insurance Company Limited.
4. The Proposer/ policy holder agrees to indemnify, without delay or demur, ICICI Lombard General Insurance Company Ltd. and its agents and keep ICICI Lombard General Insurance Company Ltd. and its agent indemnified harmless at all times from and against any and all claims, damages, losses, costs, and expenses (including attorney's fees) which ICICI Lombard General Insurance Company Ltd. may suffer or incur, directly or indirectly, arising from or in connection with, amongst other things, either of the aforesaid reasons stated in above clauses.
5. ICICI Lombard General Insurance Company Ltd. May sub-contract and employ agents to carry out any of its obligations under the RTGS/ NEFT facility. The Proposer/ policy holder may discontinue or terminate the use of RTGS/ NEFT facility by giving a minimum of 15 days prior written notice to ICICI Lombard General Insurance Company Ltd. The notice of, such termination should be given to ICICI Lombard only at its corporate address and be addressed at ICICI Lombard GIC Ltd., ICICI Lombard House (Old Tata Press Building), 414, Veer Savarkar Marg, Near Siddhi Vinayak Temple, Prabhadevi, Mumbai - 400025.
6. A confirmation of the receipt of termination notice given by the Proposer/ policy holder will be acknowledged through a confirmation letter by ICICI Lombard General Insurance Company Ltd. In no case can the Proposer/ policy holder construe his termination notice as effective unless a confirmation has been provided by ICICI Lombard to the Proposer/ policy holder stating the date of receipt of such communication by the Proposer/ policy holder.
7. The Proposer/ policy holder agrees that transaction(s) through RTGS/ NEFT facility may attract inward RTGS/ NEFT charges, which if levied by the Proposer's/ policy holder's bank, shall be borne by the Proposer/ policy holder only.
8. ICICI Lombard has the absolute discretion to amend or supplement any Terms and Condition stated herein at any time and will endeavor to give prior notice of ten days for such changes wherever feasible for the Terms and Conditions to be applicable. By using the new services, or at the completion of such period, whichever is earlier, the Proposer/ policy holder shall be deemed to have accepted the changed Terms and Conditions.
9. Submission of documents or bank details or any other information does not in any way, shape or form, imply or express or suggest admission of liability by the company.
10. Notices under these Terms and Conditions may be given in writing by delivering them by hand or e-mail or on ICICI Lombard General Insurance Company Ltd. website www.icicilombard.com or by sending them by post to the last address of the Proposer/ policy holder.
11. These Terms and Conditions will be governed by the laws of India and any legal action or proceedings arising out of these Terms and Conditions shall be initiated in the courts or tribunals at Mumbai in India.
12. I/We further undertake to refund any excess amount whether demanded by ICICI Lombard General Insurance Company Ltd. or not, which has been credited in excess to my account at any time due to any reason within 7 days of such receipt of such communication from ICICI Lombard of such excess credit or such information of excess credit coming to the knowledge of the Proposer/ policy holder through any other source.
13. I/We agree that my/ our claim payment will be credited from the date ICICI Lombard General Insurance Company Ltd. gets confirmation from its bankers, This facility will continue unless it is revoked by any party and any issuance of relevant credit instruction from ICICI Lombard General Insurance Company Ltd. to its bankers will be valid till such instruction is complete irrespective of the fact that the notice period has expired provided such a credit request has been made by ICICI Lombard General Insurance Company Ltd. before the expiry of the notice period of the Proposer/ policy holder.

Account Holder's Signature

ICICI Lombard
Nibhaye Vaade

Mailing Address: ICICI Lombard Healthcare, Varun Tower II, 1st, 4th, 5th & 6th Floor, Begumpet, Hyderabad, Telangana, Pincode – 500016.
Registered Office Address: ICICI Lombard House, 414, Veer Savarkar Marg, Near Siddhi Vinayak Temple, Prabhadevi, Mumbai 400 025.
Visit us at: www.icicilombard.com. • **E-Mail us at:** ihealthcare@icicilombard.com. • **Toll Free Number:** 1800 2666.
• **Toll Free Fax Number:** 1800 209 8880 • IRDA Registration No. 115

18/03/2024/0001