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: MOUTHI NURSING HOME PVT LTD

a) Hospital ID:

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

c) Name of the treating doctor: Dr. A. K. RAVIKUMAR (FIRST NAME / MIDDLE NAME)

e) Qualification: MS, FAIS, FIAGES

f) Registration No. with State Code: 42774

g) Phone No. 9800222404

DETAILS OF THE PATIENT ADMITTED

a) Name of the Patient: Mrs. JAYALAKSHMI. (FIRST NAME / MIDDLE NAME)

b) IP Registration Number: 518-2025

c) Gender: Male ☐ Female ☑

d) Age: Years 77 Months MM

e) Date of birth: DD MM YY

f) Date of Admission: 05 06 25

g) Time: HH 5 00 Pm

h) Date of Discharge: 08 06 25

i) Time: 12 30 Pm

j) Type of Admission: Emergency ☑ Planned ☐ Day Care ☐ Maternity ☐

k) If Maternity

i) Date of Delivery: DD MM YY

ii) Gravida Status:

l) Status at time of discharge: Discharge to home ☑ Discharge to another hospital ☐ Deceased ☐

m) Total claimed amount

SECTION B

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a)	ICD 10 Codes	Description
I. Primary Diagnosis		Discharge Summary enclosed
ii. Additional Diagnosis:		
iii. Co-morbidities:		
iv. Co-morbidities:		

b)	ICD 10 PCS	Description
i. Procedure 1:		
ii. Procedure 2:		
iii. Procedure 3:		
iv. Details of Procedure:		

SECTION C

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:

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

SECTION D

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

a) Address of the Hospital: MOUTHI NURSING HOME PVT LTD
84/2, 19.20 Perumal Kovil Street, Alamaram Bus Stop, Vadavalli

City: Coimbatore State: Tamil Nadu

Pin Code: 641041

b) Phone No. 9965522405

c) Registration No. with State Code: 181-8503

d) Hospital PAN: AADCM4345

e) Number of inpatient beds: 035

f) Facilities available in the hospital: i. OT ☑ Yes ☐ No ii. ICU ☑ Yes ☐ No

iii. Others: Diabetic foot care

SECTION E

DECLARATION BY THE HOSPITAL

(PLEASE READ VERY CAREFULLY)

We hereby declare that 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: 08 06 25

Place: Coimbatore.

Signature and Seal of the Hospital Authority:

MOWTHI NURSING HOME (P) LTD
Regd. Office: 19.20, Perumal Kovil Street
Alamaram Stop, Vadavalli,
Coimbatore - 641 041

SECTION F