भारतीय जीवन बीमा निगम
LIFE INSURANCE CORPORATION OF INDIA

HOSPITAL TREATMENT FORM **(To be filled in by the Hospital Authorities) PART 'B'**

The Benefits under this policy are fixed as per Daily Benefit opted by policyholder at proposal stage and has no relation to actual expenses / free treatment incurred by him before, during or after Hospitalization. This benefit can be claimed irrespective of any other claim under any policy.

***If* treatment *from more than one Hospital, forms from all the Hospitals duly filled in are to be submitted*)**
(If admission to ICU for more than one spell, details of such different admissions to be given separately)

Name of the patient					
Age		SEX		In.Patient No.	
Date of Admission in Hospital				Time of Admission	
Date of Discharge from Hospital				Time of Discharge	
Date of Admission in ICU				Time of Admission in ICU	
Date of Discharge from ICU				Time of Discharge from ICU	
Name of the Attending Doctor/Surgeon				**Regd. No.**	
Diagnosis					
Whether present ailment/ disease is a complication of any pre-existing condition that the patient is suffering from?					
History of past illness/ ailment/ disease					
Diagnosis		Duration of illness		**Past surgeries undergone**	
If 'Yes' please specify the disease/ailment (or) complication of any previous surgery and the onset of date of the disease					
Is the disease /ailment/disorder congenital in nature?					
Brief description of the treatment given for present hospitalization					
a)Nature of Surgery performed and Duration of surgery b)Specify the details of Surgery (laser, detailed procedure, any other modern technical incision)					
In case of Accident Cases / RTA, whether a) Under the influence of Alcohol b) Medico Legal case c) FIR lodged					

HOSPITAL / DAY CARE CENTRE DETAILS

Name of the Hospital & Address			
Hospital Registration No.		**Registered under** (1) Clinical Establishments (Registration & Regulation) Act, 2010l	**YES / NO**
Registered under (2) Enactments specified under Schedule of Section 56(1) of Clinical Establishment Act,2010 ;	**YES / NO**	**No. of beds:**	
Registered under any other Act? If YES, pl. specify:			
Is the Medical Centre under supervision of registered and qualified medical practitioner: YES /NO			
Whether the hospital is having			
A fully equipped operation Theatre: YES / NO		ICU UNIT: YES / NO	
Qualified nurses Round the clock : YES / NO		Qualified doctors round the clock: YES / NO	
Maintained daily records of patients : YES / NO		Are Daily Records accessible to LIC's authorized personnel : YES / NO	

A Clear copy of the Health Card / Photo ID (eg. PAN card / Voter card / Passport / Driving License etc) of the patient needs to be affixed here and is to be attested by the Principal Insured (PI) and attested by the Hospital Authorities.

Certificate

This is to certify that Sri/Smt/kum._____ whose ID Card/Photo is pasted as above has undergone hospitalization treatment /surgical procedure as per details given above.

We hereby confirm the particulars of treatment furnished by the claimant in the claim form are true.

Place:
Date: Signature of the Doctor / Hospital Authorities with Hospital Seal

To,
_____
_____

I hereby authorize the representatives of the TPA, M/S_____ and Life Insurance Corporation of India free and unlimited access to seek medical information (Indoor case papers, reports, documents, including photocopies thereof pertaining to my / my family members' admission/treatment etc.) from you.

I also hereby authorize the hospital/attending doctor/medical practitioner from whom I/ my family member has sought medical attention/medical treatment concerning any disease/sickness, ailment or injury to part with the above information to the TPA/LIC of India or its representatives. Myself/my successors/assigns shall not raise any dispute or litigation on passing of such information to the TPA or LIC of India or its representatives.

Date & Place Signature of the policyholder/Claimant