यूनियन बैंक ऑफ इंडिया
भारत सरकार का उपक्रम

Union Bank of India
A Government of India Undertaking

Human Resources Department, Central Office
#239, Union Bank Bhavan, Vidhan Bhavan Marg, Nariman Point, Mumbai-400021

STAFF CIRCULAR NO. 8118 October 31, 2023

To: **All Branches/ Offices**

Subject : Group Medical Insurance Policy for Retired Employees/ Family Pensioners
Policy Tenure – 01.11.2023 to 31.10.2024
'Safeway Insurance TPA Pvt. Ltd.' as "Third Party Administrator"
Information on various guidelines & procedures along-with contact details

1. The Group Medical Insurance policy for retired employees/ family pensioners is being renewed for a further period of one year i.e. from 01.11.2023 up to 31.10.2024.

2. A total of 12635 retired employees/ family pensioners successfully enrolled themselves in the Group Medical Insurance Policy for the year 2023-24, commencing w.e.f. 01.11.2023, by exercising their options through the first window (made available in the month of October 2023) and subsequently paying the requisite premium amounts.

3. It has been informed by the National Insurance Company that, they have allotted the services of 'Safeway Insurance TPA Pvt. Ltd.' as third party administrators/ service providers, for Group Medical Insurance policy pertaining to retired employees/ family pensioners, for the policy year 2023-24.

Insurance Company Name	**National Insurance Company Ltd**
TPA Name	**Safeway Insurance TPA Pvt. Ltd.**

4. **Claim intimation & Claim submission:** In terms of the guidelines in vogue, details pertaining to '**claim intimation & claim submission**', for policy year 2023-24, are provided below:

Claim Intimation

Notification of claim in case of Cashless facility	**TPA must be informed :**
In event of planned hospitalization	At least 72 (seventy two) hours prior to the insured person's admission to network provider/ PPN Hospital

In event of emergency hospitalization	Within 24 (twenty four) hours of the insured person's admission to the network provider/ PPN Hospital

Notification of claim in case of Reimbursement	**TPA must be informed :**
In event of planned hospitalization/ emergency hospitalization	Within 48 (forty eight) hours of the insured person's admission to the network provider/ PPN Hospital

Various methods of "claim intimation" are mentioned below:

a) **Email** - Claim intimation can be done by sending a detailed mail on intimation@safewaytpa.in

- **In case of 'cashless hospitalization claim', cashless/ pre-authorization request is to be sent on -** info@safewaytpa.in
  The mail, in all cases, must contain details like employee no, employee name, patient name, relationship with the employee, hospital name, treating doctor name, hospital address, date of admission in hospital, estimated expenses etc.

b) **Intimation through website :** www.safewaytpa.in

c) **Intimation through Mobile App:** "Safeway TPA Mobile App"

Upon intimation, a 'claim intimation number' is generated/ provided to the insured. For all the reimbursement hospitalization/ IPD claims, this claim intimation no. is to be mandatorily mentioned on the claim form.

- **Claim Submission:** In case of reimbursement claim, all claim documents should be mandatorily submitted within 30 days of date of treatment/ discharge to the TPA, in original. **The location-wise addresses/ details provided by 'Safeway Insurance TPA Pvt. Ltd.' for submission of 'claim documents' are provided herewith as Annexure-I to this circular.** Retirees are requested to refer to the Annexure and submit the claim documents accordingly on the basis of their locations.

- **Claim Forms & Claim Documents Check-list**: Claim form for IPD (Hospitalization) claims, OPD (Domiciliary) reimbursement claims and check-list for claim documents, as shared by Safeway Insurance TPA Pvt. Ltd. And National Insurance Company Ltd., are attached herewith as **Annexure II, Annexure III & Annexure IV** respectively.

The contact details of representatives of 'Safeway TPA' team are provided below for ready reference:

S.No	Name	Mobile Number	E-mail ID
1	CRM 1	9319748104	ubiretiree@safewaytpa.in
2	CRM 2	8287954916	ubi.zo@safewaytpa.in

- **SAFEWAY TPA Website "www.safewaytpa.in"**

- **E-Card** Link to download e-cards - http://www.safewaytpa.in/frmCardPrintIndividual.aspx

- **Network Hospitals**- To check network hospitals http://www.safewaytpa.in/hospitals_new.aspx
  The list of hospitals is dynamic and keeps on updating on daily basis. Please recheck the current status by clicking on link.

- **Employee Login Details**
  - Link for employee login – https://safewaytpa.in/Login_iba.aspx
  - User Id for employee login: Your Employee code(Eg. 01234)
  - Password: Employee Code + year of Dob (Eg. 012341955)

- **SAFEWAY TPA Mobile App "Safeway TPA",** which can be downloaded from Play store (Android Phones) & Apple Store (IOS Phones).
  - Link to download Mobile App – http://www.safewaytpa.in/frmmobile.aspx
  - Policy No: Current year policy no. without '/'
  - Insurance Company NATIONAL INSURANCE COMPANY LTD.
  - Registration is mandatory while logging in to the mobile application. Kindly type all the details exactly as mentioned above.

Mail IDs for Communication

For Grievances	grievanceiba@safewaytpa.in
For Escalation (Level 1)	ibacrm@safewaytpa.in
For Escalation (Level2)	iba@safewaytpa.in

Grievances/ complaints, if any, related to IBA Group Mediclaim Policy may be raised/ addressed on the following e-mail IDs:

a) **For Grievances related to IBA Group Mediclaim Policy, employees may contact National Insurance Company at**
   E-mail ID: iba.grievance@nic.co.in

b) **For any complaints in processing of claims including any issues with TPA**
   E-mail ID: iba.customersupport@nic.co.in

The policy document, to be issued by 'National Insurance Co Ltd', pertaining to policy year 2023-24, would be shared/ communicated in due course of time.

Contact Details: For any kind of query, regarding 'Group Medical Insurance Policy for Retired Employees/ Family Pensioners' for the policy period 2023-24, team members may be contacted on the following numbers:

Union Bank of India, Central Office, Mumbai –

Landline Nos	:	022 – 22896383
IP Nos	:	116252/ 116253/ 116264/ 116254
E-mail ID	:	staffmediclaim@unionbankofindia.bank

All concerned are requested to take a careful note of the above.

Sd/-
General Manager (HR)

List of Annexures:
Annexure I: Location – wise Address for submission of Claim Documents
Annexure II: Claim Form Part A & B
Annexure III: Domiciliary Hospitalisation/ OPD Benefit Policy Claim Form
Annexure IV: Checklist for Reimbursement/ Domiciliary Under IBA Corporate

Annexure I - Location – wise Address for submission of Claim Documents

Sl no.	Location	Address	Office Phone No.
1	New Delhi (Head Office)	815, Vishwa Sadan, District Centre, Janakpuri, New Delhi-110058	011-45451300
2	Mumbai Branch	209, 2nd floor, Kamala Spaces, S.V. Road, Above Kohinoor Showroom, Near Kheera Nagar, Santacruz (W), Mumbai – 400054	022-26789124
3	Kolkata Branch	Premier Court, 4Th Floor 4, Chandney Chowk Street, Kolkata - 700 072 West Bengal	033-40049572
4	Hyderabad Branch	5-9-60/A/27. NO 802, 8Floor, Moguls Court, Basheerbagh, Hyderabad-500 001	9205544291
5	Kochi Branch	3rd Floor, Govardhan Building Chittor Road, Ernakulam, Kochi, Kerala – 682035	8129703525
6	Bangalore Branch	BO: F2 & F3,No.1/A,Above Easy Tiger Rastaurant,1st floor,Church Street, Bangalore-560001	9632391173
7	Chennai Branch	1J, 1st Floor, Century Plaza, Near AG DMS Metro Station Anna Salai, Teynampet Chennai – 600018	8148280659
8	Ranchi Branch	Tourus Tower, 2nd Floor, 472and 472A, Beside Sahni Appartment, PP Compound, Ranchi, Jharkhand	0651-2972648
9	Jaipur Branch	242 II Floor Ganpati Plaza M.I.Road, Jaipur- 302001	0141- 4917192
10	Ludhiana Branch	3, Upper Fround Floor, Madhok Complex, Ludhiana, Punjab - 141002	9815393166
11	Patna Branch	Address: 102, I Floor, Royal Plaza, Exhibition Road, Patna, Bihar	9029376659
12	Chandigarh Branch	SCO-1, First and Second Floor, Ranjan Plaza, Palam Enclave, Zirakpur, District Mohali, Punjab	0176-2526281
13	Lucknow Branch	Prince Complex, 3rd Floor,Office No.323, Near Canara Bank, Hazrat Ganj Lucknow – 226001	7499079599
14	Vizag Branch	301, D No 50-94-29, Subrahmanyam,Nilayam, Santhi Puram, Viskhapatnam, Andhra Pradesh – 53001	9949897096
15	Guwahati Branch	1stFloor, Prag Plaza, Near Bhangagarh Bridge, P.S.-Bhangagarh, Guwahati, Assam – 781005	7099042299
16	Raipur Branch	Shop no. 232, 2nd floor, Lalganga Shopping mall, Near Shastri chowk, Raipur-492001	8448292912
17	Indore Branch	Address Manas Bhavan Hindi Sahitya Samiti Bldg. : 11,R N T Marg ,312, Indore. 452001 (M.P.)	7049969402
18	Ahmedabad Branch	No-2, First Floor, Khyati Complex, Near Mithakhali Under Bridge, Ellisbridge, Ahmedabad-380006, Gujarat	9408034545

Annexure II: Claim Form Part A & B

Safeway Insurance TPA Pvt. 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 liablity

(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 FIRSTNAME MIDDLENAME

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

f) If yes, company name:

SECTION C

DETAILS OF INSURED PERSON HOSPITALIZED: :

a) Name: SURNAME FIRSTNAME MIDDLENAME

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

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

ii) Reported to Police 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 period: 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 Prescriptions
- 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 main 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)

DECLARATION 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 Place: 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) SI. 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 policyholder	Surname, First name, Middle name
e) Address	Enter the full postal address	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-formmat
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 No
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
1) 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.		

Safeway Insurance TPA Pvt. 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:

a) 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 YY Months MM e) Date of birth: DD MM YY

f) Date of Admission: DD MM YY g) Time: HH MM h) Date of Discharge: DD MM YY i) Time: HH MM

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 C

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a)	ICD 10 Codes	Description	b)	ICD 10 PCS	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

SECTION E

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 inpatient beds f) Facilities available in the hospital i. OT ☐ Yes ☐ No ii. ICU ☐ Yes ☐ No

iii. Others:

SECTION F

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: DD MM YY

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		
i. Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format
ii. 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 Code	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		

Annexure III: Domiciliary Hospitalisation/ OPD Benefit Policy Claim Form

NATIONAL INSURANCE COMPANY LIMITED
Registered & Head Office :3, Middleton Street, Kolkata 700 071.

DOMICILIARY HOSPITALISATION/ OPD BENEFIT POLICY
CLAIM FORM

YOU ARE ADVISED TO FILL EACH AND EVERY COLUMN OF THIS CLAIM FORM and give all information correctly and completely to enable the company to process your claim promptly.

1. Name of the Insured:

2. Details of the insured person
(in respect of whom claim is made)

   a) Name of an employee :

   b) Contact Number :

   c) E-Mail Address :

3. PHS ID :

4. Employee ID :

5. Details of the Reimbursement Submitted: (As per Annexure 1)

I hereby warrant the truth of the foregoing particulars in every respect and I agree that if have made or shall make any false or untrue statement, suppression or concealment, my right to claim, reimbursement of the said expenses shall be absolutely forfeited. I further declare that, In respect of the above treatment, no benefits are admissible under any other Medical Scheme of Insurance.

Dated:

Signature of Employee

……

Acknowledgment by the Third party Administrator

Name & Signature of the TPA representative:

Date of Receiving Claim:

Total Claim Amount:

Annexure 1

I have incurred Rs _____ on the OPD treatment /bills as per the details given by me in the Schedule of Expense given below.

Patient's Name	Relationship	Date	Type of Expense	Amount (Rs)

Total:

Name:
PHS ID :

Annexure IV: Checklist for Reimbursement/ Domiciliary Under IBA Corporate

Safeway Insurance TPA Pvt. Ltd.

CHECKLIST FOR REIMBURSEMENT UNDER IBA CORPORATE

1. Claim form duly filled in all respects provided by IRDA (available in our website), clearly mentioning the amount claimed, policy no, card no, name of hospital, date of admission and discharge, contact no, mail ID and signature (mandatory).
2. Original Discharge summary duly signed and stamped by treating doctor.
3. Original Final bill with detailed breakup under different heads.
4. All investigation reports in original with reports and films.
5. All receipts in original for the claim amount for which the claim has been lodged.
6. In case of surgery where implant has been used, sticker and invoice of the implant.
7. In case claimed amount is more than 2 lac IPD (Indoor patient sheet) / OT notes.
8. FIR, MLC copy in case of injury/RTA.
9. In case of part settlement, all photocopy documents by first claim processing TPA, duly signed and stamped by the concerned authorities, claim settlement voucher and complete breakup details of deductions.
10. In case original documents are lost the photocopy documents dully attested by nodal officer of the bank along with notary attested affidavit on Rs.100 stamp paper.
11. In case of demise of proposer (main insured), succession certificate is required.
12. All bill / receipts for purchase of medicine upon which a claim is made shall bear the valid GST no. of the issue of such bills, receipts, etc. or declaration with sign & stamp of pharmacy if exempted verified by nodal officer of the concerned.
13. All report should duly sign and stamped (MD Pathologist).
14. Registration certificate of the treating facility/hospital on case to case basis.
15. PAN card copy of proposer in case of claims above 1 Lac.
16. For self-bank id card/Aadhar card & any one of the KYC documents for dependents & addition of new baby.
17. Cancelled cheque bearing the name of proposer. If the cancelled cheque is not bearing the name of the proposer, photocopy of first page of passbook showing the account details of proposer unless the details of insured provided by the nodal officer as one time exercise.

***These are the documents that are **NORMALLY REQUIRED** while processing the reimbursement claims.Apart from this there can be other queries for particular claim **DEPENDING ON THE REQUIREMENT** and also **AFTER RECEIVING QUERY REPLIES.**

CHECKLIST FOR DOMICILIARY CLAIMS UNDER IBA CORPORATE

1. Claim Form PART A
2. FINAL DIAGNOSIS on Prescription
3. All original bills & receipts claimed
4. Name of patient on all bills, documents.
5. Original Investigation report & films supporting the documents.
6. Original doctor's prescription supporting the medicines /Investigation/Consultations/Physiotherapy Etc.
7. Medicines bills must have GST number or declaration with sign &stamp of pharmacy if exempted verified by nodal officer of the concerned.
8. GOVT. approved ID Proof showing age similar to policy.
9. A copy of cancel cheque bearing the name of Proposer/A copy of first page of Bank's Passbook unless the details of insured provided by the nodal officer as one time exercise.

*Please keep Scanned or photocopy of all submitted documents for your reference before submission.

*Documents can be submitted either at any of the branch office or HO of the TPA.

Safeway Insurance TPA Pvt. Ltd.

815, VishwaSadan, Distt.CentreJanakpuri, NewDelhi-110058 E-Mail:support@safewaytpa.in, Website:www.safewaytpa.in

Phone: 011 - 4142 5671, 45451300 (100 lines),
Fax: +91-11 - 4142 5672 CIN: U67200DL2004PTC129929