Medical Insurance
Notice to all Retired employees

Policy Documents 2018-2019 available on bank's website

Path: Bank of Baroda Website -> Human Resources-> Insurance Policies

Please note to adhere to the following:

1. Time limit for Notification (Intimation) of documents

Notification of claim in case of Cashless / Reimbursement facility	TPA must be informed:
In the event of planned hospitalisation	At least 72 (seventy two hours prior to the insured person's admission to hospital.
In the event of emergency hospitalisation	Within 24 (twenty four) hours of the insured person's admission to hospital.

2. Time limit for submission of documents

Type of claim	Time limit for submission of documents to Bank HO/TPA
Where Cashless Facility has been authorised	Immediately after discharge.
Reimbursement of hospitalisation and pre hospitalisation expenses (limited to 30 days)	Within 15 (fifteen) days of date of discharge from hospital
Reimbursement of post hospitalisation expenses (limited to 90 days)	Within 15 (fifteen) days from completion of post hospitalisation treatment

3. Please note that the documents declared below are mandatory:

- Duly filled claim form (Annexure A & B)
- Indoor case papers – (Photocopy certified by Hospital)
- Original discharge card
- Original hospital Final bill
- Original hospital bill payment receipt
- Original investigation reports (If any).
- All original Prescription of medicines & Investigation reports
- Registration copy of hospital – "Form C" with mentioned No. of beds and validity date.
- Registration copy of hospital in case of Ayurveda / Naturopathy / Homeopathy Treatment.

Note: In case of Ayurveda /Siddha/ Homeopathic / Unani treatment, Hospitalisation expenses are admissible only when the treatment is taken as an in-patient, in a Government Hospital or in any Institute recognised by Govt. and/or accredited by Quality Council of India / National Accreditation Board on Health

Claim Submission (Domiciliary Treatment) –

- Original prescription, investigation reports and bills required on monthly basis.
- **All bills / receipts for purchase of medicine upon which a claim is made shall bear the valid GST No. of the issuer of such bills, receipts, etc.**
- Medical expenses incurred in case of disease which needs domiciliary treatment as may be certified by the attending medical practitioner.
- The cost of Medicines, Investigation, and consultations, etc..... In respect of domiciliary treatment shall be reimbursed for the period of stated by the specialist and or the attending doctor, if no period stated the prescription of the purpose of reimbursement shall be valid for 90days only.
- **Attached herewith the documents for your ready reference.**
  For Claim intimation, reimbursement Claim status & general Inquires please contact on following toll free / email on below Address :-

Toll Free No.	**1800 233 2707 (from 10:00 PM to 05:00 PM on working days)**
Email ID	**bob_baroda@mediassistindia.com**
Escalation to	**medicalinsurance.ho@bankofbaroda.com**
BOB HO Address	**Medical Insurance Cell, Bank of Baroda, Head Office, 6th Floor, Baroda Bhavan, R C Dutt Road, Vadodara – 390 007**
Website	**https://portal.medibuddy.in**
Mobile APP	**MEDIBUDDY User ID : BOB<EMP No> Password: BOB <EMP No>** **Eg: User ID: BOB1234 Password: BOB1234**
Policy No.	**5001002818P111515547 (Without Domiciliary)** **5001002818P111517362 (With Domiciliary)** **5001002818P111520761 (TOP Up)**

- **Guidelines for employees for availing cashless facility :**
  a. At the time of admission in hospital under cashless facility initial approval request from hospital will be considered by TPA within 2-3 hours after receiving all documents from hospital.
  b. At the time of discharge final bill request will be processed by TPA within 3-4 hours after getting all final bills and necessary documents from hospital.
- For Premium Deduction Certificate (80D) please approach your base branch. (Annexure C)

Please note above with immediate effect for avoiding delay in settlement of Claims.

Medical Insurance Cell
Head Office, Baroda

Date : 19/03/2019

CLAIM FORM FOR HEALTH INSURANCE POLICIES – PART A

Name of Insurance Company: **United India Insurance Co. Ltd.** Client Name : **BOB / BOI / DEB / NAB**

TO BE FILLED IN BY THE INSURED

The issue of this Form is not to be taken as an admission of liability
(To be filled in block letters)

DETAILS OF PRIMARY INSURED

a) Policy No.		b) Sl. No./Certificate No.	
c) Company/TPA ID No.			
d) Name			
e) Address			
City			
State		Pin Code	
Ph. No		Email ID	

DETAILS OF INSURANCE HISTORY

a) Currently covered by any other Mediclaim/Health Insurance			Yes	No
b) If yes, Company Name				
Policy No		Sum Insured (₹)		
c) Date of commencement of first Insurance without break	___ / ___ / _____		(Copies of Policies to be attached)	
d) Have you been hospitalized in the last 4 years? (since inception of the contract)	Yes	No	Date	___ / ___ / _____
	Diagnosis			
e) Have you been covered by any other Mediclaim/Health Insurance in last 4 years			Yes	No
f) If yes, Company Name				

DETAILS OF INSURED PERSON HOSPITALIZED

a) Name						
b) Gender	Male	Female	c) Age	years	months	d) Date of Birth ___ / ___ / _____
e) Relationship to Primary insured	Self	Spouse	Child	Father	Mother	
	Other	(Please Specify)				
f) Occupation	Service	Self Employee	Homemaker	Student	Retired	
	Other	(Please Specify)				
Address (if different from above)						
City						
State				Pin Code		
Ph. No		Email ID				

DETAILS OF HOSPITALIZATION

a) Name of Hospital where Admitted					
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 of Disease first detected/Date of Delivery				___ / ___ / _____	
e) Date of Admission ___ / ___ / _____	f) Time	g) Date of Discharge ___ / ___ / _____		h) Time	
i) If injury give cause	Self inflicted	Road Traffic Accident			
Substance Abuse/Alcohol consumption		i. If Medico legal		Yes	No
ii. Reported to police	Yes	No	iii. MLC Report & Police FIR attached	Yes	No
j) System of Medicine					
k) Date of Surgery ___ / ___ / _____		l) Claim Intimated		Yes	No
i. Intimated to whom	SBU	Intermediaries	Call Centre	Health Claims Team	
ii. Intimation No. & date				___ / ___ / _____	
iii. If not Intimated, reason?					

DETAILS OF CLAIM

a) Details of the treatment expenses claimed

i. Pre-hospitalization Expenses	₹	ii. Hospitalization Expenses	₹
iii. Post-hospitalization expenses	₹	iv. Health-Check up Cost	₹
v. Ambulance Charges	₹	vi. Others (code)	₹
vii. Pre-hospitalization period	days	**Total**	₹
		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	₹	ii. Surgical Cash	₹
iii. Critical Illness Benefit	₹	iv. Convalescence	₹
v Pre/Post hospitalization Lump sum benefit	₹	vi. Others	₹
		Total	₹

Claim Documents Submitted - Check List			
Claim Form Duly signed		Operation Theatre Notes	
Copy of the claim intimation		ECG	
Hospital Main Bill		Doctor's request for investigation	
Hospital Break - up Bill		Investigation Reports (CT/MRI/USG/HPE)	
Hospital Bill Payment Receipt		Doctor's Prescriptions	
Hospital Discharge Summary		Pre-Hosp. Bills	
Pharmacy Bill		Post-Hosp. Bills	
		Others	

DETAILS OF BILLS ENCLOSED

Sl. No.	Bill No.	Date	Issued by	Towards (Hospitalization/Pre-hospitalization/ Post-hospitalization	Amount (₹)
1		__/__/____			
2		__/__/____			
3		__/__/____			
4		__/__/____			
5		__/__/____			
6		__/__/____			
7		__/__/____			
8		__/__/____			
9		__/__/____			
10		__/__/____			

Do you want to opt for Automatic Reinstatement of Sum Insured in the event of a claim? If, Yes, applicable premium at short period rates would be deducted from the claim amount due to you. This reinstated sum will not be available for the same hospitalization. It will be available for treatment (other than certain chronic diseases) including the same illness or disease but separate independent case of hospitalization which are not case of relapse within 45 days of first hospitalization. Please contact the agent/our office for further details: Yes / No

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT (Please submit a cancelled cheque copy for NEFT)

a) PAN	b) Account Number
c) Bank Name and Branch	
d) Cheque/DD Payable details	e) IFSC Code

DECLARATION BY THE INSURED

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

Place: _____ Date: __/__/____

Signature of the Insured

Important:

1. Please submit copy of valid Photo ID.
2. For claimed amount above 1 lac, it is mandatory to submit the KYC (Know your customer) form.

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
(To be filled in block letters)

Please include the original preauthorization request form in lieu of PART 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)	
d)	Name of the treating doctor								
e)	Qualification		f) Registration No. with State Code			g) Ph No.			

DETAILS OF THE PATIENT ADMITTED

a)	Name of the Patient									
b)	IP Registration Number			c) Gender	Male		Female		d) Age	Years / Months
e)	Date of birth	__/__/____		f) Date of Admission	__/__/____				g) Time	
h)	Date of Discharge	__/__/____		i) Time						
j)	Type of Admission	Emergency		Planned			Day Care		Maternity	
k)	If Maternity	i Date of Delivery	__/__/____	ii Gravida Status						
l)	Status at time of discharge	Discharge to home		Discharge to another hospital			Deceased			
m)	Total Claimed Amount	₹								

DETAILS OF AILMENT DIAGNOSED (PRIMARY)

a)		ICD 10 Codes	Description
	i Primary Diagnosis		
	ii Additional Diagnosis		
	iii. Co-morbidities		
	iv. Co-morbidities		
b)		ICD 10 Codes	Description
	i Procedure 1		
	ii. Procedure 2		
	iii. Procedure 3		
	iv. Details of Procedure		

c)	Present ailment is a complication of PED?	Yes		No		(If Yes, specify details)				
d)	Pre-authorization obtained	Yes		No						
e)	Pre-authorization Number									
f)	If authorization by network hospital not obtained, give reason									
g)	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	Operation Theatre notes	Doctor's reference slip for investigation
Original Pre-authorization request	Hospital main bill	ECG
Copy of the Pre-authorization approval letter	Hospital break-up bill	Pharmacy bills
Copy of photo ID card of patient verified by hospital	Investigation reports	MLC report & Police FIR
Hospital Discharge summary	CT/MR/USG/HPE investigation reports	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.

Date of Registration ___/___/_____

Expiry date of Registration ___/___/_____

Name of the Registering Authority

d) PAN

e) Number of Inpatient beds

f) Facilities available in the hospital

i. OT Yes No

ii. ICU Yes No

iii. Others

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. The signature of the insured is taken on this form after Claim Form B is fully filled up by us.

Hospital have required infrastructure to fulfill the hospital definition as per IRDA guideline, which is reproduced below:

- Has at least 10 inpatient beds, in those towns having a population of less than 10,00,000 and 15 inpatient beds in all other places.
- Has fully qualified nursing staff under its employment round the clock.
- Has fully qualified doctor(s) in charge round the clock.
- Has a fully equipped operation theatre of its own where surgical procedures are carried out.
- Maintains daily Medical records of patients and will make these accessible to the Company's authorized personnel.

Place: _____ Date: ___/___/_____

Signature of Insured/Claimant

Signature and Seal of the Hospital Authority

DATE :

TO WHOM IT MAY CONCERN

THIS IS TO CERTIFY THAT SHRI/SMT _____ ADDRESS _____

HAS OPTED FOR THE TAILOR MADE GROUP INSURANCE POLICY OF UNITED INDIA INSURANCE COMPANY. SHE/HE HAS PAID A PREMIUM OF _____ (IN WORDS_____) ON DATE _____.

THIS CERTIFICATE IS ISSUED SPECIFICALLY FOR THE PURPOSE OF INCOME TAX BENEFIT MEDICAL INSURANCE PREMIUM.

BRANCH HEAD

NAME:

BRANCH:

BRANCH SEAL: