CORPORATION BANK RETIRED OFFICERS' ASSOCIATION (REGD.)
(A wing of CBOO)
Regd. Office: No.6, II Floor, Meridian Guru Plaza, Near KSRTC Bus Stand, Bejai, Mangaluru-575 004.
Phone No: Mob: 63622 39292, 0824 - 2224809 E-mail: cbroamangalore@gmail.com website: www.cbroa.org

CIRCULAR NO. 02/2020 **DATE: 05-03-2020**

TO ALL MEMBERS & ASSOCIATE MEMBERS

Dear friends,

IBA MEDICAL INSURANCE POLICY FOR RETIREES

1.0 BACKGROUND:

In terms of Joint Note dated 25-05-2015 and 10th Bipartite Settlement signed between IBA and Associations / Unions of Officers and Award Staff, **Medical Insurance Scheme for Officers / Employees and their dependents including retired officers / employees and their dependent spouse** was implemented in the Bank as per HO Cir. No. 624/2015 dated 03-10-2015. The Scheme replaced hospitalisation reimbursement scheme which was prevailing in the Bank. Later, the Scheme was being renewed every year with modification as agreed between IBA and Unions.

2.0 DETAILS REGARDING THE PRESENT POLICY:

2.1 Policy Period: 1st November 2019 to 31st October 2020

2.1.1 Insurer: United India Insurance Co. Ltd. (UIIC)

2.1.2 Third Party Administrator (TPA): M/s. Vipul Medcorp Insurance TPA Pvt. Ltd.

2.2 Coverage:

The retired (including VRS) / Resigned employees of Corporation Bank and / or their Widow / Widower are covered under the Basic Policy upto a sum of **Rs.4.00 lakhs** per annum **(for Officers)**. Family Pensioner (spouse of the deceased retiree) is also eligible to join the Policy and get the coverage by paying the premium.

2.3 Super Top Up Policy:

The members can also opt for Super Top up policy of Rs.5.00 lakhs by paying additional premium. On opting for Super Top Up Policy, the coverage will be for Rs.9.00 lakhs (Rs.4.00 lakh + Rs.5.00 lakh). **The reimbursement under Super Top Policy will trigger only after exhausting the basic policy amount of Rs.4.00 lakhs.**

2.4 Difference between Top Up Policy and Super Top Up Policy:

Under Top Up policy, once the policy is triggered, further availment under the policy is **not permitted.** For Example, A person has Rs.4.00 lakhs basic policy and Rs.5.00 lakhs Top up policy. His hospitalisation expenses come to say, Rs.6.00 lakhs. He avails reimbursement of Rs.6.00 lakhs under Basic and top up policy. In this case, he cannot avail further reimbursement even though he had cover of Rs.3.00 lakhs which is not availed. **Under Super Top Up policy, the member can avail reimbursement under the policies, any number of times upto Rs.9.00 lakhs**.

2.5 IBA Group Health Insurance Policy Document:

The Group Health Insurance Policies issued by United India Insurance Company along with Policy Number are furnished below:

A) Base policy WITHOUT Domiciliary Treatment Cover (for Rs. 4.00 Lakhs) : 5001002819P112345074

B) Base policy WITH Domiciliary Treatment Cover (for Rs. 4.00 Lakhs) : 5001002819P112344997

C) Super Top up policy (for Rs.5.00 Lakhs) : 5001002819P112368363

The policy documents are available at our website, ***cbroa.org*** **under "Benefit to Retirees> Staff Welfare Measures".**

2.6 Benefits under the IBA Medical Insurance Policy:

1. **Pre-existing diseases are covered** under the policy which is normally not covered upto a period of 4 years in other policies.
2. **No waiting period.** The benefit is available from day one unlike 30 days waiting period under normal mediclaim policies.
3. **Pre and Post Hospitalisation** expenses 30 days prior to and 90 days (60 days in normal policies) post hospitalisation are covered.
4. **Room Rent upto Rs.5000/- per day** is covered.
5. **ICU charges upto Rs.7500/- per day** is covered.
6. **Ambulance charges upto Rs.2500/- per trip** to hospital and / or transfer to another hospital or transfer from hospital to home, if medically advised are covered. **Taxi / Auto expenses** in actual maximum **upto Rs.750/- per hospitalisation.** Ambulance charges actually incurred on transfer from one center to another center due to non-availability of medical services / medical complication shall be payable in full.
7. **Congenital Anomalies i.e.** diseases or physical abnormality present from birth are covered and expenses for treatment of such congenital diseases, defects are covered under the policy which is not normally available under other policies.
8. **Psychiatric Diseases:** Expenses for treatment of psychiatric and psychosomatic diseases covered **with or without hospitalisation.**
9. **Advanced Medical Treatment:** All new kinds of approved advanced medical procedures for eg. Laser surgery, stem cell therapy for treatment of diseases is payable on **hospitalisation / day care**.
10. **Treatment taken for Accidents** is payable even on OPD **basis in a Hosptial** upto the sum insured.
11. **Treatment for Genetic Disorder and Stem Cell Therapy** is covered.
12. **Physiotherapy Charges** shall be covered for the period specified by the Medical Practitioner even if taken at home.

13. **Day Care Procedure:** The following Day care Procedures i.e. **Medical treatment and /or surgical procedure which is –**

(i) undertaken under General or Local Anaesthesia in a hospital / DAY CARE CENTRE in less than 24 hours because of technological advancement and

(ii) which would have otherwise required hospitalisation of more than 24 hours)

- are covered:

1. Adenoidectomy	2. Appendectomy
3. Ascitic / Plueral Tapping	4. Auroplasty (not of cosmetic nature)
5. Coronary/ Renal Angiography	6. Coronary Angioplasty
7. Dental Surgery	8. D & C
9. Excision of Cyst / Granuloma / Lump / Tumor	10. Eye Surgery
11. Fracture including hairline fracture / dislocation	12. Radiotherapy
13. Chemotherapy including parental chemotherapy	14. Lithotripsy
15. Incision and drainage of abscess	16. Varicocelectomy
17. Wound suturing	18. FESS

19. Operation / Micro surgical operations on the nose, middle ear / internal ear, tongue, mouth, face tonsils & adenoids, salivary glands & salivary ducts, breast, skin & subcutaneous tissues, digestive tract, female / male sexual organs

20. Haemo Dialysis	21. Fissurectomy / Fistulectomy
22. Mastoidectomy	23. Hydrocele Surgeries
24. Hysterectomy	25. Inguinal / ventral / umbilical / femoral hernia surgeries
26. Parenteral Chemotherapy	27. Polypectomy
28. Septoplasty	29. Piles / Fistula surgeries
30. Prostrate Surgeries	31. Sinusitis Surgeries
32. Tonsillectomy	33. Liver Aspiration
34. Sclerotherapy	35. Varicose Vein Ligation
36. All scopies along with biopsies	37. Lumbar Puncture

DAY CARE CENTRE means any institution established for day care treatment of illness and /or injuries or a medical set up within a Hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified medical practitioner AND must comply with all minimum criteria as under:

a. Has qualified nursing staff under its employment

b. Has qualified Medical Practitioner(s) in charge

c. Has fully equipped operation theatre of its own where surgical procedures are carried out

d. Maintains daily record of patients.

Treatment normally taken on an outpatient basis is not included in the scope of this definition.

14. Ambulatory devices i.e. Walker, Crutches, Belts, Collars, Caps, Splints, Braces, Stockings, Elastocrepe bandages, external orthopaedic Pads, sub-cutaneous Insulin Pump, Diabetic Foot Wear, Glucometer (including Glucose Test Strips), Nebulizer, Prosthetic device, Thermometer, alpha/water bed and such similar items are covered.

2.7 What is not covered under the Policy?

The following are NOT covered under the policy:

1. Injuries or disease directly or indirectly caused by or arising from or attributable to War, Invasion, Act of Foreign Enemy, War-like operation (whether war be declared or not) and by nuclear radiation.
2. Cost of Spectacles, Contact Lenses, Hearing Aids other than Intra-Ocular Lenses and Cochlear Implant, Cost of buying any external device.
3. Circumcision, Vaccination, Inoculation.
4. Cosmetic or Aesthetic treatment of any description.
5. Plastic Surgery other than as may be necessitated due to an accident or as a part of any illness, Obesity Treatment.
6. Convalescence, rest cure, Obesity Treatment and its complications including Morbid Obesity, Sterility (infertility), venereal disease, intentional self-injury and use of intoxicating drugs / alcohol.
7. Dental treatment or surgery cosmetic in nature except on account of accident.
8. Expenses on buying vitamins & tonics unless forming part of treatment and certified by treating Doctor.
9. Charges incurred at Hospital primarily for diagnostic, X-ray or Laboratory examinations or any other diagnostic studies not consistent with or incidental

to the diagnosis and treatment of positive existence of presence of any ailment, sickness or injury, for which confinement is required at a Hospital / Nursing Home, unless recommended by the attending doctor.

10. Diagnostic charges and treatment cost incurred for cases where no active line of treatment was followed.
11. Voluntary Medical Termination of Pregnancy during the first 12 weeks from the date of conception.
12. Acquired Immune Deficiency Syndrome (AIDS) and HIV.
13. Medical Expenses for an Organ Donor is not covered.
14. All non-medical expenses including convenience items for personal comfort such as charges for telephone, television, barber or beauty services, diet charges, baby food, cosmetics, tissue paper, diapers, sanitary pads, toiletry items and similar incidental expenses, unless otherwise they are necessitated during the course of treatment.
15. Expenses on purchase of medicine **not supported by** bills / receipts / cash-memos with valid GST No. of the issuer of such bills / receipts / cash-memos.

However, all Taxes, Surcharges, Service charges, Registration Charges, Admission Charges, Nursing Charges and Administration Charges are covered under the policy are payable.

3.0 Empanelled OR Network Hospitals:

The TPA has provided a list of more than 6000 hospitals at important centres in the country. A State-wise List of Hospital is available at our website, ***cbroa.org*** **under "Benefit to Retirees> Staff Welfare Measures".** Further, you may contact our Central Committee members, who have been provided with a copy of the List. You may log into website of TPA, ***vipulmedcorp.com***.

3.1 Choice of Hospital:

The member can opt any of the hospitals in the network for cashless treatment. You can also choose a hospital which is not in the list in which case the cashless facility will not be available and only expenses will be reimbursement.

3.2 Care to be taken while admitting to a Hospital:

Before taking admission to any Hospital, one should ensure that the Hospital satisfies the laid down criteria. As per the policy, Hospital / Nursing Home should have **registered as a Hospital with the local authorities** under the Clinical Establishments (Registration and Regulation) Act, 2010 or under the specified enactments mentioned in Schedule of Sec. 56(1) of the Act **Hospital shall comply with the following minimum criteria:**

1. Has at least **10 in-patient beds** in towns having **population of less than 10 lakhs** and at least **15 in-patient beds in all other places.**

2. Has qualified nursing staff under its employment round the clock.
3. Has qualified Medical Practitioner(s) in charge round the clock.
4. Has a fully equipped Operation Theatre.
5. Maintains daily records of patients.

3.3 Alternate Treatment :

For Alternate Treatment like **Ayurveda, Unani, Siddha, Naturopathy and Homeopathy, hospitalisation expenses are admissible ONLY when** the treatment has been undergone in –

1. A Government Hospital or in any institute **recognised by the Government and/or accredited by Quality Council of India / National Accreditation Board on Health (NABH).**

2. Teaching Hospitals of **Ayurveda, Unani, Siddha, Naturopathy and Homeopathy** colleges **recognized by Central council of Indian Medicine (CCIM).**

3. **Ayurveda, Unani, Siddha, Naturopathy and Homeopathy** hospitals having **registration with a Government Authority** under appropriate State / UT and:

a) Has at least 15 in-patient beds;

b) Has minimum 5 qualified and registered Ayurveda, Unani, Siddha, Naturopathy and Homeopathy doctors;

c) Has qualified paramedical staff under its employment round the clock.

d) Has dedicated Ayurveda, Unani, Siddha, Naturopathy and Homeopathy therapy sections;

e) Maintains daily records of patients

4.0 Medical ID Cards:

The UIIC medical ID card will be issued to the insured by the TPA. We understand that M/s VIPUL Medcorp Ltd has prepared laminated cards and started despatching the same. All insured would receive the cards shortly.

5.0 CLAIM PROCEDURE

5.1 Process for Cashless Hospitalisation:

1. **Cashless Facility** is available only in network hospitals. Before getting admitted to a Hospital, ensure that the Hospital is one among the list of network hospitals.

2. **Planned Hospitalisation:** If the hospitalisation is planned, inform TPA about **7 days in advance** through email.

3. **Emergency Hospitalisation:** In case of hospitalisation in emergency, inform TPA **within 24 hours** of admission through email.

4. **Documents to be carried before admission to a Hospital:** Please note to take the following documents while getting admitted to network hospital:

   a) Medical ID card issued by the TPA

   b) ID Card issued by the Bank

   c) KYC documents such as Aadhar Card, PAN Card, Voter ID Card etc.

   Please note to carry the copies of above documents while going to the hospital for admission. Network Hospitals would be having insurance desk which will fill up the prescribed form and send to TPA for pre-authorisation. On verification and satisfaction of the details provided, TPA will issue the authorisation letter specifying the sanctioned amount. Normally, the TPA will sanction initially only a part of the total estimated cost of treatment and balance will be sanctioned on submission of final bill after treatment. The treatment shall take place within 15 days of the pre-authorisation.

5. The payment to the Hospital will be made directly by the TPA.

6. In the event of **any change in diagnosis and planned treatment** during hospitalisation and change in estimated cost, the network **hospitals shall obtain a fresh authorisation letter from TPA**.

7. At the time of discharge the insured person shall verify and sign the discharge papers and pay for non-medical and inadmissible expenses.

5.2 Cashless Facility Claim Settlement:

The network hospital on discharge of the insured from hospital will prepare Discharge Summary, raise original bills, laboratory test reports and bills, bills for x-ray and other diagnostic charges along with doctor's prescription etc. Please check all the bills and verify as to whether the bills are connected to the services rendered by the hospital before signing. **Please also ensure that non-consumable items are not added to the bill disproportionately.** The hospital would be sending a mail to the TPA regarding submission of bills. **Please ask the hospital to send a copy of the mail to you.**

Even in case of package treatment, the detailed bills as mentioned above are required for submission of claims.

Claims for Pre and Post-Hospitalisation will be settled on a reimbursement basis on production of cash paid receipts.

5.3 Procedure for Claim of Hospitalisation Reimbursement:

If the admission is taken in a hospital other than in the network, please ensure that the **hospital complies with the criteria laid down in Para 3.2 & 3.3 above.**

5.3.1 Claim Form:

The prescribed claim form - **VIPUL Claim form** (enclosed) shall be duly filled up and shall be supported with the following original documents and submitted **within 30 days from the date of discharge from the hospital:**

1. Copy of photo ID with age proof
2. Copy of Medical Card issued by TPA
3. Attending medical practitioner's / surgeon's certificate regarding diagnosis / nature of operation performed along with date of diagnosis, investigation test report etc. supported by prescription by the attending medical practitioner.
4. Original discharge summary duly signed.
5. Original final bill with all original deposit and final payment receipt.
6. Original invoice with payment receipt and implant stickers for all implants used during surgeries i.e lens sticker and invoice in cataract surgery, stent invoice and sticker in Angioplasty surgery.
7. All previous consultation paper indicating history and treatment details for current ailment; Practitioner's prescription and invoice / bill with receipt from diagnostic centre.
8. All original medicine / pharmacy bills along with Medical Practitioner's prescription.
9. FIR copy – **in case of accident cases only**.
10. Copy of death summary and copy of death certificate **(in case of death claims only).**
11. Pre-and Post-operative imaging reports – **in accident cases only.**

6.0 Submission of Claims:

The VIPUL claim Form duly filled up and signed by the claimant along with the documents mentioned in 5.3.1 shall be submitted to Bank Claim Processing Hub **(ZO in our Bank, PAD Staff Welfare Cell for HO retirees) or nearest VIPUL Medcorp Ltd Office as per your convenience.** You should also enclose **a cancelled cheque leaf** in support of the details given about your Bank account in the claim form. **A list of Vipul Offices along with contact details are furnished in Annexure-I.**

You can also use **Vipul Selfcare App** using your login ID and password already provided to you by the TPA to lodge the claim as well as to know the status of the claim.

The TPA shall scrutinize the claim form and accompanying documents and if any deficiency shall be intimated to the claimant within 7 working days of submission of documents.

6.1 Time Limit for submission of Documents

Type of Claim	Time Limit for submission of documents to TPA/ Company
Where Cashless Facility has been authorised	Immediately after discharge
Reimbursement of Hospitalisation and Pre-Hospitalisation expenses (limited to 30 days)	**Within 30 (Thirty) days** of discharge from hospital
Reimbursement of Post-Hospitalisation Expenses (limited to 90 days)	**Within 30 (Thirty) days** from completion of post hospitalisation treatment

7.0 Claim Settlement:

On submission of final document(s), the insurer shall settle the claim **within a period of 24 days.** The amount will be credited to the Bank account given in the claim form.

In the case of delay in payment, UIIC shall pay interest from the date of receipt of last necessary documents to the date of payment of claim @2% above the Bank Rate prevelent on the beginning of the financial year in which claim is paid.

8.0 Rejection of Claim:

If the insurer, for any reason, rejects the claim under the policy, they shall communicate to the insured person in writing explicitly mentioning the grounds for rejection / repudiation and **within 30 days from the receipt of the final document.**

9.0 Representation on Rejection of Claim:

Insured Person, if he so desires, may represent **within 15 days from the date of receipt of the claim decision,** to the company for reconsideration of the decision.

Such claims would go through a Committee set up by the Bank, TPA and United India Insurance Co. Ltd. representative.

Members who are representing on the rejection of claim are requested to send a copy of their letter to Central Office for follow-up.

10.0 Administration of the Scheme:

The Scheme is administered by Staff Welfare Cell at PAD-HO. For any clarification, please contact **Staff Welfare Cell, PAD-HO, Mangalore.** ***(Email ID: welfare@corpbank.co.in)***.

Friends, we have tried to give almost every detail regarding the IBA Medical Insurance Scheme along with operational details. For any query regarding hospitalisation / claim, you may contact the Vipul representatives near to you **(details given in Annexure-I).** You may feel free to contact any of Central Office bearers or Central Committee Members for any help in this regard. Kindly preserve this circular for your future reference

With greetings,

[D N PRAKASH]
GENERAL SECRETARY

ANNEXURE-I

OFFICES OF VIPUL MEDCORP LTD.

HEAD OFFICE
515, Udyog Vihar, Phase 5 Gurgaon, Haryana - 122 016 Phones : 0124-4833900, Fax No.: 0124-4699611-12 4308211, E-Mail: info@vipulmedcorp.com
DELHI
219, Ansal Chamber II, Bhikaji Cama Place, New Delhi - 110 066, Phones: 011-46074578-81
NORTH REGION
AMRITSAR
122-123, First Floor, Deep Complex, Court Road, Amritsar - 143 001. Phones : 0183-5056482 **Contact Person: Ms. Hema Pathak**. E-mail: amritsar@vipulmedcorp.com
CHANDIGARH
S.C.I. No. 98, First Floor, Industrial Area Phase-2, Chandigarh -160 002 Phones: 0172-4629601, 02, 03. **Contact Person : Mr. Ashwani Kumar, Contact Mobile: 74282 96555** E-mail Id: chandigarh@vipulmedcorp.com
DEHRADUN
Shop No. 30, Windlas Shopping Complex, 11-A, Rajpur Road, Near Clock Tower, Dehradun - 248 001 Phones : 0135-3200004, **Contact Person: Mr. Bikram Negi, Contact Mobile : 94120 50436** E-mail Id : dehradun@vipulmedcorp.com
FARIDABAD
Plot No : 116 M , First Floor, NIIT 5, Near by Dayanand College, Faridabad -121 001 Phones : 0129-4004017-18. **Contact Person : Mr. Mohit Saxena, Contact Mobile : 093119 86374** E-mail Id : faridabad@vipulmedcorp.com
INDORE
#306, 3rd Floor, Shreevardhan Complex 4, 90 R.N.T. Marg, Indore - 452 001. Phones : 0731-4285670-75, Fax No.: 0731-4208920. **Contact Person : Mr. Sankalp Nagar, Contact Mobile : 093297 33002** E-mail Id : indore@vipulmedcorp.com
JAIPUR
S-10, Shyam Nagar, Ajmer Road, Jaipur - 302 019. Phones : 0141- 4182000 to 4182049, Fax No.: 0141-4182028. **Contact Person: Mr. Loveleen Arora, Contact Mobile : 92054 74293** E-mail Id : jaipur@vipulmedcorp.com
KANPUR
313, 3rd Floor, City Centre, The Mall, Kanpur - 208 003. Phones : 0512-2391013,14 **Contact Person : Mr. Akhilesh Goswami, Contact Mobile : 93119 86334**
LUDHIANA
SCO No. 121, Fourth Floor, Cabin No. 401, Feroze Gandhi Market, Ludhiana - 141 001 Phones : 0161-4633088, **Contact Person : Dr. Deepa Chauhan** E-mail Id: ludhiana@vipulmedcorp.com
NOIDA
Quantum Building, Basement, Plot no. C-3, Sector 3, Noida- 201 301. Phones : 0120-2442533 Fax No.: 0120-4238603, E-mail Id: noida@vipulmedcorp.com
SOUTH REGION
BENGALURU
110, 4th Floor, Sudham Nagar, K.H. Road, Near Suzuki Show Room, Bengaluru - 560 027 Phones : 080- 0870888, 40927707, 08, 09, 91, 93. Fax No.: 080-41249694 **Contact Person: Mohd. Lathifudeen, Contact Mobile : 096069 34104** E-mail Id: bangalore@vipulmedcorp.com

CHENNAI

G.R. Complex, Annexure Building, Second Floor, No. 407 & 408, Anna Salai, Nandanam, Chennai - 600 035.
Phones : 044 49126666. Fax No. : 044-24335716. **Contact Person: Mr. K. Rajshekaran**
E-mail id : chennai@vipulmedcorp.com

HYDERABAD

Door No. 6-3-347/9, Flat No. 306, 3rd Floor, Riviera Apartments, Dwarakapuri Colony, Panjagutta, Hyderabad - 500 082. Phones : 040-40021845. Fax No.: 040-40024849
Contact Person: Mr. Alfred Sampathraj, Contact Mobile : 099710 06988
E-mail Id: hyderabad@vipulmedcorp.com

KOCHI

Mariam Tower, Door No. 36/3120-B-3, Kaloor Kadavanthra Road, Kathrikadavu, Kochi – 682 017
Phones : 0484-2102021, 2330079. Fax No. : 0484-2330080
Contact Person : Mr. Rajesh R., Contact Mobile : 097444 97212
E-mail: cochin@vipulmedcorp.com

EAST REGION

GUWAHATI

1 Hatigaon, Dispur, PO Hatigaon, Guwahati - 781 038
Contact Person: Mr. Tapash Bharadwaj, Contact Mobile : 70021 74341
E-mail: guwahati@vipulmedcorp.com

KOLKATA

19, R.N. Mukherjee Road, Main Building (2nd Floor), Kolkata -700 001
Phones: 033-40205700, 40205701. Fax No.: 033-40205712
Contact Person: Mr. Arup Banerjee, Contact Mobile : 093781 78895
E-mail: kolkata@vipulmedcorp.com

PATNA

Yamuna Tower, Campus of Maurya Dental Care, Near Jain Mandir, Besides PWD Office,
Gulzar Bagh Station Road, Patna-800 007
Ph.: 0612-2385894, 0612-2385895. **Contact Person: Mr. Rajeev Agrawal, Contact Mobile: 099311 07825**
E-mail: patna@vipulmedcorp.com

WEST REGION

AHMEDABAD

IInd Floor 202, Binali Complex, Opp. Torrent Power, Zonal Office, AEC, Naranpura, Ahmedabad - 380 013.
Phones: 079-40051202. **Contact Person: Mr. Rakesh Sharma, Contact Mobile: 093270 32180**
E-mail: ahmedabad@vipulmedcorp.com

MUMBAI

Unit no.15, Ground Floor, Shilpin Centre, G. D. Ambekar Marg, Wadala (W), Mumbai - 400 031
Phones : 022-40764545 (24 Lines). Fax No. : 022-40764555 **Contact Person : Mr. Pramod Turbe**
E-mail : mumbai@vipulmedcorp.com

PUNE

Office No.45, 5th Floor, Lokmanaya House, Opp:Shastrinagar Police Station, Paud Road, Kothrud - 411 038
Phones: 020-25394055. **Contact Person: Dr. Sabbyasachi Mazumdar. Contact Mobile: 80553 34411**
E-mail : nsppune@vipulmedcorp.com

SURAT

712, 7th Floor, City Center, Sosyo Circle, Udhana Magdalla Road, Surat - 395 007
Phones : 0261 - 2630140/2630142. E-mail Id : surat@vipulmedcorp.com

VADODARA

449-450, Phoenix Complex, Near Suraj Plaza,Sayajiganj, Vadodara - 390 005
Phones : 0265-6643222 (10 Lines). Fax No.: 0265-2225302. E-mail Id: vadodara@vipulmedcorp.com

CONTACT PERSONS –

VIPUL BANGALORE (FOR CORPORATION BANK)

LEVEL	NAME/DESIGNATION	CONTACT No.	EMAIL ID
1	**Central SPOC, Senior Executive**	**96069 34122**	corpbank@vipulmedcorp.com
2	**Mr. Jayaraj, Dy. Manager**	**99002 83784**	blrcorp@vipulmedcorp.com
3	**Mr. Vinod, Sr. Manager**	**85953 06195**	vinod@vipulmedcorp.com
4	**Mr. Mallikarjuna, Branch Head**	**96069 34104**	mrao@vipulmedcorp.com
5	**Mr. Lathif, Zonal Head**	**74010 94786**	lathif@vipulmedcorp.com
6	**Mr. S Guru Kumar, Vice President**	**98799 88048**	gurukumar@vipulmedcorp.com
	Dr. Deepika Arora, Vice President	**85279 81555**	deepika@vipulmedcorp.com

CONTACT PERSONS AT DIFFERENT CENTRES

BRANCH	NAME	MOB. NO.
Ahmedabad	**Mr. Mitesh Parmar**	**74900 38735**
Amritsar	**Mr. Bheema**	**78379 31108**
Bangalore	**Ms. Violet Shalini**	**99002 36195**
Chandigarh	**Mr. Ashwini**	**98912 36522**
Chennai	**Mr. Rajhashekharan**	**95664 44947**
Cohin	**Mr. Rajesh**	**97444 97212**
Delhi	**Sr. Executive**	**92051 84158**
Faridabad	**Mr. Mohit**	**93119 86374**
Hyderabad	**Mr. Alfred**	**99710 06988**
Indore	**Mr. Sandeep**	**93297 33015**
Jaipur	**Ms. Richa**	**93090 10423**
Kolkata	**Mr. Ayan Mitra**	**75950 87065**
Ludhiana	**Dr. Deepa**	**81461 78797**
Mangaluru	**Mr. Nishanth**	**96069 34122**
Mumbai Thane	**Mr. Pramod Turbe**	**98705 40540**
Patna	**Dr. Rajeev Agarwal**	**99311 07825**
Pune	**Dr. Sachi**	**77570 41659**
Surat	**Mr. Gajanan Pawar**	**98980 55838**
Vadodara	**Mr. Sunil Pathak**	**26566 43222**

Redefining Healthcare Services...
Vipul Medcorp Insurance TPA Pvt Ltd.
An ISO 9001:2015 Company

CLAIM FORM FOR HEALTH INSURANCE POLICIES OTHER THAN TRAVEL AND PERSONAL ACCIDENT - PART A
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) PolicyNo: b) Sl. No / Certificate No:

c) Company / TPA ID No:

d) Name

e) Address:

City: State:

Pin Code: Phone No: Email ID

DETAILS OF INSURANCE HISTORY:

a) Currently covered by any other Mediclaim / Health Insurance: ○ Yes ○ No b) Date of commencement of first Insurance without break:

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

Diagnosis e) Previously covered by any other Mediclaim / Health insurance: ○ 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 Employed Homemake Student Retired Other (Please Specify)

g) Address:

City: State:

Pin Code: Phone No: Email ID

DETAILS OF HOSPITALIZATION:

a) Name ol 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 Disease first detected /Date of Delivery:

e) Dated of Admission: f) Time: : g) Date ol 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:

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-Checkup 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 (code) 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
- ☐ Operation Theatre Notes
- ☐ ECG
- ☐ Doctor's request for investigation
- ☐ Investigation Reports (Including CT MRI / USG / HPE)
- ☐ Doctor's Prescriptions
- ☐ Others

DETAILS OF BILLS ENCLOSED:

S.No	Bill No	Date	Issued By	Towards	Amount (Rs)
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

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:

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.

Date: 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) Sl. No/ Certificate No.	Enter the social insurance number or the certificate number of social health insurance scheme	As allotted by the organization
c) Company TPA ID No.	Enter the TPA ID No	License number a s 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 format
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 a s 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 policyholder	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
i) E-mail ID	Enter e-mail address of patient	Complete e-mail address
SECTION D - DETAILS OF HOSPITALIZATION		
a) Name of Hospital where admitted	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	Enter date of discharge
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 Medicine	Enter the system of medicine followed in treating the patient	Open Text
SECTION E - DETAILS OF CLAIM		
a) Details of Treatment Expenses	Enter the amount claimed a s treatment expenses	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 benefit claimed	Enter the amount claimed a s 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 amounts in rupees		

Redefining Healthcare Services...
Vipul Medcorp Insurance TPA Pvt Ltd.
An ISO 9001:2015 Company

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 indude the original preauthorization request form in lieu of PART A
(To be filled in block letters)

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) Phone 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) Dated of Admission: g)Time: : h) Date ol 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)	ICD10 Codes	Description
i. Primary Diagnosis		
ii. Additional Diagnosis:		
iii. Co-morbidities:		
iv. Co-morbidities:		

b)	ICD 10 PCS	Description
i. Procedure1		
ii. Procedure2:		
iii. Procedure3:		
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

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 report & Police FIR
- 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. with State Code

d) Hospital PAN: e) Number of inpatient beds: d) 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 fad, our right to claim under this claim shall be forfeited.

Date :

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 Hospital	Enter the name of hospital	Name of 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
d) Name of treating doctor	Enter the name of the treating doctor	Name of doctor in full
e) Qualification	Enter the qualifications 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 hospital	Name of hospital 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 admission	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		
Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format
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 PCS and description of the first procedure	Standard Format and Open text
Procedure 2	Enter the ICD 10 PCS and description of the second procedure	Standard Format and Open text
Procedure 3	Enter the ICD 10 PCS 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 authorities
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 doctor along with the state code	As allocated by the Medical Council of India
d) Hospital PAN	Enter the permanent account number	As allotted 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		

CONSENT FORM FOR VERIFICATION & COLLECTION OF IPD PAPERS

To, Dated:

(Hospital Name) .....

(Address) .....

.....

Dear Sir / Madam,

SUBJECT: CONSENT FORM FOR VERIFICATION & COLLECTION OF IPD PAPERS

I hereby authorize the representative of Vipul Medcorp Insurance TPA Pvt Ltd to verify & collect photocopy of all of my IPD papers related to following hospitalization :-

Name of the Patient- .....

Hospital UHID No- .....

Date of Admission .....

Date of Discharge .....

Diagnosis as per Discharge Card .....

Self attested photo id proof of Patient/Guardian (if patient is minor) is attached

Thanking you.
Yours truly,

(Signature of the Paitent / Guardian (if the patient is minor))

Policy Holder's Details :-

Name : .....

Address : .....

.....

Contact No : .....
Policy No : .....
Vipul Card No :.....

(Signature of the Insured)

LIST OF CLAIM DOCUMENTS:-

- Receipted Copy of the Intimation Letter / Reference number of online intimation
- Duly Filled & signed Claim Form of the underwriter as per specification of IRDA. Available in website
- Original Discharge Card / Summary issued by the hospital.
- Original Final Bill & numbered receipts of the Hospital, in support of payment.
- Original numbered Paid Receipts for investigations carried out.
- Original Investigation Reports.
- All Imaging Films, ECG Strips, Doppler / Angiogram CD etc.
- Original stickers for implants used during operation along with invoice copy.
- Original Prescriptions and corresponding Medicine bills/ cash memo mentioning expiry date & batch No. of the medicine.
- Hospital Registration Certificate in case of a unknown small hospital.
- Any other original documents related to the claim.
- MLC/FIR in case of Accident cases / Attending doctor's certificate in case MLC/FIR not done.
- Patient ID/Age Proof.
- Cancelled cheque of the POLICY HOLDER with name printed on it. Otherwise copy of the first page of bank pass book to accompany the cheque foil. PLEASE NOTE THAT IT IS MANDATORY.
- For claims valued at Rs. 1 Lac or more, document as specified by IRDA towards ID with address proof of the POLICY HOLDER must be submitted for compliance of KYC norms.
- Copy of current year & previous years policy copies.
- Copy of Aadhaar card of Proposer/Employee.
- Copy of PAN card of proposer/Employee in case of claim value is more than 50,000/-.

Please note that the above list has been drawn without prejudice and is illustrative and not exhaustive.

GIPSA NETWORK-DECLARATION FORM
(To be filled by the Hospitals)

Name of the Hospital:.....Date of Admission.....

Address:.....

PATIENT NAME/INSURED NAME (BLOCK LETTERS):..... AGE/SEX .....

(To be filled by the Insured/policy holder/Attendant)

1. *Do you have an Insurance policy?* *YES/NO*

If yes, then please select: New India/ United India/ National Insurance/ Oriental Insurance/others

*Policy No*_____
TPA Name _____
TPA card No: _____

2. Have you contacted TPA or Insurance Company for cashless facility? *YES/NO*

3) Whether patient opted for Eligible Room Category under Policy: *YES/NO*

If No, then kindly mention the opted room category:.....

On my own option, I wish to avail above facility and I hereby agree to pay on my free will, after being explained in detail by the Hospital authority in my own and understandable language about the above mentioned Facility/Procedure/Treatment and associated cost of it, which is over and above the agreed tariff for the treatment. Further, if I opt to go for final bill reimbursement with insurance company, respective insurance company will reimburse only as per agreed tariff for the treatment and balance amount will be borne by me / patient only.

I have also been explained that when room service of a category other than eligible room rent is availed by the patient, not only the difference in room rent but also an equal proportion of all other charges associated with the treatment shall be borne by me/ patient only

Signature:.....
Name of the Patient/Patient's attendant:

Signature:.....
Name of the Hospital Representative &Hospital Seal:

Mobile No.....
E –Mail.....
PAN / Form 60: .....
Aadhar Card Number.....