फॉरेस्ट डेव्हलपमेंट कॉर्पोरेशन ऑफ महाराष्ट्र लिमीटेड

(महाराष्ट्र शासनाचा अंगीकृत व्यवसाय)
CIN : U45200 MH 1974 SGC 017206
एफडीसीएम भवन, ३५९-बी, हिंगणा रोड, अंबाझरी, नागपूर-४४००३६
Email: md@fdcm.nic.in, gm.hq@fdcm.nic.in

क्रमांक:प्रशा/आस्था-५/प्र.क्र.४५७ 9eel नागपूर,दिनांक 11 SEP 2023

ज्ञापन

विषय :- एफडीसीएम लिमीटेड मधील अधिकारी / कर्मचारी तसेच परसेवेवरील अधिकारी /कर्मचारी यांना नॅशनल इन्श्युरन्स कंपनीची मेडीक्लेम पॉलीसीबाबत.

1.0 एफडीसीएम लिमीटेड मधील अधिकारी, कर्मचारी तसेच परसेवेवरील अधिकारी कर्मचाऱ्यांसाठी नॅशनल इनश्युरन्स कंपनी लिमीटेडची मेडीक्लेम पॉलीसी **दिनांक २९.०३.२०२३** पासुन लागु करण्यात आली आहे.

2.0 एफडीसीएम लिमीटेडने **३ लाखाकरीता** पॉलीसी संलग्नीत केली असुन रु ३.०० लाख पेक्षा जास्त खर्च झाल्यास दाव्यातील उर्वरीत रक्कम **' कॉर्पोरेट बफर '** मधुन अदा करणे अभिप्रेत आहे. तसेच, कॉर्पोरेट बफरसंबधी मंजुरी करिता कर्मचा-याने त्यांचे वरिष्ठ कार्यालयास कळविणे आवश्यक आहे.कॉपोरेट बफरसंबधी वैदयकीय बिले ही विहित वेळेत सादर होईल याबाबत दक्षता घेण्यात यावी.

3.0 नॅशनल इनश्युरन्स कंपनी लिमीटेडद्वारे Reimbursement Claim Form,Certificate (To be filled by hospital) व Check List पुरविण्यात आलेले असुन सदरहु Format मध्येच वैदयकीय बिल सादर होईल, याबाबत दक्षता घेण्यात यावी. माहितीकरिता सदर दस्ताऐवज यासोबत सहपत्रित करण्यात येत आहे.

4.0 वैदयकीय बिल सादर करतांना नॅशनल इनश्युरन्स कंपनी लिमीटेडद्वारे पुरविण्यात आलेल्या Check List मधील सर्व दस्ताऐवज जोडले आहे काय ? याबाबत खात्री करुनच वैदयकीय बिल सादर करावे.जेणेकरुन वैदयकीय बिलामध्ये त्रुटी आढळुन येणार नाही व वैदयकीय बिलाची प्रतिपुर्ती लवकरात लवकर होईल.

5.0 काही विभागाद्वारे त्यांच्या अधिनिस्त असलेल्या अधिकारी/कर्मचारी यांचे वैदयकीय बिल हे थेट नॅशनल इन्शुरन्स कंपनीला पाठविण्यात येत असल्याचे दिसुन येते. त्यामुळे अधिकारी/कर्मचारी यांचे वैदयकीय बिलाचे नोंद ठेवणे या कार्यालयास कठीण होत आहे. त्याअनुषंगाने, कळविण्यात येते की, नॅशनल इन्शुरन्स कंपनीला पाठविण्यात आलेल्या अधिकारी/कर्मचा-यांचा वैदयकीय बिलाची एक प्रत या कार्यालयास पृष्ठांकित करावी.

6.0 आपल्या अधिनिस्त असलेल्या अधिकारी/कर्मचारी यांचे वैदयकीय बिल हे Discharge झाल्यानंतर **६० दिवसाच्या आत सादर करावे.** तसेच, Pre Hospitallization चे वैदयकीय बिल ३० दिवसात **व** Post Hospitallization चे वैदयकीय बिल सुध्दा ६० दिवसाच्या आत सादर करणे क्रमप्राप्त आहे.

D‹Mediclaim<General Letters

8.0 कॅशलेस उपचाराकरिता महाराष्ट्रातील सर्व जिल्ह्यातील किंवा संपूर्ण देशातील दवाखाने शोधावयाचे असल्यास geninsindia.com या संकेतस्थळाला भेट द्यावी. Network Hospital वर Click करुन त्या शहरातील Hospital शोधावे.

9.0 नॅशनल इन्श्युरन्स कंपनीच्या अधिकाऱ्यांचे भ्रमणध्वनी क्रमांक खालीलप्रमाणे आहे.

नॅशनल इनश्युरन्स कंपणी लिमीटेडची मेडीक्लेम पॉलीसी			
१	पॉलीसी क्रमांक	280400/50/22/10002919	
२	संकेत स्थळ	geninsindia.com	
३	भ्रमणध्वनी क्रमांक व ई - मेल		
	श्री अश्विन इंगळे	ashwin.ingale@geninsindia.com	९२२५२३९३०७
	श्री राहुल बागडे	rahulm.bagde@nic.co.in	८४११८८५९९२
	श्री अजय पारवेकर	nagpurgenis@gmail.com	९२२५२३९३०६
	कार्यालय संपर्क	**nagpur@genisindia.com**	**७१२-२२२५०२९**

१०.० तसेच, दवाखान्यामध्ये भरती व्हावयाचे असल्यास उपरोक्त नमुद प्रतिनिधीना संपर्क साधावा किंवा संबधीतांचा ई-मेल आयडीवर Intimation देण्यात यावे.यामध्ये रुग्णाचे नाव Policy Holder शी नाते,दवाखानाचे नाव तसेच ई-मेल पाठवण्याचे नाव व मो.नंबर नमुद असावा.

उपरोक्त नमुद संपुर्ण माहिती हि प्रत्येक अधिकारी/कर्मचारी यांचे पर्यंत पोहचवण्याची कार्यवाही आपले स्तरावरुन करण्यात यावी.

सहपत्र-वरीलप्रमाणे.

(संजीव गौड)
महाव्यवस्थापक (मुख्यालय)

प्रति,
महाव्यवस्थापक
एफडीसीएम लिमीटेड
नागपूर, प्रदेश नागपूर.

प्रादेशिक व्यवस्थापक
एफडीसीएम लिमीटेड (सर्व)

प्रतिलीपी :- विभागीय व्यवस्थापक, नॅशनल इन्शुरन्स कंपनी लिमिटेड यांना माहितीकरिता अग्रेषित.
अग्रेषित
प्रतिलीपी :- विभागीय व्यवस्थापक, एफडीसीएम लिमीटेड (सर्व) यांना माहिती व पुढील कार्यवाहीस्तव अग्रेषित.
प्रतिलीपी :- कक्ष प्रमुख (सर्व)
प्रत :- व्यवस्थापकीय संचालक कार्यालयातील अधिकारी / कर्मचारी (सर्व)
प्रत- सुचना फलक
प्रत एफडीसीएम संकेतस्थळ

D‹Mediclaim<General Letters

Genins India Insurance TPA Ltd.
Third Party Administrator in Health Insurance

REIMBURSEMENT CLAIM FORM

TO BE FILLED BY THE INSURED

The issue of this Form is not to be taken as an admission of liablity

Toll Free No. 1800-345-3323
Fax No. 95-120-4144170-71

(To be Filled in block letters)

SECTION A

DETAILS OF PRIMARY INSURED:

a) Policy No.:

b) Sl. No/ Certificate no.

c) Company / TPA ID (MA ID)No:

d) Name: SURNAME FIRST NAME MIDDLE NAME

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 FIRST NAME MIDDLE NAME

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
- OperationTheater Notes
- ECG
- Doctols request for investigation
- Investigation Reports (Including CT / MRI / USG / HPE)
- Doctols 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: e) IFSC Code:

d) Cheque / DD Payable details:

SECTION H

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.

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) Sl. 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-forrmat
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.		

CERTIFICATE

(TO BE FILLED BY THE HOSPITAL/ NURSING HOME/ CLINIC AUTHORITY)

This is to certify that _____

was admitted under my treatment from _____ at _____ to _____ at _____

and detail information is as under:-

1. Name of Hospital/ Nursing Home _____
2. Whether the same is registered with the local authority or not _____
3. If so, Registration No _____
4. If not answer the following queries:-
   A. No of inpatient beds in the Hospital/ Nursing Home: _____
   B. Whether you have fully equipped Operation Theater of your own. Yes/ No
   C. Whether you have fully qualified Nursing Staff in your employment round the clock. Yes/ No
   D. Whether you have qualified Doctor in Charge round the clock. Yes/ No
5. Date/ Time of Admission _____
6. Date/ Time of Discharge _____
7. History of present illness with duration of the presenting complaints:
   (a) What is the exact nature of complaint with which the patient first presented (seen) _____
   (b) Since how long he/ she has been suffering for the same _____
8. Past History of the disease _____

Signature of Doctor
Or
Hospital Authorities
(Seal of Hospital)

CHECK LIST FOR CLAIM SUBMISSION

Claimant's /Employee Name:..... Employee No:.....

Patient's Name:.....Patient's Genins Card ID No:.....

Claim No. and /or Policy No:.....

Mobile no.: .....E-Mail ID:.....

Please put the page number in the box provided,

1) Duly signed Claim Form in original — **Page No.** ☐

2) Copy of the claim intimation — **Page No.** ☐
(In case of delayed / non-intimation, self declaration for reason for the same)

3) Copy of Photo ID other than Genins (e.g. Election / Aadhar / PAN / Ration Card or Passport) **Page No.** ☐

4) Copy of Hospital registration Certificate / Duly filled Format for Hospital certificate — **Page No.** ☐
(Applicable for non-network hospitals)

5) Original Discharge summary /Death Summary / Day care summary as applicable — **Page No.** ☐
(Gives the summary of diagnosis and course of treatment in hospital)

6) Duly attested (by the hospital) copy of Operation theatre notes wherever applicable — **Page No.** ☐

7) Implant sticker / invoice wherever applicable — **Page No.** ☐
(In case of self purchase of Implants used in Cataract, Heart surgeries, Abdominal Surgeries, Knee replacement surgeries etc., vendor invoice and payment receipt also required)

8) Police FIR / Medico Legal Certificate (MLC) — **Page No.** ☐
(Mandatory for accidental / burns / suicidal / poisoning /other injury cases. In case not done, reason for the same given by the hospital on letter head signed and stamped by the hospital authority required)

9) Original Main Hospital bill with bill no. — **Page No.** ☐

10) Original Hospital bill break up — **Page No.** ☐
(With detailed break up of various heads like Room Rent/OT charges/Nursing etc)

11) Original Hospital Bill Payment Receipt with receipt number — **Page No.** ☐
(With seal & signature of hospital authority)

12) Original Pharmacy and Investigation cash memos / bills — **Page No.** ☐
(Along with supportive doctor's prescriptions and Investigation reports & films)

13) Copy of cancelled cheque of claimant /employee — **Page No.** ☐
(Not applicable if payment is made in favour of corporate)

14) KYC compliance documents if claim is equal or above one lakh of Rupees — **Page No.** ☐
(This includes latest photograph and Address proof in addition to Photo ID. as above
Not applicable if payment is made in favour of corporate)

Total no. of pages ☐

Points to Remember:

- **Do not forget to attach this checklist with the claim documents.**
- **Arrange the documents in the same order as in the checklist. This way you can ensure that you have not missed out a document.**
- **Please retain copies of all the documents submitted to us for future reference.**
- **In case of claim submission beyond the stipulated time period please add self declaration detailing reason for the sa**
- **Doctor's registration number on doctor's letterhead with signature if not included in hospital documents sho taken. This is applicable for non-network hospitals only.**

CLAIMANT'S / EMPLOYEE'S SI