



**UnitedHealthcare India
Claims Document Submission-Self Service Tool**

Overview



(Please click on the link below to see/print the document checklist for more details. Please submit the check list along with your claim documents)

[Document Checklist](#)



Claims documents are classified into:

a) Mandatory Documents:

(Documents without which the claim will not be paid by the insurer and the claim file will be returned to you.)

Some important Mandatory Documents are listed below:

- [✦Original Signed Claim form](#)
- [✦Original Discharge Summary/Card from the Hospital](#)
- [✦Original Hospital Main Bill](#)
- [✦Original Cash receipts/Credit card charge slip](#)
- [✦Original Lab reports/Images e.g. X ray Plates/ECG/Ultrasound report.](#)
- [✦Certificate form Hospital on No of beds and Registration No.](#)

b) Non Mandatory Documents:

(Documents without which the claim can be paid post deduction of any amount due toward the said missing document.)

Some examples are:

- [✦Original Medicine bills with prescription from attending doctor-Stamped and signed.](#)
- [✦Receipts for tests/investigations undergone at the hospital.](#)

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It is hence important that you insist on all of the above during your stay at the hospital before the discharge.
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Points to Remember-While in Hospital

- ✚ Insist on a receipt for every transaction involving your money paid to the hospital.
- ✚ Preserve every receipt for the payments you make to the hospital including Credit Card transaction slips.
- ✚ Make sure that you collect all the reports (both printed as well as images like X ray films, ECG reports) before discharge.
- ✚ For any consultation by a specialist from outside the hospital and whose charges won't be billed by the Hospital in their bill, do obtain a receipt for the services rendered by the said doctor as well as a certificate regarding his registration Number of the hospital
- ✚ For any medicines purchased from a chemist outside the hospital (for whom the hospital would not raise a bill), please obtain prescriptions from the hospital for the said medicine.
- ✚ Make sure that you obtain a certificate from the hospital giving the following information:

- a) Hospital Registration Number
- b) Number of Beds in Hospital
- c) Operation Theater Facility
- d) Round the Clock Nursing Staff.

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→ The certificate should be on Hospital Letter Head & affixed with the Stamp and Signature of Hospital

Document identification made easy for you!



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In the next few slides, you can see screen shots of some of the documents for your ready reference. These will help you with the following:

- ✚ Identify the relevant documents from the set of documents you have for the claim.
- ✚ Identify the source of such a document for ease of your obtaining the same.
- ✚ Identify whether the document is classified as a mandatory/Non mandatory document.

IMP

Please note the screenshots are only indicative and may not exactly resemble the corresponding document in your list. For any help please call us at our call center or write to us.



Signed Claim Form-Reverse Page

10. If the claim is for domiciliary hospitalisation, please indicate

a) Date of commencement of treatment	a)
b) Date of completion of treatment	b)
c) Name & address of attending practitioner	c)
d) Telephone no.	d)
e) Registration no.	e)

11. Schedule of expenses incurred by the claimant under hospitalisation/ domiciliary hospitalisation (to be supported by bills/ receipts, cash memos etc.)

	Expenses incurred in the hospital	Pre hospitalisation expenses (Rs)	Post hospitalisation expenses (Rs)
Hospitalisation Benefit			
Domiciliary hospitalisation			

I have incurred the above expenses for the treatment of the disease / illness / accident referred to here.

- In support of the claim, I enclose the following documents (please indicate by ✓)
1. Bill, receipt and discharge certificate card from the hospital.
 2. Cash Memo from the hospital / chemists(s) supported by proper prescription.
 3. Receipt and pathological test reports from a pathologist supported by the note from the attending Medical Practitioner / Surgeon demanding such pathological tests.
 4. Surgeon's certificate stating the nature of operation performed and Surgeon's bill and receipt.
 5. Attending Doctor's / Consultant's / Specialist's / Anesthetist's bill and receipt and certificate regarding diagnosis.
 6. In case of domiciliary hospitalisation, receipt from a qualified nurse who attended the patient at his / her residence duly supported by a certificate from attending Medical Practitioner.
 7. Certificate from the attending Medical practitioner giving reasons for allowing treatment at home.
 8. Certificate from the attending Medical Practitioner / Surgeon that the patient is fully cured.

I hereby warrant the truth of the foregoing particulars in every respect and I agree that if I 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 or Insurance.

Dated at _____ this day of _____ 200__



XXXXXX
Signature of the Claimant

Name of Document

Signed Claim Form (SCF) back page

Type Of document:

Mandatory

Available at:

Send Request to customerservice@uhcindia.com

Relevance:

Carries declaration and Signatures of Insured/Employee

Make sure the signature of the employee is affixed before sending



Original Discharge Summary (continued)

25.8 pg, MCHC- 32.6g/dl, PL - 210000/cu.mm
DIFFERENT COUNT - Neutrophils - 70.8 % , Lymphocytes - 24.3 % , Monocytes - 3. 7%, Eosinophils - 1.1 % , Basophils - 0.1 %
BT - 2'00''mins , CT - 7'00''min.

INVESTIGATIVE PROCEDURES:

05.03.08 : KUB and Pelvis Scan Report :
Retroverted uterus with echogenic endometrium of 0.65 cms.
Bilateral polycystic ovaries noted.
There was an anechoic cyst seen in the left ovary probably a follicle.
A thick torted ovarian pedicle with a whorled appearance of vessels within was suggestive of torsion of the left ovary with retained arterial and venous flow. (2.8 x 1.9 x 3.1cms).

COURSE OF TREATMENT IN THE HOSPITAL:


Left side - laparoscopic ovarian cystectomy done under GA on 05.03.08.
Indication : Ovarian cyst torsion.
Incision : 3 ports.
Per Operative Findings :
Left ovarian cyst (5 x 6 cms) twisted twice.
Upon untwisting blue colour changed to pink.
Cyst had a serous component and a sebaceous component with hair(dermoid)- sent for HPE.
Post Operative period was uneventful. She received a course of antibiotics and analgesics.
Cyst sent for Histopathology.

CONDITION ON DISCHARGE:

Satisfactory.

FURTHER ADVICE ON DISCHARGE:

TAB. AUGMENTIN 375 mg 1-1-1 TILL 10.03.08.
TAB. RANTAC 150 mg 1-0-1 TILL 10.03.08.
TAB. COMBIFLAM 1-1-1 TILL 10.03.08.
REVIEW WITH DR. T.P.REKHA AT OBG OPD AFTER 1 WEEK WITH HPE RPEORT WITH PRIOR APPOINTMENT
FOR APPOINTMENT CONTACT (080 2502 3262).
IN CASE OF EMERGENCIES PLEASE CONTACT (080) -25260902.

Dr. 
CONSULTANT

Typed By
(Netra.R.)

Verified By
(Dr. GARIMA)

Checked By
(KAVITHA)

Page No. 2

Name of Document

Original Discharge Summary

Type Of document:

Mandatory (ORIGINAL)

Available at:

Hospital where treatment was taken

Relevance:

Summary of the entire hospitalization including diagnosis and line of treatment



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Hospital Main Bill

INSPIRED BY LIFE
A UNIT OF MEDICAL RELIEF SOCIETY OF SOUTH KANARA (REGD.)
BANGALORE - 560 017, (Karnataka State) Tel.: (01 080) 25289441, 25289442, 25289443

ICR116105 No. 0057801
Date: 06-Mar-2008 17

Hospital No. Dept.: OBG Ward: 9TH FLOOR D AGE: 25 Year(s)
LP No. Name: HRS. Address: Address: Address:
Admission Date: 05-Mar-2008 04:04 PM
Discharge Date: 05-Mar-2008 05:00 PM
No. of Days: 1
Category: EXE-SPL

DOCTOR NAME: DR. R. S. IYER
SPONSOR NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
BED NO: 0837EX-C

SLNO	PARTICULARS	AMOUNT (Rs)
1	BED CHARGES	4500.00
2	SERVICE/NURSING CHARGES	1000.00
3	ADMISSION CHARGES	200.00
4	ANESTHESISTS FEE	3740.00
5	BIOCHEMISTRY	3900.00
6	CONSULTATION - REXHA. T.P	1400.00
7	CONSULTATION - SOMMINI G IYER	700.00
8	DIET CHARGES	58.00
9	DRUG RETURNS	-227.91
10	HAEMATOLOGY	1100.00
11	HISTOPATHOLOGY	1800.00
12	MEDICAL EQUIPMENT	6000.00
13	OT DRUGS	2125.28
14	OT MATERIALS	5016.03
15	OTHER SERVICES	300.00
16	PHARMACY DRUGS	1377.09
17	SURGEONS FEE	24310.00
18	THEATRE CHARGES	4800.00
19	WARD DRUGS	1008.16
20	WARD MATERIALS	28.00
BILL AMOUNT		63135.00
DEPOSIT(S)		2498.00
NET AMOUNT		60637.00

IN WORDS: SIXTY THOUSAND SIX HUNDRED THIRTY SEVEN RUPEES Only
DEPOSIT DETAILS
DP277303 - 06/03/2008 05:03 PM - 2498.00 - CreditCard

RECEIVED BY
DATE: 06 MAR 2008

Prepared by: _____ Checked by: _____ Cashier: _____
Received By: _____ Receipt No: _____

Name of Document

Hospital Main Bill

Type Of document:

Mandatory (ORIGINAL)

Available at:

Hospital where treatment was taken

Relevance:

Complete expenditure of hospitalization with break up of broad heads.



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Hospital Main Bill (Breakup)

IP CHARGE CHECKLIST(ICR116105) DATE: 10-Mar-2008
 TIME: 04:11:47 PM

MANIPAL HOSPITAL
 BANARSI 560017

HOSPITAL NO: DEPT: OBG Age: 25 Year(s)
 IPNO: WARD: 8TH FLOOR D
 NAME: MRS.
 ADDRESS:

ADMIT DATETIME: 05-Mar-2008 04:54 PM
 DISCHARGE DATETIME: 06-Mar-2008 05:06 PM

NG OF DAYS: 1
 CATEGORY: EXE-SPL

DOCTOR NAME: XXXXXXXXXXXXXXXXXXXXXXXX
 SPONSER NAME: UNITED HEALTH GROUP XXXXXXXX (P
 BED NO: 0857EX-C

Sl.	TEST/SERVICE	Amount
1	BED CHARGES	
1	EXE-SPL 0857EX-C 1 Days	4500.00
	Sub Total ...	4500.00
2	SERVICE/NURSING CHARGES	
2	EXE-SPL 0857EX-C 1 Days	1000.00
	Sub Total ...	1000.00
3	ADMISSION CHARGES	200.00
4	ANASTHESISTS FEE	
4	SOWMINI G IYER 05-Mar-2008	1660.00
5	SOWMINI G IYER 05-Mar-2008	2080.00
	Sub Total ...	3740.00
6	BIOCHEMISTRY	
6	CA - 125	2400.00
7	BUN (Blood Urea Nitrogen)	300.00
8	CREATININE - Serum	300.00
9	ELECTROLYTES (NA, K & CL)	780.00
10	GLUCOSE - RANDOM	200.00
	Sub Total ...	3900.00

continue....

Name of Document

Hospital Main bill (Breakup)

Type Of document:

Mandatory (ORIGINAL)

Available at:

Hospital where treatment was taken

Relevance:

Gives break up of expenditure on hospitalization for Room Rent/Doctors fee/Nursing/OT charges Surgeons Fee/Test charges etc

Medico Legal Certificate (MLC-Format)



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MEDICO LEGAL CASE RECORD

Name: _____ Hospital No.: _____
Age: _____ M.L.C. No.: _____
Sex: _____ Date: _____
Address: _____ Time of arrival _____
Patient brought by: Wife/Husband/ Children _____
Relative _____
Police _____
Onlookers _____

Occupation: _____
Identification Marks: _____

History: _____

History of Alcohol Consumptions: _____
Clinical Findings: _____

Signature of Medical Authority _____
Date: _____

Name of Document

MLC (Medico Legal Certificate-Format)

Type Of document:

Mandatory (Copy with Policy attestation)

Available at:

Hospital where treatment was taken

Relevance:

Necessary in Road Traffic Accidents.
Must certify that the patient was not
Under influence of Alcohol at the time
Of the accident



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Medico Legal Certificate (MLC- Sample)

FRX NO. : +91 33 2320 8334 Apr. 04 2008 11:00AM P1

Empidi

~~XXXXXXXXXXXX~~ Hospitals
KOLKATA

ACCIDENT / INJURY - POLICE INTIMATION

Name: _____ Age/Sex: 29 Yrs/M
 UHID No. _____ Admitted: Yes / No (If Yes) Bed No.: 163 IP No.: _____
 Treating Physician: XXXXXXXXXXXX

Father's / Husband's Name: _____ Occupation: SERVICE
 Address: Sree Duran City: _____
 Pin Code: _____

Occurred at: 9:45 AM on _____ (date)
 Brought in at: 11 AM on _____ (date)
 Site of occurrence: on Rajarhat road near SPM Police Station: Rajarhat
 Identification Marks: 1. on building
 2. Nothing significant

Nature of the injury: Simple Grievous Opinion Reserved
 Injury Report: Swelling & tenderness (L) arm & few small abrasions
to right wrist lower third humerus
 Present Status: conscious, alert. Hemodynamically stable
 Dying Declaration taken: Yes No
 Alleged cause: As per patient statement he was travelling in a
car (sitting on the rear seat) while a motor bus (moving) suddenly
came from side & his car collide with it and he
sustained injury.

The patient is brought by me to Apollo Gleneagles Hospitals - Emergency Department, and the above information given by me is true and correct to the best of my knowledge.

Name: _____ Relation: Colleague
 Address: 21 Lane KOL-50
 Signature: _____ Date/Time: 02/04/08 1:30 PM

Police Intimated: Yes / No _____ Date/Time: 02/04/08

Received By: _____ Doctor's Signature: _____
 Signature: _____
 Date: 02/04/08

-016 08/2008

Police Stamp

Name of Document

MLC (Medico Legal Certificate-Sample)

Type Of document:

Mandatory (Copy with Policy attestation)

Available at:

Hospital where treatment was taken

Relevance:

Necessary in Road Traffic Accidents.
Must certify that the patient was not Under influence of Alcohol at the time Of the accident



Certificate format from Treating Hospital

Print on Hospital Letter Head

TO WHOMSOEVER IT MAY CONCERN

This is to certify that this _____ Hospital / Nursing Home Registration Number is _____.

It also has the following facilities.

1. _____ (Number) inpatients beds.
2. Fully equipped operation theatre.
3. Fully qualified nursing staff under its employment round the clock.
4. Fully qualified doctor should be in charge round the clock.

In case of queries fell free to call on _____.

Thanking You

Sincerely

Authorised Signatory

Hospital Seal:

Doctors Sign & Hospital Seal.

NOTE: This letter is to be taken on the hospital Letter Head

Name of Document

Hospital Certificate

Type Of document:

Mandatory
(on Hospital Letter head)
With seal of Authorized person)

Available at:

Hospital where treatment was taken

Relevance:

Necessary to identify whether the hospital Infrastructure and Manpower Qualifies for insurance claim settlement



Medicine Bill

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XX
 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 XXXXXXXXXXXXXXXXXXXXXXX

TIN No. : XXXXXXXX
 CST No. : XXXXXXXXXXXX

TAX PHARMACY BILL

NAME : _____ CASH BILL

DOCTOR : _____

IP CODE : DR. XXXXXXXX BILL NO. : 2133516

HOSPITAL NO. : 424283 BILL DATE : 19/04/2008 BILL TIME : 13:53

SL	NAME OF THE MEDICINE	BATCH NO./EX. DATE	QTY.	AMOUNT
1	AUGMENTIN 1.2 GM I.V.INJ	NT445 (12/2009)	1	204.23
2	NORMAL SALINE 500ML (VIAFLEX)	879013 (11/2009)	3	184.61
3	COSY SHEET LARGE WITH STRIPS	96321 (12/2012)	1	62.50
4	LATEX EXAMINATION GLOVES	EI0810 (12/2012)	20	96.14
5	ALCO SWAB	NS12 (12/2012)	5	7.21
6	NORMAL SALINE 500ML (CLARIS)	A181309 (2/2011)	1	17.00

Sub Total Amount : 571.69

VAT AMOUNT : 22.87

VAT Amount :

NET AMOUNT PAYABLE : 594.50

Name of Document

Medicine bill

Type Of document:

Mandatory (**Original**)

Available at:

Chemist where Medicine purchased

Relevance:

This along with the doctors advise
Is evidence of medicine purchased
During the treatment.

FAQ'S



Q. I am asked to submit Investigation reports. What should I do?

Ans: Investigation reports mean the pathological and diagnostic tests that you have undergone during the treatment on treating doctors advise. Some examples are blood tests, urine examination, X ray, ECG etc.

Q.2 I am asked to clarify/Justify prolonged stay at the hospital. How can I justify the duration of stay in the hospital?

Ans: You are not expected to justify the stay duration. This needs to be explained by the treating hospital and the treating doctor on their letter head. This is asked by insurers when the duration of stay is more than the average duration of stay for a particular treatment. Please contact the hospital and obtain the same.

Q.3 I am asked to submit a sticker/invoice. What does this mean?

Ans: A Sticker or invoice is asked to prove the charges incurred for a lens (cataract) or any other implant like pace maker, prosthetic joint etc used during surgery.

Q.4 I am asked to submit indoor case papers/ICP. What does it mean and where do I obtain these from?

Ans: Indoor case papers are the complete treatment record during your stay at the hospital. These are internal records of the hospital and can be demanded from them. The hospital will be able to provide you a copy of the entire set and you need to submit the same to us.

FAQ'S



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Q.5. I am asked to provide break up of medicine and investigation charges. Where do I get these from?

Ans: This hospital main bill provided to you does not always provide individual break up of expenses for each medicine administered or each test done by you. The hospital however maintains a record of each of these transactions. We need these details to assess your claim and get approval from the insurer. You can demand this from the hospital. (See slide no.10 for a sample)

Q.6. I am asked to provide time of admission and discharge from the hospital. What should I do?

Ans: Please approach the Hospital where the treatment was taken and ask them to provide the “date and time of admission” and “date and time of discharge” from the hospital on their letter head. This is necessary to determine whether hospitalization was for more than 24 Hrs.

Q.7 I am asked to provide the hospital registration no, number of beds, availability of nursing staff, Operation theater availability etc. How do I know these and where do I get these?

Ans: These details are required by the insurer to determine whether treatment has been taken in a registered hospital and whether it has the necessary infrastructure and facilities to qualify as a hospital as per terms and condition of the policy. Please obtain these details from the hospital as per format on slide no.13.

Q.8. I am asked to provide a FIR and MLC report. What are these are where should I get these from?

Ans: The FIR report is the “First information report” to the police. The MLC report is called the “Medico Legal certificate” that is prepared by the Hospital in case of Road Traffic accident and is endorsed by the Police. The medico legal certificate must mention that the patient was not under influence of alcohol at the time of accident. (MLC format on slide no. 11 and 12 for a sample)



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Thank You

For further assistance please call us at:
Toll free: 1800-22-8484 / 1800-22-4646

Or email at:



customerservice@uhcindia.com

Or write to us at:

Document Recovery Department
UnitedHealthcare India (Private) Limited
3 B, Gundecha Onclave, Kherani Road, Saki Naka
Andheri East, Mumbai-400 072

CHECK LIST FOR SUBMISSION OF CLAIM

Very IMP:

-  **Do not forget to attach this checklist with the Claim file.**
-  **Arrange the documents in the same order as in the checklist, checking against the designated box when you do so. This way you can ensure that you have not missed any documents.**

Employee Name:- _____ Employee No: _____ Claim No. _____

Name of the company: _____

Contact Number: _____ Mobile no. _____ E- Mail ID: _____

Check list for Documents: Please put a "X" mark against the box

Original Claim Form duly signed by you.

[Fill the claim amt in Signed Claim Form]

Original Main Hospital bill with Bill Number & break up,

(With detailed break up of various heads like Room Rent/OT charges/Nursing etc).

Original Discharge summary

(Gives the summary of diagnosis and treatment in hospital)

Original Death summary

(Only in case of death of Patient during Hospital stay).

Original Hospital Payment Receipt with receipt number

(With seal & signature of hospital) (if main bill does not carry a bill number).

Original Payment Receipt with receipt number

(For consultation/surgeon charges if charged outside the main hospital bill).

Hospital registration number

(Registration No. & Number of beds, on hospital letterhead with signature).

Doctor's registration number

(On doctor's letterhead with signature).

Original Pharmacy and Investigation bills

(Along with prescriptions & Lab reports).

Original prescriptions

(On doctor's letterhead mentioning duration and dosage for medicines and advice for diagnostic tests).






investigation reports in original/attested from hospital

(Reports for all tests done along with images)

Police FIR / Medico Legal Certificate (MLC)

(Mandatory for All Road traffic accidents-Duly attested by Police with

Points to remember

-  Please retain copies of all the documents submitted to us for future reference.
-  For any assistance with any of the above formats, please contact us at customerservice@uhcindia.com or call at 1800 22 4646
-  Please retain a POD copy of the courier for tracking your consignment in case of any delay etc.
-  The above list of documents is indicative. In case of any other document requirement as specified by the insurance company our Document recovery Team will contact you on receipt of your claim documents by us.
-  For Implants used in Cataract, Heart Valve surgeries, CABG, Abdominal Surgeries, Knee replacement surgeries, please submit the bill from the vendor for the prosthetic device used along with Sticker.