

 <p><b>बैंक ऑफ महाराष्ट्र</b> Bank of Maharashtra आज का महाराष्ट्र</p>	<p><b>मानव संसाधन प्रबंधन विभाग</b> <b>Human Resources Management Department</b> प्रधान कार्यालय: लोकमंगल, 1501, शिवाजीनगर, पुणे-5 Head Office: LOKMANGAL, 1501, SHIVAJINAGAR, PUNE-5 टेलीफोन/TELE : 020-25614270-72 ई/मेल-e-mail: <a href="mailto:bomcowelfare@mahabank.co.in">bomcowelfare@mahabank.co.in</a></p>	
---	---	---

AX1/Welfare/ IBA GMC Ret. Policy- TPA/Cir.155/2022-23

November 07, 2022

**ALL THE BRANCHES / OFFICES OF THE BANK**

Madam / Dear Sir,

**Re.: IBA Retirees Group Medical Insurance Policy – TPA - Ericson Insurance TPA Pvt. Ltd. W. e. f 01.11.2022.**

National Insurance Co. Ltd. has been entrusted the job for providing cover under IBA Group Insurance Policy for the year 2022-23 for the retirees by Indian Banks' Association vide their letter No. HR & IR/MBR/MEDINS/11501 dated 13.09.2022.

Ericson Insurance TPA Pvt. Ltd. has been appointed as Service provider for the current year retirees IBA Mediclaim Policy of Bank of Maharashtra by National Insurance Company Limited.

Reimbursement claims as well as cashless claim of all hospitalization incurred on or after 1<sup>st</sup> November 2022 will be processed by Ericson Insurance TPA Pvt. Ltd.

Claim forms enclosed as Annexure – I.

**Contact details, E-mail IDs, and address of Ericson Insurance TPA Pvt. Ltd is as under:**

Toll Free No	18002022034
Call centre support	022 4154 8300
Claim intimations to be sent on	intimation@ericsontpa.com
For what's app Intimation	9167251896
Cashless request to be sent on	care@ericsontpa.com
Query Reply email co-ordinations	adr@ericsontpa.com
Hospital List	<a href="https://bit.ly/3xJhndl">https://bit.ly/3xJhndl</a>
Official website	<a href="http://www.ericsontpa.com">www.ericsontpa.com</a>

**Head office Address:** - 11-C, Corporate Park, ST Road, Chembur (East), Mumbai – 400 071.

**Regional office Address:** - Dnyaneshwar Paduka Chowk, Shreenath Plaza, Office No.12, C- Wing, ground floor, FC Rd, Shivaji nagar, Pune, 411004

For escalation please contact on below numbers or E-mail Ids

Level of Contact	Name	Contact Number	Email ID
Level 1	(Account Manager)	8976881601	bom@ericsontpa.com
Level 2 (For BOM HO)	Mr. Sunil Patil (Branch Manager)	7208963272	spatil@ericsontpa.com
Level 3	Mr. Rajaram Kandarkar (HOD)	7208042977	rajaram@ericsontpa.com

**Claims documents should be directly submitted to**

1. Claims Department, ERICSON INSURANCE TPA Pvt. Ltd, 11-C, 2nd Floor, Corporate Park, S.T. Road, Chembur, Mumbai – 400074
2. Claims Department, ERICSON INSURANCE TPA Pvt. Ltd, Dnyaneshwar Paduka Chowk, Shreenath Plaza, Office No.12, C- Wing, ground floor, FC Rd, Shivaji nagar, Pune, 411004

**Yours faithfully,**

**RAJESHKUMAR  
KAMALASEKARAN**

Digitally signed by RAJESHKUMAR  
KAMALASEKARAN  
Date: 2022.11.07 18:49:12 +05'30'

**(K. Rajesh Kumar)  
General Manager  
HRM**



## ERICSON INSURANCE TPA PVT. LTD.

11-C, Corporate Park, S. T. Road, Chembur, Mumbai - 400071

Website: [www.ericsontpa.com](http://www.ericsontpa.com)

E mail: [care@ericsontpa.com](mailto:care@ericsontpa.com)

Tel. No: 022-25280280

Fax No: 022-25270200

### CLAIM SUBMISSION CHECKLIST

Name of the Insured: - \_\_\_\_\_ Patient Name:- \_\_\_\_\_

Name of the company: - \_\_\_\_\_ Employee ID: - \_\_\_\_\_

Policy No: - \_\_\_\_\_ UHID: - \_\_\_\_\_

Contact Number: - \_\_\_\_\_ E- Mail ID: - \_\_\_\_\_

#### **Please put tick mark against the submitted documents:**

- |   |                          |
|---|--------------------------|
| <b>Completely filled Original Claim Form with claimed amount, duly signed by you.</b><br>(In case of cashless claim, hospital need to get the same filled & signed from insured)                  | <input type="checkbox"/> |
| <b>Original Main Hospital bill with Bill Number &amp; break up of all the charges mentioned in the bill.</b><br>(Break up of Room rent, Nursing, Pharmacy/Medicines, Investigation charges etc. ) | <input type="checkbox"/> |
| <b>Original Discharge summary with Hospital seal &amp; signature of the authorized person.</b><br>(Provides details of complaints & treatment given to patient during hospitalisation)            | <input type="checkbox"/> |
| <b>Original Death summary.</b><br>(In case of death of Patient during Hospital stay).   | <input type="checkbox"/> |
| <b>Original Hospital Payment Receipt with receipt number.</b><br>(With seal & signature of hospital)  | <input type="checkbox"/> |
| <b>Original consultation letters with numbered Payment Receipt.</b><br>(For consultation/surgeon charges, follow up charges charged outside the main hospital bill).                              | <input type="checkbox"/> |
| <b>Hospital registration certificate copy.</b><br>(Mentioning hospital Registration No. , Number of beds & validity).   | <input type="checkbox"/> |
| <b>Doctor's registration number with specialisation details.</b><br>(On doctor's letterhead with signature).  | <input type="checkbox"/> |
| <b>Original Pharmacy and Investigation bills</b><br>(Along with prescriptions & Lab reports).   | <input type="checkbox"/> |
| <b>Original prescriptions</b><br>(On doctor's letterhead mentioning duration and dosage for medicines and advice for diagnostic tests).   | <input type="checkbox"/> |
| <b>Investigation reports In original/attested from hospital</b><br>(Reports for all tests done along with images)   | <input type="checkbox"/> |
| <b>Police FIR / Medico Legal Certificate (MLC)</b><br>(Mandatory for All Road traffic accidents/poisoning & burns cases-Duly attested by Police with seal)  | <input type="checkbox"/> |
| <b>Invoices of the implants or Lenses used for the surgery.</b><br>(Surgeries like cataract, angioplasty, knee replacement etc)   | <input type="checkbox"/> |

#### **NOTE:-**

1. Kindly keep a copy of the submitted documents with you for future references.
2. Do not forget to collect the acknowledgement copy from our executives for the submitted documents.
3. Claim form, Discharge summary/death summary, final bill with receipt, Hospital registration copy, MLC/FIR, Implant invoices, supportive investigation reports are the mandatory documents which needs to be submitted in the relevant claims for faster settlement of claim.
- 4 .Please note that this is just an indicative checklist & not an exhaustive one, the documents requirement may vary as per the insurer's guidelines which will be intimated accordingly.
5. For any assistance please feel free to call our customer care executives on Tel.no. 022-25280280



**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 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
<b>SECTION A - DETAILS OF PRIMARY INSURED</b>		
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.	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
<b>SECTION B -DETAILS OF INSURANCE HISTORY</b>		
a) Currently covered by any other Medclaim / Health Insurance?	Indicate whether currently covered by another Medclaim / 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 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 Medclaim / Health Insurance?	Indicate whether previously covered by another medclaim / Health Insurance	Tick Yes or No
f) Company Name	Enter the full name of the Insurance Company	Name of the organization in full
<b>SECTION C -DETAILS OF INSURED PERSON HOSPITALIZED</b>		
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
i) E-mail ID	Enter e-mail address of patient	Complete e-mail address
<b>SECTION D - DETAILS OF HOSPITALIZATION</b>		
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	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 Medicine	Enter the system of medicine followed in treating the patient	Open Text
<b>SECTION E - DETAILS OF CLAIM</b>		
a) Details of Treatment Expenses	Enter the amount claimed as 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 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
<b>SECTION F - DETAILS OF BILLS ENCLOSED</b>		
Indicate which bills are enclosed with the amount in rupees		
<b>SECTION G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT</b>		
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
<b>SECTION H - DECLARATION BY THE INSURED</b>		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.		

**CLAIM FORM - PART B**  
**TO BE FILLED IN BY THE HOSPITAL**  
 The issue of this Form is not to be taken as an admission of liability  
 Please include the original preauthorization request form in lieu of PART A

(To be Filled in block letters)

**DETAILS OF HOSPITAL**

a) Name of the hospital:

b) Hospital ID:  c) Type of Hospital: Network :  Non Network :  (if non network fill section E)

c) 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) Date of Admission:  g) Time:  h) Date of Discharge:  i) Time:

j) Type of Admission: Emergency  Planned  Day Care  Maternity  k) If Maternity  l) Date of Delivery:  m) Total claimed amount

l) Status at time of discharge: Discharge to home  Discharge to another hospital  Deceased

**DETAILS OF AILMENT DIAGNOSED (PRIMARY)**

a) ICD 10 Codes	Description	b) ICD 10 PCS	Description
I. Primary Diagnosis: <input type="text"/>	<input type="text"/>	I. Procedure 1: <input type="text"/>	<input type="text"/>
II. Additional Diagnosis: <input type="text"/>	<input type="text"/>	ii. Procedure 2: <input type="text"/>	<input type="text"/>
iii. Co-morbidities: <input type="text"/>	<input type="text"/>	III. Procedure 3: <input type="text"/>	<input type="text"/>
iv. Co-morbidities: <input type="text"/>	<input type="text"/>	iv. Details of Procedure: <input type="text"/>	<input type="text"/>

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

ll) 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**

- |  |  |
|--|--|
| <input type="checkbox"/> Claim Form duly signed                                | <input type="checkbox"/> Investigation reports                                 |
| <input type="checkbox"/> Original Pre-authorization request                    | <input type="checkbox"/> CT/MR/USG/HPE investigation reports                   |
| <input type="checkbox"/> Copy of the Pre-authorization approval letter         | <input type="checkbox"/> Doctor's reference slip for Investigation             |
| <input type="checkbox"/> Copy of Photo ID Card of patient Verified by hospital | <input type="checkbox"/> ECG   |
| <input type="checkbox"/> Hospital Discharge summary                            | <input type="checkbox"/> Pharmacy bills  |
| <input type="checkbox"/> Operation Theatre Notes                               | <input type="checkbox"/> MLC reports & Police FIR                              |
| <input type="checkbox"/> Hospital main bill                                    | <input type="checkbox"/> Original death summary from hospital where applicable |
| <input type="checkbox"/> Hospital break-up bill                                | <input type="checkbox"/> Any other, please specify                             |

**DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)**

a) Address of the Hospital:

City:  State:

Pin Code:  b) Phone No.  c) Registration No. with State Code:

d) Hospital PAN:  e) Number of inpatient beds  f) Facilities available in the hospital i. OT  Yes  No ii. ICU  Yes  No

iii. Others:

**DECLARATION BY THE HOSPITAL**

(PLEASE READ VERY CAREFULLY)

We hereby declare that the information furnished in this Claim Form is true & correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited.

Date:

Place:

Signature and Seal of the Hospital Authority:

SECTION A

SECTION B

SECTION C

SECTION D

SECTION E

SECTION F

**GUIDANCE FOR FILLING CLAIM FORM - PART B (To be filled in by the hospital)**

DATA ELEMENT	DESCRIPTION	FORMAT
<b>SECTION A - DETAILS OF HOSPITAL</b>		
a) Name of the hospital:	Enter the name of hospital	Name of the hospital in full
b) Hospital ID	Enter ID number of hospital	As allocated by the TPA
c) Type of Hospital	Indicate whether in network or non network hospital	Tick the right option
c) Name of treating doctor	Enter the name of the treating doctor	Name of doctor in full
e) Qualification	Enter the qualification of the treating doctor	Abbreviations of educational qualifications
f) Registration No. with State Code	Enter the registration number of the doctor along with the state code	As allocated by the Medical Council of India
g) Phone No.	Enter the phone number of doctor	Include STD code with telephone number
<b>SECTION B - DETAILS OF THE PATIENT ADMITTED</b>		
a) Name of Patient	Enter the name of patient	Name of patient in full
b) IP registration Number	Enter insurance provider registration number	As allotted by the insurance provider
c) Gender	Indicate Gender of the patient	Tick Male or Female
d) Age	Enter age of the patient	Number of years and months
e) Date of Birth	Enter date of birth	Use dd-mm-yy format
f) Date of Admission	Enter date of admission	Use dd-mm-yy format
g) Time	Enter Time of admission	Use hh:mm format
h) Date of Discharge	Enter date of Discharge	Use dd-mm-yy format
i) Time	Enter time of Discharge	Use hh:mm format
j) Type of Admission	Indicate type of admission of patient	Tick the right option
k) If Maternity		
i. Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format
ii. Gravida Status	Enter Gravida status if maternity	Use standard format
l) Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
M) Total claimed amount	Indicate the total claimed amount	In rupees (Do not enter paise values)
<b>SECTION C - DETAILS OF AILMENT DIAGNOSED (PRIMARY)</b>		
a) ICD 10 Code		
Primary Diagnosis	Enter the ICD 10 Code and description of the primary diagnosis	Standard Format and Open text
Additional Diagnosis	Enter the ICD 10 Code and description of the additional diagnosis	Standard Format and Open text
Co-morbidities	Enter the ICD 10 Code and description of the Co-morbidities	Standard Format and Open text
b) ICD 10 PCS		
Procedure 1	Enter the ICD 10 Code and description of the first procedure	Standard Format and Open text
Procedure 2	Enter the ICD 10 Code and description of the second procedure	Standard Format and Open text
Procedure 3	Enter the ICD 10 Code and description of the third procedure	Standard Format and Open text
Details of Procedure	Enter the details of the procedure	Open text
c) Pre-authorization obtained	Indicate whether pre-authorization obtained	Tick Yes or No
d) Pre-authorization Number	Enter pre-authorization number	As allotted by TPA
e) If authorization by network hospital not obtained, give reason	Enter reason for not obtaining pre-authorization number	Open text
f) Hospitalization due to injury	Indicate if hospitalization is due to injury	Tick Yes or No
Cause	Indicate cause of injury	Tick the right option
If injury due to substance abuse/alcohol consumption test conducted to establish this	Indicate whether test conducted	Tick Yes or No
Medico Legal	Indicate whether injury is medico legal	Tick Yes or No
Reported to Police	Indicate whether police report was filed	Tick Yes or No
FIR No.	Enter first information report number	As issued by police authorities
If not reported to police, give reason	Enter reason for not reporting to police	Open text
<b>SECTION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST</b>		
Indicate which supporting documents are submitted		
<b>SECTION E - DETAILS IN CASE OF NON NETWORK HOSPITAL</b>		
a) Address	Enter the full postal address	Include Street, City and Pin Code
b) Phone No.	Enter the phone number of hospital	Include STD code with telephone number
c) Registration No. with State Code	Enter the registration number of the Hospital obtained from local body like City Corporation / Municipality	As allocated by the City Corporation / Municipality
d) Hospital PAN	Enter the permanent account number	As allocated by the Income Tax Department
e) Number of Inpatient beds	Enter the number of inpatient beds	Digits
f) Facilities available in the hospital	Indicate facilities available in the hospital	Tick the right option. If others, please specify
<b>SECTION F - DECLARATION BY THE HOSPITAL</b>		
Read declaration carefully and mention date (In dd:mm:yy format), place (open text) and sign. and stamp		