Human Resources Management Department
मानव संसाधन प्रबंधन विभाग
Head Office: LOKMANGAL,1501,SHIVAJINAGAR,PUNE-5
प्रधान कार्यालय: लोकमंगल, 1501, शिवाजीनगर, पुणे-5
टेलीफोन / Tel: 020-25614272
ई-मेल / E-Mail: bomcowelfare@mahabank.co.in

AXI/Staff Welfare Cell / IBA GM .Ins. Ret /Cir.138 /2021-22 November 16, 2021

ALL THE BRANCHES / OFFICES OF THE BANK

Dear Sir/Madam,

Re: IBA Group Medical Insurance Policy for Retried Employees – Appointment of TPA – "Medsave Health Insurance TPA Ltd" w.e.f 01-11-2021.

The Indian Bank's Association has vide their letter No. HR&IR/MBR/MEDINS/10257 dated 24.8.2021 informed that for the year 2021-22, National Insurance Company Limited has been allotted the Group Insurance Policy for the Retired Employees.

Medsave Health Insurance TPA Ltd has been appointed as Service provider for current year retirees Mediclaim Policy of Bank of Maharashtra by National Insurance Company Limited.

Claims of all hospitalizations incurred on or after 1st November 2021 will be processed by Medsave Health Insurance TPA Ltd. Claim forms are enclosed as Annexure I.

Escalation Matrix, address, Contact details and email IDs of Medsave Health Insurance TPA Ltd are as under.

Escalation Matrix - Medsave Health Insurance TPA Limited		
Reimbursement Claim Intimation (Call center No)	callcenter@medsave.in	011- 71221234
Help Line No.		1800120111234

Client Servicing:

Contact Person	**Designation**	**E-mail Address**	**Contact No.**
Mr. Saharsh More	CRM - Mumbai	bom@medsave.in	9560505266
Mr. Amay Deshmukh	CRM - Pune	bompune@medsave.in	9310062361
Mr. Vaibhav Ghevade	Asst. Manager	vaibhav@medsave.in	9319900570
Mr. S N Shetty	Asst. Vice President	shetty@medsave.in	9322818506
Dr. Shashikat Kasbe	Vice President	drshashikant@medsave.in	9561174730

List of Branches and contact details where retirees can submit their claim documents:

Sr No.	Branch Location	Address	Phone	E-Mail	Contact Person
1	AHMEDABAD	B – 805, 8th Floor, Wall Street – 2, Near, Gujarat College, Ellis Bridge, Ahmedabad, GUJARAT - 380006	079-48901039, 079- 48901040, 7428654000	mhclahmedabad@medsave.in	Mr. K. Bhatt
2	AMRITSAR	98, Second Floor, Deep Complex, Court Road, Amritsar, AMRITSAR, Punjab - 143001	0183-5021075, 7087117224	riteshmahajan@medsave.in	Ritesh Mahajan
3	BANGALORE	303 A, 3rd floor, Cears Plaza, Land mark, Opp. Bangalore Club, Residency Road, Bangalore, Karnataka - 560025	080-41142763, 080-22108471, 7899112484 Fax- No:080-41142763	mhclbangalore@medsave.in	Karan Grover
4	BHOPAL	221 Zone-I, Maharana Pratap Nagar, Bhopal, MADHYA PRADESH - 462011	0755 -4285406, 9303317900	mhclbhopal@medsave.in	Mr. Vinay Richharia
5	CHANDIGARH	SCO-66, Second Floor, Sector-40/C, Chandigarh, Punjab - 160036	0172-4632023, 0172- 2625970, 7307834131 Fax- No:0172-5045015, 0172-2620023, 0172-4632023	mhclchandigarh@medsave.in	Dr. Arvin Bakshi
6	CHENNAI	3E, Shakthi Towers, 3rd Floor, No.766, Anna Salai, Chennai, Tamilnadu - 600002	044-42634012, 9560606373, Fax-No:044-42634032	mhclchennai@medsave.in	George Felix H E
7	COIMBATORE	9 A , Seetha Complex (Ist Floor) 115 , Sarojini Street Ram Nagar, Coimbatore, Tamilnadu - 641009	0422-4506068, 9364248800	mhclcoimbatore@medsave.in	Mr. M Sumesh
8	GANDHI NAGAR	421/B, 4th Floor, Infocity Super Mall-1,Infocity, Gujarat, Gandhinagar, Gujarat - 382007	9289016041	sthpo@medsave.in	Mr. Roshan Thakur
9	GUWAHATI	Sanmati Plaza, 1st Floor , G.S.Road,Near Sentinel Building, Guwahati, Assam - 781005	0361-2460548, 7002247454, Fax-No:0361-2460548	mhclguwahati@medsave.in	Ms. Sonali

10	HYDERABAD	2D, 2nd floor, Dhruvatara Apartments, Behind Nova ENT Hospital, Erramanzil, Somajiguda, Hyderabad, Telangana - 500082	040-40242077, 040-40213788, 9910399000	bm.hyderabad @medsave.in	Mr. Jude Michael
11	INDORE	310, Trade House, 14/3, South Tukogunj, Indore, MADHYA PRADESH - 452001	0731-4044810, 8527694003, Fax-No:0731-4044810	mhclindore@medsave.in	Mr. Pramod Shashtri
12	KOCHI	2nd Floor, Central Arcade Azad Road,Kaloor, Kochi, Kerala -682017	0484-4047121, 07428913680 Fax- No:0484-4047615	mhclkochi@medsave.in	Mr. Joseph Harry
13	KOLKATA	A.K Trade Center Pvt. Ltd., 3rd Floor, 1/1 Camac Street, Kolkata, West Bengal - 700016	033-22262420/22292732/40062614,8448498748 Fax-No:033-22299282	mhclkolkata@medsave.in	Mr. Anup Agarwal
14	MUMBAI	265, Engineer Building, 3rd Floor, S.G. Marg,(Princess street), Mumbai, Maharashtra - 400002	022-22032509, 022-22094221, 022-49619710, 9322818000	bom@medsave .in,	Mr. S N Shetty
15	NASHIK	Off No-504,5 th floor, Genesis, Shri Hari Kute Marg, Behind SSK Solitaire Hotel, Tidke Colony, Nashik, MAHARASHTRA - 422002	0253-4001513, 9561094140	mhclnashik@medsave.in	Dr. Sarika Pawar
16	NEW DELHI	F-701 A, Lado Sarai, Mehrauli, New Delhi, Delhi - 110030	011-71221234, 9910995367 Fax-No:011-29521067, 011-29521071	geeta@medsave.in, info@medsave.in	Ms. Geeta Vaid
17	PATNA	Flat No.401, 4th Floor, B-Block, Ashiana Chamber, Exibition Road,Patna, Bihar - 800001	7366832222	statecoordinator @medsave.in	Mr Dhananjay
18	PUNE	Office no 14, B Wing , Bilwakunj society,265,266 Shukrwar Peth,Near Chinchechi Talim, PUNE, MAHARASHTRA - 411002	020-24444993/4, 9561174730	drshashikant@ medsave.in	Dr.Shashikant Kasabe
19	RAIPUR	Avanti Vihar Main road, Target GYM building Opposite Study Circle 2nd floor, Raipur, CHHATTISGARH - 492006	0771-4009218, 9755591800	mhclraipur@medsave.in	Mr. Subodh Kant

20	SHIMLA	Jai Karan Building Near Laxmi Narayan Mandir, Kasumpati, SHIMLA, Himachal Pradesh - 171009	,9625778000, 7018008488	jverma534@gmail.com	Mr.Jeevan Verma
21	VADODARA	2nd Floor, 205-Helix Complex, Opp. Surya Hotel, Beside Raj Trade Center, Sayajigunj, VADODARA, GUJARAT - 390005	0265-2225077, 8511150221, 9375800000	bm.vadodara@medsave.in	Manish Panchal

Branch Heads / Departmental Heads are requested to bring the contents of this circular to all retirees and display the same in the notice board.

Yours faithfully,

MRUDUL CHINTAMAN JOGLEKAR Digitally signed by MRUDUL CHINTAMAN JOGLEKAR Date: 2021.11.16 12:59:06 +05'30'

(Mrudul Joglekar)
Deputy General Manager
HRM

Toll Free No: 180011142
callcenter@medsave.in

MEDSAVE HEALTHCARE (TPA) LIMITED
F- 701, Lado Sarai, Mehrauli
New Delhi 110030
Web: www.medsave.in

CHECKLIST OF ENCLOSURES FOR SUBMISSION OF CLAIM

[Please tick the appropriate [ ] box]

Name of the claimant: .... Employee Code: ....

CARD No: .... Policy No: ....

No of Enclosures: .... Date Of Submission:...................................

GENERAL

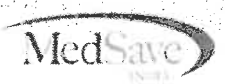
1. Duly filled & Signed claim form by insured [ ]
2. Photo copy of E Card/ health Card [ ]
3. Photo copy of ID Card * [ ]
4. Original copy of consolidated bill of hospital with breakup [ ]
5. Original copy of receipt of payment [ ]
6. All original prescription for bill attached [ ]
7. All original investigation /pathological/reports along with films/CD. [ ]
8. Original discharge summary of hospital duly Signed by the treating doctor with hospital Seal and registration number. [ ]
9. Original invoice of implants (viz Stents/ PHS mesh /IOL etc) [ ]
10. First consultation letter for the presenting Complaints. [ ]
11. Pre/Post hospitalization bills/receipts/ reports in original pertaining to the incidence for which hospitalization has happened [ ]
12. Original prescription/doctors notes of previous treatment for the presenting complaints [ ]
13. Cancelled cheque along with IFSC details or a copy of the pass book and NEFT form [ ]

FOR DEATH CASES

1. Attested copy of death summary of the hospital duly signed by the treating doctor with hospital seal and registration number [ ]
2. Attested copy of death certificate from competent authorities [ ]
3. Legal Heir certificate/ letter from the underwriting office to settle the claim in the name of nominee/ dependents [ ]

FOR RTA

1. Attested copy of MLC Report [ ]
2. Attested Copy of FIR [ ]
3. Original copy of treating doctor's certificate with circumstances and injuries sustained due to RTA [ ]
4. Original copy of Treating doctors certificate for any evidence of influence of Alcohol/ other Narcotics substance during the accident [ ]



CLAIM FORM - PART A

TO BE FILLED IN BY THE INSURED (To be filled in block letter)

The issue of this form is not to be taken as an admission of liability

SECTION A

DETAILS OF PRIMARY INSURED

a) Policy No : b) Sl. No/certificate No :

c) Company / TPA ID No :

d) Name :

e) Address :

City : State :

Pin Code : 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 : (copy of policies to be attached)

c) If Company Name : Policy No :

Sum Insured (Rs.) :

d) Have you been hospitalized in the last 4 year? Yes No Date : 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 :

b) Gender : Male Female c) Age : Year Months d) Date of Brith

e) Relationship to Primary Insured : Self Spouse Child Father Mother Other (Please specify)

f) Occupation : Service Self Employed Homemaker Student Retired Other (Please specify)

e) Address (if different from Above) :

City : State :

Pin Code : Phone No : Email ID :

SECTION D

DETAIL OF HOSPITALIZATION

a) Name of Hospital where Admitted :

b) Room Category Occupied : Day Care Single Occupancy Twin Sharing 3 Or more beds per room

c) Hospitalization due to : Injury Illness Maternity d) Date of Injury / Date Disease First Detected / Date of Delivery :

e) Date of Admission : f) Time : g) Date Of Discharge : h) Time :

i) If Injury Give Cause : Self Inflicted Road Traffic Accident Substance / 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 :

SECTION E

DETAIL 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. Other (code) : Rs.

Total **Rs.**

vii. Pre-hospitalisation 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.

ii. Critical Illness Benefit : Rs. iv. Convalescence : Rs.

v. Pre/Post Hospitalization Lump Sum Benefit : Rs. vi. Other : Rs.

Total **Rs.**

(IMPORTANT: PLEASE TURNOVER)

Claim Documents Submitted - Check List

SECTION E

- Claim Form Duly Signed
- Copy of the claim Intimation
- Hospital Main Bill
- Hospital Break-up Bill
- Hospital Bill Payment Receipt
- Hospital Discharge Summary
- Pharmacy Bill
- Operation Theater Notes
- ECG
- Doctor's Request For Investigation
- Investigation Report (Including CT / MRI/ USG / HPE)
- Other

DETAILS OF BILL ENCLOSED

SECTION F

Sl. No	Bill No	Date	Issued by	Towards	Amount (RS)
1.				Hospital Main Bill	
2.				Pre-hospitalization:________Nos	
3.				Pre-hospitalization:________Nos	
4.				Pharmacy Bills	
5.					
6.					
7.					
8.					
9.					
10.					

DETAILS PRIMARY INSURED'S ACCOUNT

SECTION G

a) Pan :

b) Account Number :

c) Bank Name and Branch :

d) Cheque/ DD Payable details :

e) IFSC Code :

DECLARATION BY THE INSURED

SECTION H

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, 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.

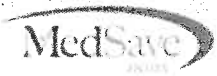
Date :

Place :

Signature of the insured

ANTI-MONEY LAUNDERING REQUIREMENT (For claim more than or equal to Rs. 1 Lakh - One Document each from (1) and (2))

1. Proposer's Identification (a) Passport (b) PAN Card (c) Voter's ID Card (d) Driving License (e) AADHAR Card
2. Proposer's Address (a) Current Telephone /Mobile Bill (b) Current Bank Passbook (c) Electricity Bill (d) Ration Card (e) Valid Rent Lease Agreement



CLAIM FORM - PART B

TO BE FILLED IN BY THE HOSPITAL (To be filled in block letter)

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

DETAILS OF HOSPITAL

SECTION A

a) Name of Hospital :

b) Hospital ID : c) Type of Hospital : ☐ Network ☐ Non Network (If non network section E)

d) Name of the treating doctor :

e) Qualification : f) Registration No. with State Code :

g) Phone No :

DETAILS OF THE PATIENT ADMITTED

SECTION B

a) Name of the Patient :

b) IP Registration Number : c) Gender : Male Female d) Age : Year Months

e) Date of Birth : f) Date of Admission : g) Time :

h) Date of Discharge : i) Time : j) Type of Admission : Emergency Planned Day Care Maternity

k) If Maternity : i. Date of Delivery : ii. Grade of status :

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

DETAIL OF AILMENT DIAGNOSED (PRIMARY)

SECTION C

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

c) Present ailment is a complication of PED? Yes No i) (If Yes, Specify Details) :

d) Pre-authorization obtained : Yes No e) Pre-authorization Number :

f) If authorization by network hospital not obtained, give reason :

g) Hospitalization due to Injury : Yes No i) (If Yes, give cause) Self-inflicted Road Traffic Accident Substance abuse/ alcohol consumption

i) If injury due to substance abuse/ alcohol consumption, Test Conducted to establish this : Yes No (If Yes, Attach Report) iii) If Medico Legal : Yes No

v) FIR no : vi) If not reported to police give reason:

CLAIM DOCUMENTS SUBMITTED - CHECK LIST

SECTION D

- Claim From Duly Singed
- Original Pre-authorization request
- Copy of Pre-authorization Approval latter
- Copy of photo ID card of patient verified by hospital
- Hospital Discharge summary
- Operation Theater notes
- Hospital main bill
- Hospital break-up bill
- Investigation report
- CT/MR/USG/HPE investigation report
- ☐ Doctor's reference slip for investigation
- ☐ ECG
- ☐ Pharmacy bills
- ☐ MLC report & Police FIR
- Original death summary from hospital where applicable
- Any other, please specify

(IMPORTANT : PLEASE TURN OVER)

DETAILS IN CASE OF NON NETWORK HOSPITAL

SECTION E

a) Address of Hospital :

City : State :

Pin Code : b) Phone No : c) Registration No :

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

iii) Other :

DECLARATION BY THE INSURED

SECTION F

(PLEASE READ VERY CAREFULLY)

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, 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

DECLARATION BY THE HOSPITAL

SECTION G

(PLEASE READ VERY CAREFULLY)

We hereby declare that the information furnished in this Claim Form is true & correct to the best of our my knowledge and belief. If we have made any false or untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited. The signature of the insured is taken on this form after Claim Form B is fully filled up by us.

Date :

Place : Signature and Seal of the hospital Authority