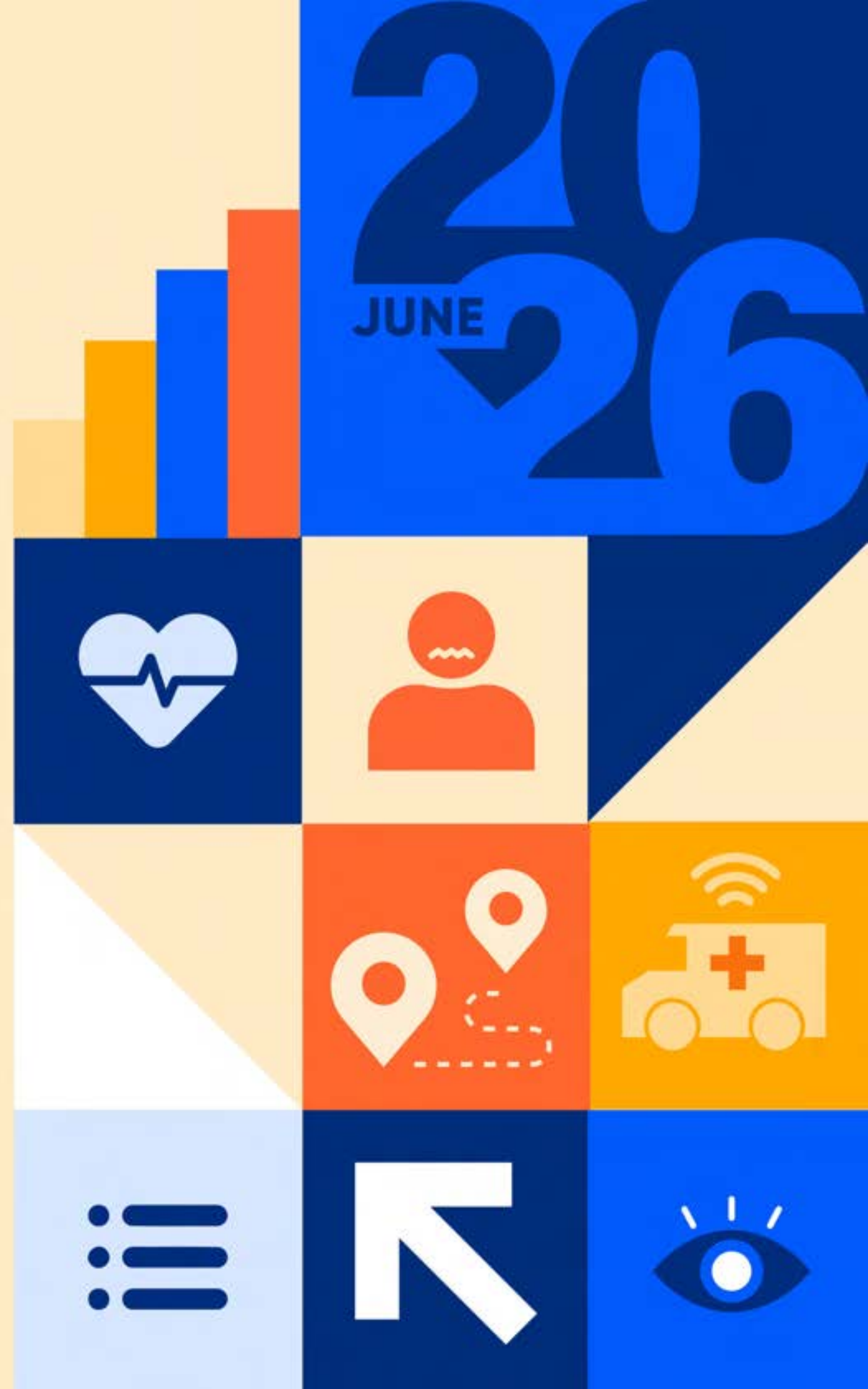


# Is India Happy with Health Insurance Claims?

2.0

A Consumer Insights Report by Policybazaar



# From the CEO's Desk



“

आपद्रुतं च न जहाति ददाति काले  
सन्मिलक्षणमिदं निगदन्ति सन्तः ॥

- Nitishatakam

**A true friend never abandons you in  
times of adversity and selflessly renders  
support when it is needed most.**

**In health claims, a single legitimate claim denied can undo the trust built by countless approvals...**

This second edition of our claims study arrives at a meaningful inflection point for India's health insurance industry. As honourable Chairman IRDAI, has said, "The insurance sector, and especially the health insurance sector, is at an unstable equilibrium at the moment."<sup>1</sup> Health insurance claims are the subject of intense debate in the media; the regulator has taken several steps to strengthen the process and build more trust in insurance; insurance companies continue to pay thousands of crores in claims and yet find themselves subject to intense scrutiny over those that are not paid.

At Policybazaar, we sit at a unique vantage point, talking to crores of customers, working with the entire insurance industry and seeing directly the experience that consumers get with insurance. To bring clarity to this debate, **we have a developed an industry first composite measure – the Health Claims Experience (HCX™) Index** – that moves beyond single-question satisfaction to capture what policyholders truly experience across the full arc of a claim.

The first edition score of 82.8 out of 100 tells us the system is working for many people, most of the time. **But this is not enough. We need to move in the direction to make it work for all people, all the time.**

Cashless claims are in better shape with an HCX™ of 86.7, driven by process improvements that are real and measurable. But those who were pushed toward reimbursement by denial, network gaps or discharge pressure, face a relatively harder journey.

**The key finding in the report is that customers are looking for transparency**, as the share of claimants who say they were not given any clear reason for rejection has risen. That is a gap the industry must close with urgency. A denied claim without an explanation does not just frustrate a customer; it breaks trust in a way that is very hard to rebuild.

The way forward is clear. The industry must simplify and strengthen every step of the claim journey, ensuring the protection customers invest in is matched by the experience they receive. With collective commitment, every claim can strengthen trust, not only in health insurance, but in the support system behind every Indian family.

# Key Takeaways

1

## HEALTH CLAIMS EXPERIENCE (HCX™) SCORE

82.8

Claim process functional, but not frictionless

India's health claim experience shows a system that is functional, yet the complexity of the claims process and consistent gaps across claim mode, region and hospitalization frequency signal that meaningful improvement remains.

2

## HCX™ - CASHLESS

86.7

Cashless sets the experience benchmark

Cashless records an HCX™ that shows it remains the easier route for customers. Its strength comes from reduced upfront burden, simpler paperwork, nearby network hospitals and faster approval movement.

# Key Takeaways

3

# 76%

## BORROWED DURING TREATMENT

Up from 68% last year

Many claimants opt for reimbursement when cashless is unavailable, delayed or not worth waiting for at discharge. This becomes more stressful when customers must arrange funds upfront. In fact, 76% of reimbursement claimants reported borrowing funds during treatment, up from 68% last year. This shows how the lack of upfront cashless support can quickly create financial pressure, even if claims are later reimbursed.

4

# 73.7

## HCX™ - REIMBURSEMENT

Trails cashless by  
13 points

Reimbursement posts an HCX™ indicating it is a far more effort-heavy journey. The lower score reflects the responsibility customers carry across payments, documentation, follow-ups and settlement.

# Key Takeaways

5



## WHAT NEXT

### Clearer Communications, Simpler Processes and Stronger Verification at Purchase

A combined view of rejection dissatisfaction and future expectations points to a clear theme: customers want greater clarity and assurance, throughout the journey.

- 73% of those dissatisfied with rejections cited the reason as unclear, highlighting a communication gap.
- Customers' top improvement asks centre on frequent updates to cashless hospital lists, simpler claim forms, and stronger verification at purchase to avoid surprises later.

- 39% of customers demand stronger verification at the point of purchase, with the South leading at 44% across all regions. Conditions missed at onboarding become the grounds for rejection or pushing towards reimbursement.

Together, these signal rising expectations for transparent, streamlined processes and more proactive communication to strengthen trust across the journey.



***I met with an accident and got unconscious. I had injuries across my body and had to be on bed rest for two months. The bill was more than ₹1 lakh. It was a lot of money, but because I had insurance, only a small amount was deducted and the rest came back. Otherwise, it would have been very difficult financially.***

**– Male, 57**

Kochi

# Recommendations for the Industry

**This edition's findings reveal a paradox. Cashless approvals are getting faster and smoother. Yet for too many policyholders, the emotional and administrative burden remains as heavy. To bridge this gap, the industry must move from "reactive processing" to "proactive protection."**



## Enforce Specificity in Denial Communications



### The Mandate:

Replace "umbrella" language with granular, actionable reasons. No claim should be closed with vague terms like "not admissible." Denials must cite the specific clause and the evidence used (e.g., "Clause X.X: Smoking history not disclosed"). Crucially, every denial must include clear recourse or appeal options to empower the consumer.



### The Evidence:

Satisfaction with the rationale for partial or complete claim rejections was the lowest among all claim process stages (e.g., only 54% of reimbursement claimants were satisfied with rejection rationale for post-hospitalization claims).

# Recommendations for the Industry

## 2 Shift Medical Underwriting to the Onboarding Stage



### The Mandate:

Verify comprehensively at purchase; honor unconditionally at claim. The "investigative" approach to claims often penalizes customers for systemic gaps left open during onboarding. Industry players should conduct rigorous medical verification upfront. If a condition is not flagged during a comprehensive purchase-time check, it should not be invoked as "undisclosed" later.



### The Evidence:

39% of customers cite stronger verification at purchase as a top improvement ask to avoid the trauma of a late-stage rejection.



## 3 Adopt Lifecycle Pre- Authorizations for Chronic Care



### The Mandate:

One authorization for the full treatment course. For chronic cycles like chemotherapy or dialysis, the requirement for fresh pre-authorization for every visit is an unnecessary administrative hurdle. A single authorization should cover the clinical plan, with re-verification required only if the treatment protocol changes.



### The Evidence:

Customers with multiple hospitalizations score just 73.2 on the HCX™—an 11-point drop from single-admission patients—highlighting the cost of repeated friction.

# Recommendations for the Industry

## 4 Bridge the Coordination Gap via App-Led Claims



### The Mandate:

Digitize the initiation; automate the tracking. The rise in dissatisfaction regarding "lack of updates" suggests a failure in manual communication. Insurers must enable app-based triggers where a customer enters three data points—hospital, doctor, and ailment—and the system takes over. Real-time, "pizza-tracker" style updates can resolve coordination failures without structural changes to medical protocols.



### The Evidence:

For reimbursement, lack of timely updates as a reason for dissatisfaction doubled from 27% to 54% this year.



## 5 Decouple the Patient from the Paperwork Chain



### The Mandate:

Universal forms and hospital-led document submission. The industry must mandate a single, universal claim form. Furthermore, the responsibility for submitting bills and discharge summaries must shift from the patient to the provider. If DigiYatra can move a traveller through an airport without a single physical document, a network hospital should be able to close a claim without a recovering patient hand-carrying their discharge summary.



### The Evidence:

Simpler process (42%) and forms (41%) rank among the top three customer asks.

# Recommendations for the Industry



## 6 Standardize "Consumables" to Eliminate Hidden Deductions



### The Mandate:

Full honor of add-ons without internal sub-exclusions. Customers who purchase "Consumable Add-ons" often find standard items like surgical gloves or IV tubes still billed to them. These are not optional extras; they are fundamental to care. Honoring add-ons in full prevents customers from feeling nicked and dimed by minor exclusions at settlement.



### The Evidence:

73% of dissatisfied claimants in 2024-25 reported they were not given a clear or specific reason for their rejection, up significantly from 53% in 2023.



## 7 Transition from "Patient Collateral" to Good-Faith Discharge



### The Mandate:

Decouple physical discharge from final administrative closure. Current friction at the TPA desk often leads to patients being "held" until the final authorization arrives. Once pre-authorization is granted, the patient should be allowed to settle any known overages and leave, at least in preferred network hospitals. The insurer and hospital must settle the final nuances in the back-end, not at the discharge gate.



### The Evidence:

The primary deterrent for choosing cashless claims remains the "wait for claim approval after discharge" (59%).

# Research Design

## 2,228 RESPONDENTS

A face-to-face survey was conducted with 2,228 personal health insurance policyholders who purchased their policy online (insurer websites, aggregators, etc.) or offline (agents, banks, etc.) to assess claim process satisfaction and the reasons behind it.

432  
FEMALES



1,796  
MALES

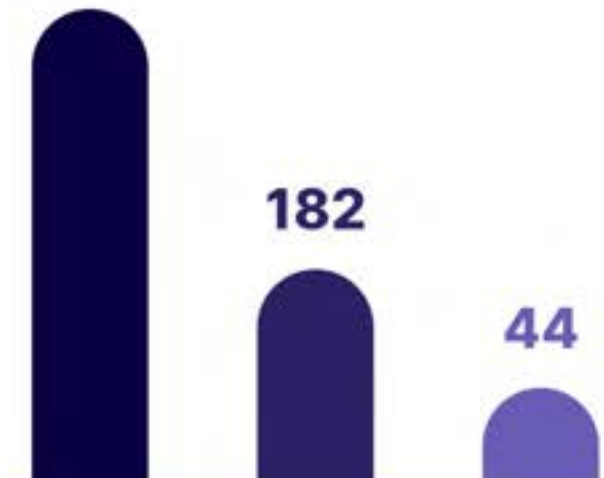


■ NCCS A  
■ NCCS B  
■ NCCS C

2,002

182

44



Respondents were either the policy proposer or the family member most involved in the claim process.

**No. of Respondents**

May themselves have undergone hospitalization

--  
41  
867  
506  
790  
24

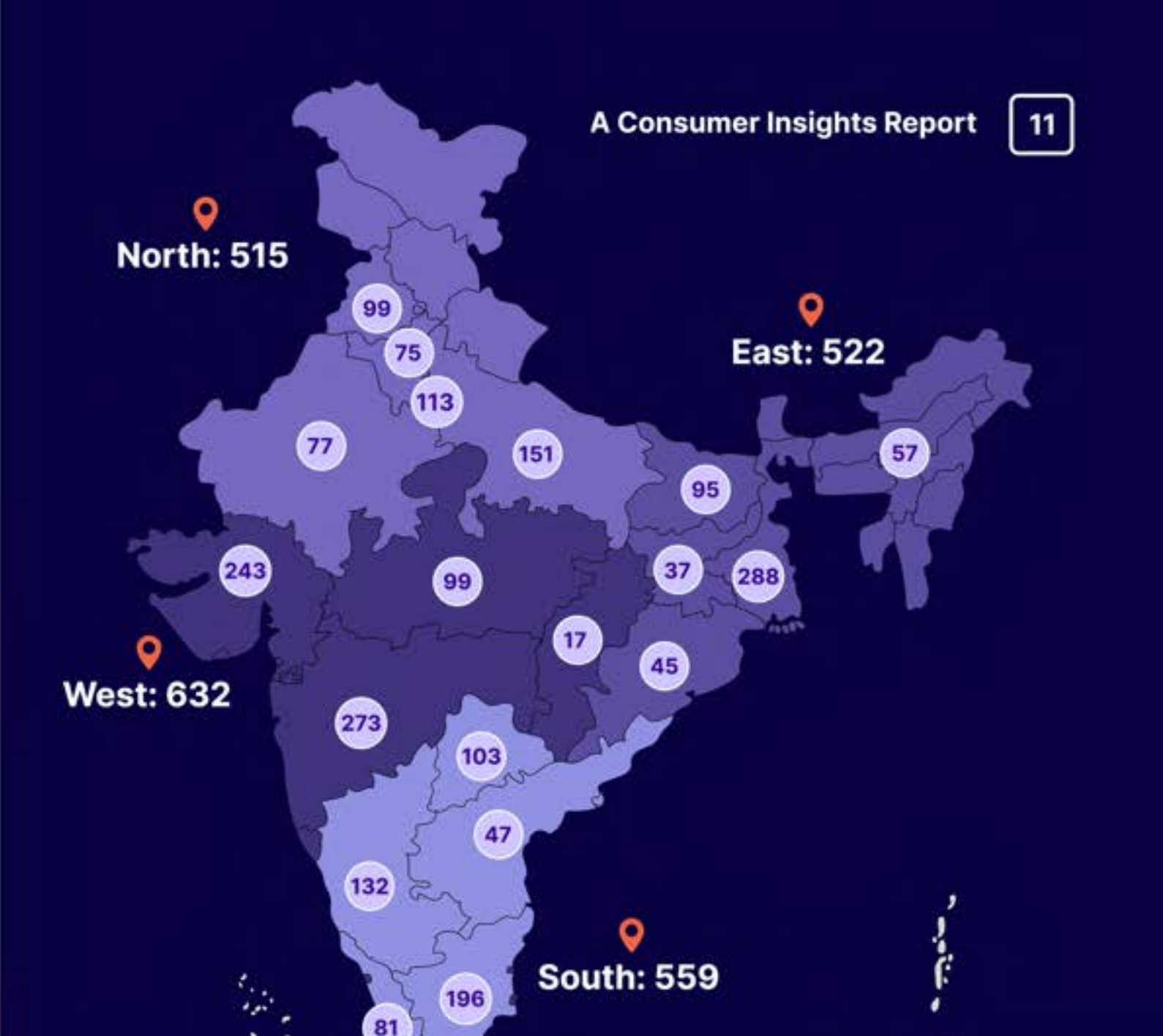
**Age (in years)**



**No. of Patients**

Hospitalized member-covered in insurance policy

128  
49  
671  
406  
699  
275



**Metro- 925**

Delhi	113
Mumbai	121
Pune	48
Ahmedabad	157
Bangalore	62
Chennai	130
Hyderabad	80
Kolkata	214

**Tier 2- 1,042**

Ghaziabad	27	Vadodara	63
Gurugram	21	Surat	23
Noida/Gr Noida	11	Indore	99
Faridabad	12	Coimbatore	42
Ludhiana	74	Cochin	44
Mohali	25	Mysore	47
Jaipur	54	Hubli Dharwad	23
Ajmer	23	Vijayawada	47
Lucknow	74	Patna	73
Agra	39	Ranchi	37
Nagpur	82	Guwahati	57
		Bhubaneswar	45

**Tier 3- 261**

Sonipat	22
Panipat	20
Ahmednagar	22
Bilaspur	17
Tiruvallur	24
Alleppey	37
Warangal	23
Gaya	22
Howrah	31
Hoogly	43

# Health Insurance and Claim Process

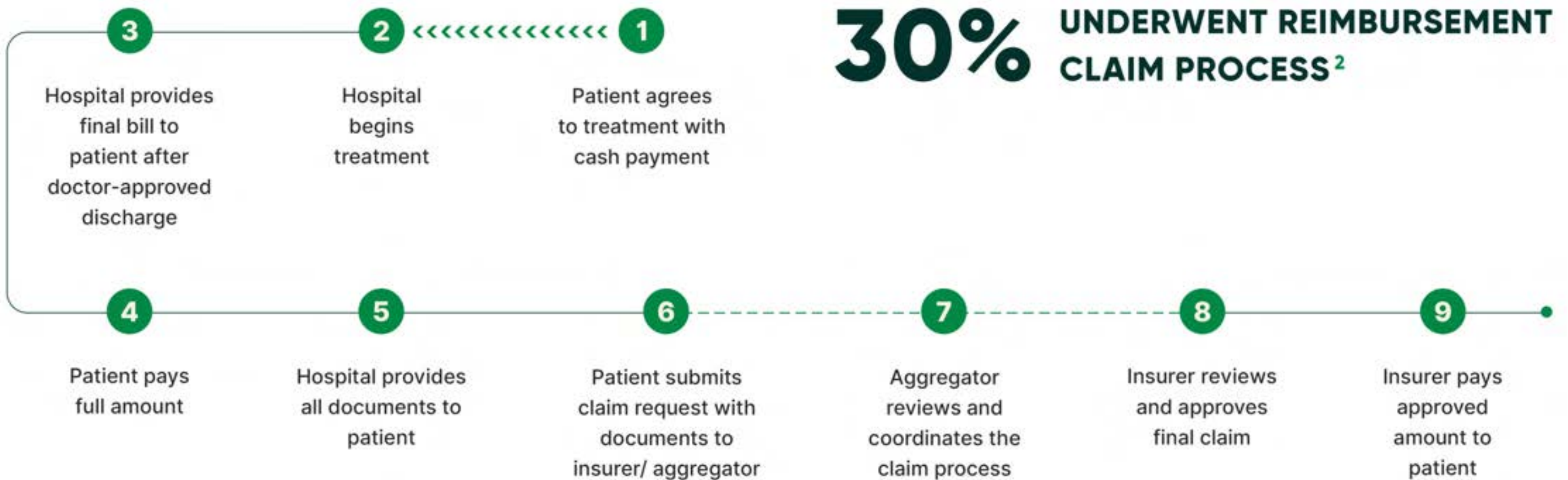


**70%** UNDERWENT CASHLESS CLAIM PROCESS<sup>1</sup>



Note: <sup>1</sup>The split between cashless and reimbursement kept broadly in line with industry proportions.

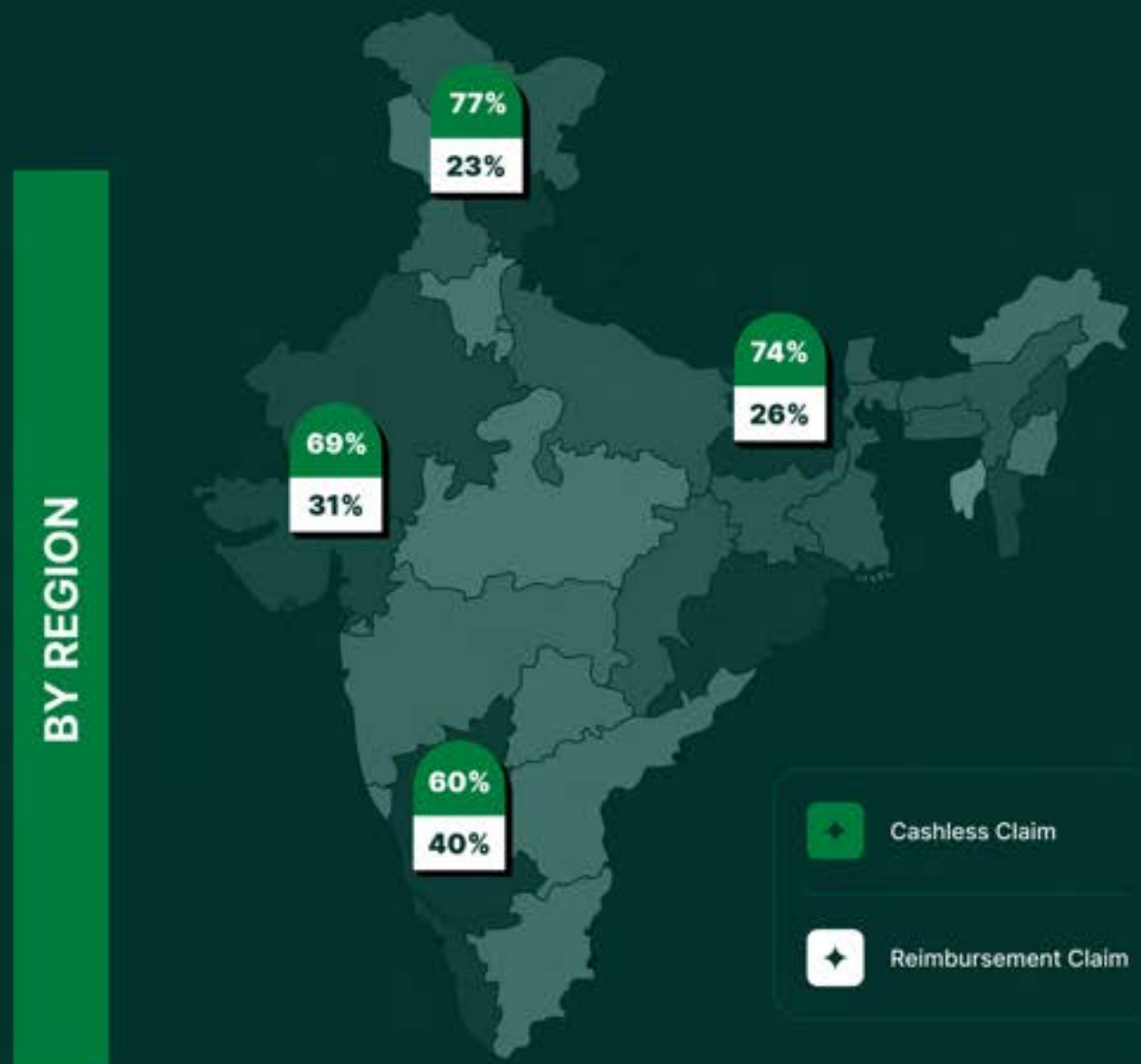
The two primary mechanisms for claims – cashless and reimbursement – differently affect the policyholder’s experience with health insurance. Cashless claims offer policyholders an access to medical services without immediate financial strain, while reimbursement claims require policyholders to fund the upfront initial costs and later seek reimbursement. This report delves into the depths of health insurance claims and how they shape the insurer-policyholder relationship.



Note: <sup>2</sup>The split between cashless and reimbursement kept broadly in line with industry proportions.

On an average, people tend to prefer cashless claims across regions, city-tiers, and ages. The reimbursement process is typically selected only when:

- Cashless facility is unavailable at the desired hospital
- Cost of treatment is low and patient does not want to wait for claim settlement before discharge
- Cashless request is rejected



BY GENDER

**31%**  
Reimbursement  
Claim

**69%**  
Cashless  
Claim

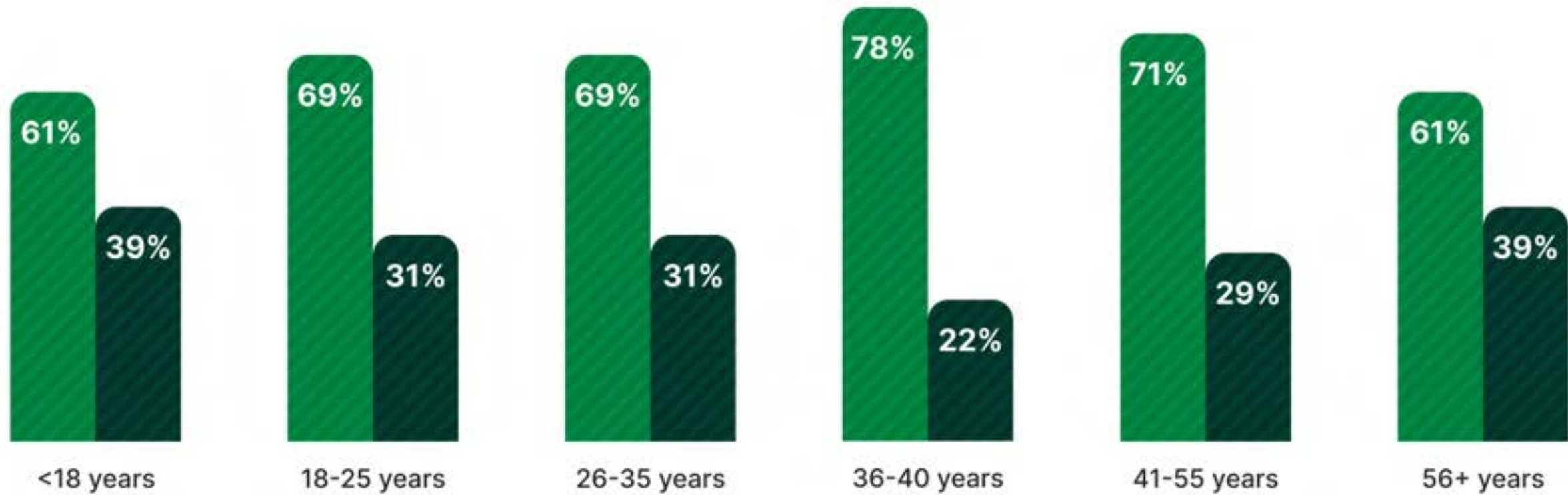


**25%**  
Reimbursement  
Claim

**75%**  
Cashless  
Claim



BY AGE OF PATIENTS



# Introducing the Health Claims Experience Index (HCX™)



A single score verdict on how well the industry serves customers through claims

This edition of 'Is India Happy with Health Insurance Claims' report introduces a new measure to capture what India's health insurance policyholders truly go through when they file a claim:

## HCX™ SCORE (0 TO 100)

Captures the full claim journey in one score, by combining...



### HCX™ SCORE ≠ SHARE OF AMOUNT APPROVED

Low score may stem from friction at any point — the hospital experience, channel, claim process, etc.

## Reading the HCX™ Score:

We have categorized the HCX™ performance tiers as follows.

Effortless HCX™ Band  
**90 & Above** Range

The customer's experience genuinely exceeded expectations

Moderate HCX™ Band  
**70 to 89.9** Range

The system delivered on its promise but with some strain

Difficult HCX™ Band  
**Below 70** Range

The experience fell short on either feeling or delivery

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1

# India's Health Claim Experience Verdict: Functional but Still Falling Short

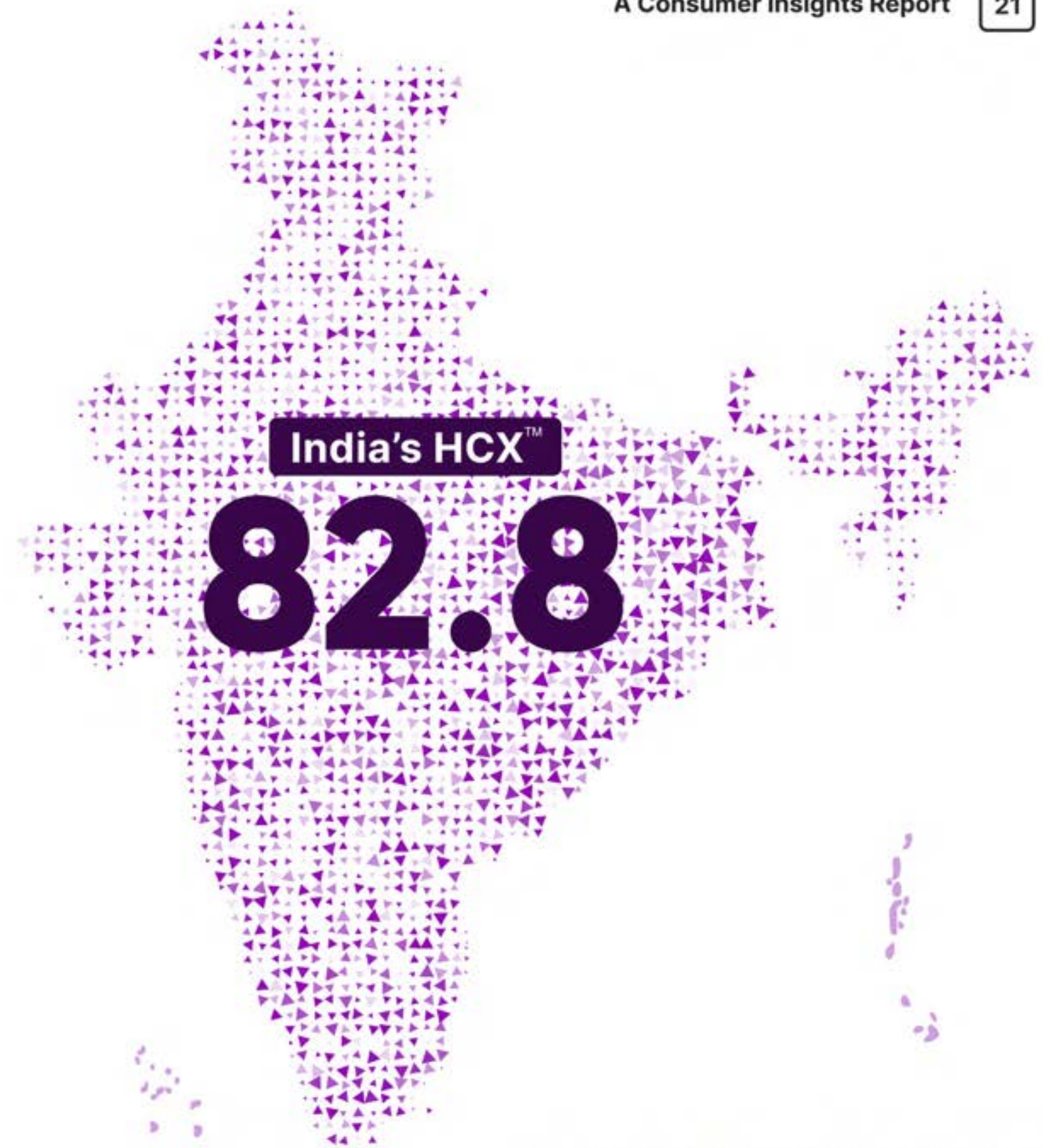


82.8

HCX™ satisfactory for most claimants, most of the time. Still some way to go to get it right each time

At 82.8 out of 100, India's health insurance claim experience sits firmly inside the 'Moderate' band. It is a credible base, suggesting that the system holds together for most customers, most of the time. At the same time, the score shows where the next leg of progress needs to come from: **'Stronger cashless push, better approval amounts and clearer reasons when claims are partially or completely rejected.'**

The headline of 82.8 disguises a wide internal range, and the splits underneath tell the more important story.



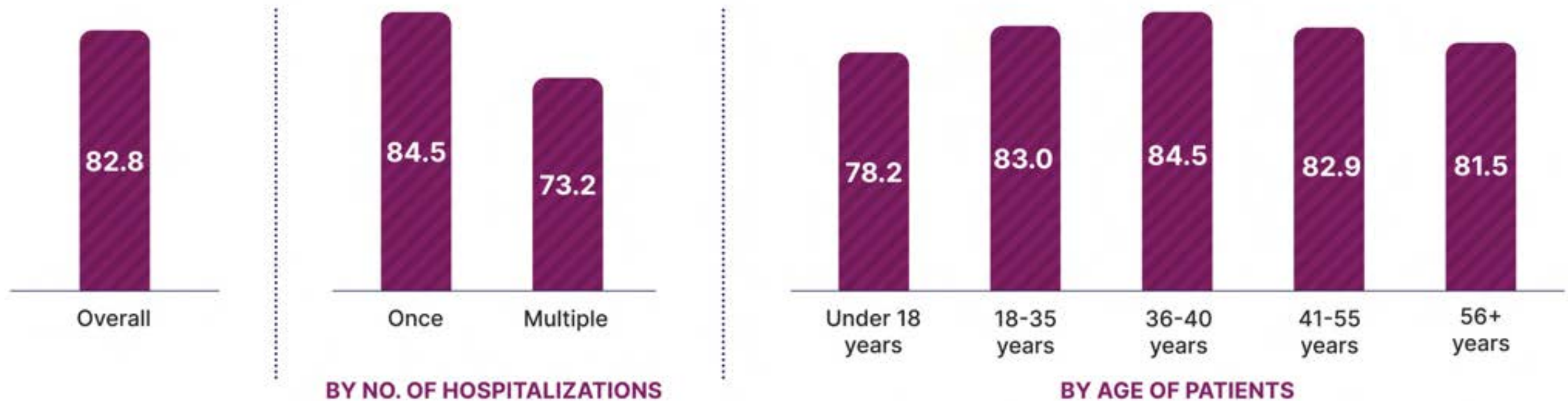
HCX™ Score ≠ Share of Amount Approved

Note: Please refer to 'Introducing the Health Claims Experience Index (HCX™)' to understand how to read the HCX™ score.

Hospitalization frequency creates one of the widest gaps in the data. Customers with a single hospitalization report an HCX™ of 84.5, while those with multiple hospitalizations drop to 73.2, the lowest across all segments. The score weakens across all four parameters when the number of hospitalizations rises.

Middle-aged patients (36-40 years) record a relatively steadier experience, helped by stronger current experience scores and a higher intent to continue with health insurance.

## HCX™ – by Number of Hospitalizations and Age – 2024-25



Base: 2024-25: Overall: 2,228; Once: 1,889; Multiple: 339; Under 18: 128; 18-35: 720; 36-40: 406; 41-55: 699; 56+: 275  
Note: Please refer to 'Introducing the Health Claims Experience Index (HCX™)' to understand how to read the HCX™ score.

South and West both sit lower than North and East. Tier-2 cities post 86.0, while Metros come in at 79.4 indicating that the densest hospital networks alone do not guarantee a stronger claim experience, especially as expectations are higher in bigger cities.

Repeat hospitalizations, metro complexity, and higher reimbursement rates in the South all pull the score down, not because of who the customer is, but because of what the claim pathway asks of them. The mode of claim, more than any other variable, is where that burden shows up most sharply, and cashless is where the clearest relief is found.

## HCX™ – by Region and City Tier – 2024-25



Base: 2024-25: All Respondents: 2,228; North: 515; East: 522; West: 632; South: 559; Metro: 925; Tier 2: 1,042; Tier 3: 261  
Note: Please refer to 'Introducing the Health Claims Experience Index (HCX™)' to understand how to read the HCX™ score.

2

## Cashless Sets the Standard for a Better Claim Experience



86.7

HCX™ for Cashless



Easier paperwork, better network reach and shorter approval waits push cashless to an HCX™ of 86.7, making it the low-effort claim journey



A cashless claim does what reimbursement often cannot: it reduces the customer's financial burden at the hospital and shifts the procedural burden away from them. The cashless score of 86.7 signals a more seamless and reassuring claim journey, while reimbursement at 73.7 points to a noticeably weaker route.

This 13-point gap is one of the sharpest split, driven significantly by Experience Performance (Sentiment), apart from Claim Assurance.

## HCX™ by Type of Claim – 2024-25



Base: 2024-25: All Respondents: 2,228; Cashless: 1,560; Reimbursement: 668

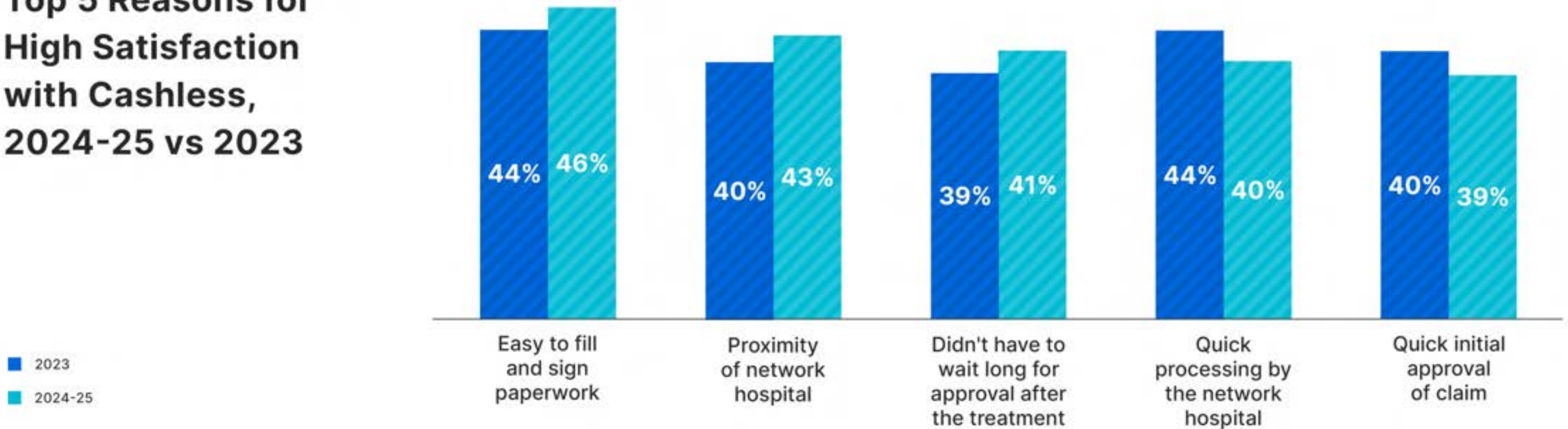
Note: Please refer to 'Introducing the Health Claims Experience Index (HCX™)' to understand how to read the HCX™ score.

In 2024–25, the cashless experience was shaped by both claims process efficiency and hospital responsiveness—factors that were also among the top drivers of satisfaction in 2023. The gains came primarily from improvements in process-led elements: respondents citing easy paperwork increased from 44% in 2023 to 46% in 2024–25, nearby network hospitals rose from 40% in 2023 to 43% in 2024–25,

and low approval wait times at discharge improved from 39% in 2023 to 41% in 2024–25.

However, hospital responsiveness as a reason for satisfaction though still a key contributor, declined from 44% in 2023 to 40% in 2024–25. Qualitative discussions suggest this dip was partly driven by understaffed TPA desks at hospitals.

## Top 5 Reasons for High Satisfaction with Cashless, 2024-25 vs 2023



Note: Respondents could select up to 3 options; the sum may exceed 100%  
Base: 2024-25: Cashless: 1,318; 2023: Cashless: 1,284  
Q. What made your experience good?

These reasons point to two strengths working together: process efficiency and access. When the network hospitals are involved, TPA and insurer coordinate well, cashless becomes not just faster, but easier for the customer at a moment of stress. This is what makes reimbursement feel like a less viable choice rather than an equal alternative.



***I had to get my wife's gastric polyp treated. When I went to one of the biggest hospitals in Patna, there was only one person available at the TPA desk. It took three hours to just get the initial process done.***

**– Male, 40**

Patna

3

## Reimbursement Process Not a Real Choice over Cashless



Opting for reimbursement claim driven by Convenience in the West and the South vs. Cashless Denials in the North & East

Of the respondents who had a reimbursement claim, ~60% cited not having to wait for approval before discharge as a key reason for the choice. In essence, it is at best a pseudo-choice, one that would not exist if discharge approvals were faster.



*In November last year, I had to get my child's sinus operated. I was thinking of going for a cashless claim, but the doctor told me that I'll have to wait for hours after treatment if I went for cashless mode. He recommended that I get the bill amount reimbursed. Though everything eventually went well, the cashless claim would have made my experience much better.*



- Male, 40, Patna

## Reasons for Opting Reimbursement

	Overall	By Region			
		North	East	West	South
Did not want to wait after treatment for claim to get approved before discharge	59%	49%	38%	67%	70%
Raise a single claim for hospitalization as well as pre-post expenses	45%	45%	31%	66%	36%
Cashless request was rejected (FORCED)	30%	52%	42%	27%	15%
Cashless option was not available at the hospital	29%	30%	14%	46%	22%
No one told that cashless option was available on my policy	28%	43%	36%	23%	18%

Note: Respondents could select up to 3 options; the sum may exceed 100%  
 Base: 2024-25: Overall: 668; North: 117; East: 133; West: 197; South: 221  
 Q. Why did you opt for a reimbursement mode for the most recent health claim?

Sig higher than Overall for the same year at @95% CI  
 Sig lower than Overall for the same year at @95% CI

The difference between choice and no-choice became starker as we delved into reasons across regions.

**The West and South (Convenience):**

Respondents prioritized speed and convenience, with 67% in the West and 70% in the South choosing reimbursement to avoid discharge delays. 66% in the West also opted to raise a unified single claim.

**The North & East (Friction):**

High rates of pre-authorization denial for cashless - 52% in the North and 42% in the East (vs 30% overall) — pushed customers toward reimbursement, indicating inconsistencies in cashless clearance.

**Reason for Opting Reimbursement: Cashless Option Not Available at The Hospital - by Treatment Expenses**



Among respondents with treatment costs below ₹50k, over 50% cited the absence of a cashless facility at their hospital as the primary reason for opting for reimbursement. Simply put, when the financial outlay is modest, policyholders are far less motivated to seek out a cashless-empanelled hospital, making the choice of reimbursement less a deliberate preference and more a reflection of convenience winning over effort at the time of admission. The lower the cost, the lower the perceived need to navigate network hospital listings or wait for pre-authorization.

Base: 2024-25: Overall: 668, <₹50k: 196; ₹50k-1L: 219; ₹1L-3L: 220; ₹3L+: 33  
Q. Why did you opt for a reimbursement mode for the most recent health claim?



***My mother suddenly fell unconscious, and we had to rush her to a nearby hospital. We did not have time to check which hospital was in the network for cashless treatment, and we also could not intimate the insurance company. She was admitted for 2 days, and the expense was around ₹25-30 K, which my brother was able to pay at the time. While at the hospital, I spoke with the agent, who told us that he would get it reimbursed, and he did***

**– Male, 36**

Agra

4

## A Debt Sentence: The High Cost of Not Waiting



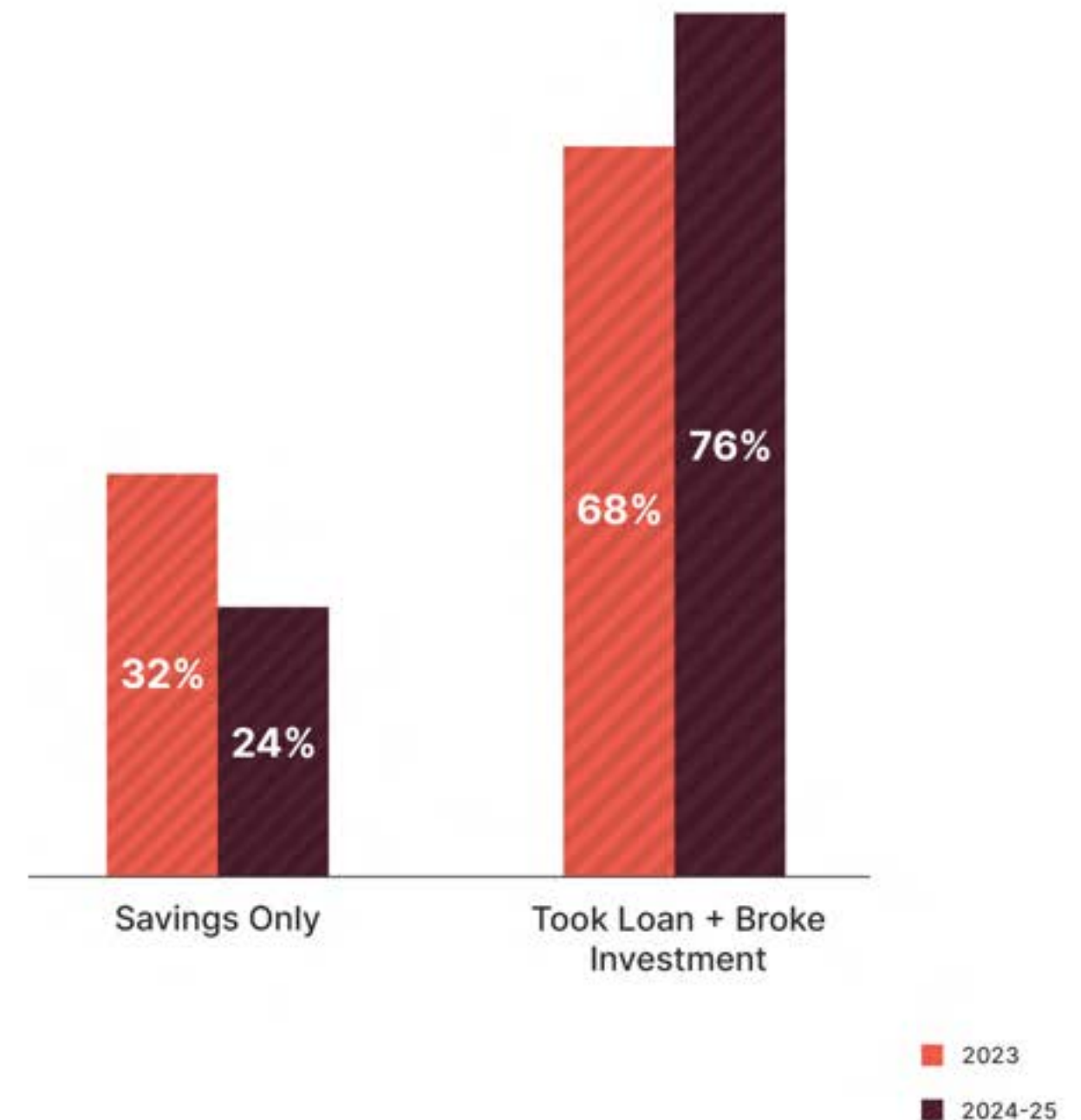
76%

Reimbursement claimants  
borrowed or broke investments,  
turning medical bills into an  
immediate financial burden

The study also exposes persistent friction points, often amplified in the reimbursement process. The biggest difference between the two claim types is the financial shock absorber provided by cashless claims. When cashless is unavailable or denied, claimants face immediate, high-stakes financial stress, with a looming threat to long-term financial plans as well.

- The consequence of a reimbursement claim is substantial: 76% of claimants had to take a loan or break investments, marking a sharp rise from 68% in 2023.
- Correspondingly, the ability to manage costs only with liquid savings dropped from 32% to 24% in 2024-25.

## Source of Finance for Treatment, 2024-25 vs 2023

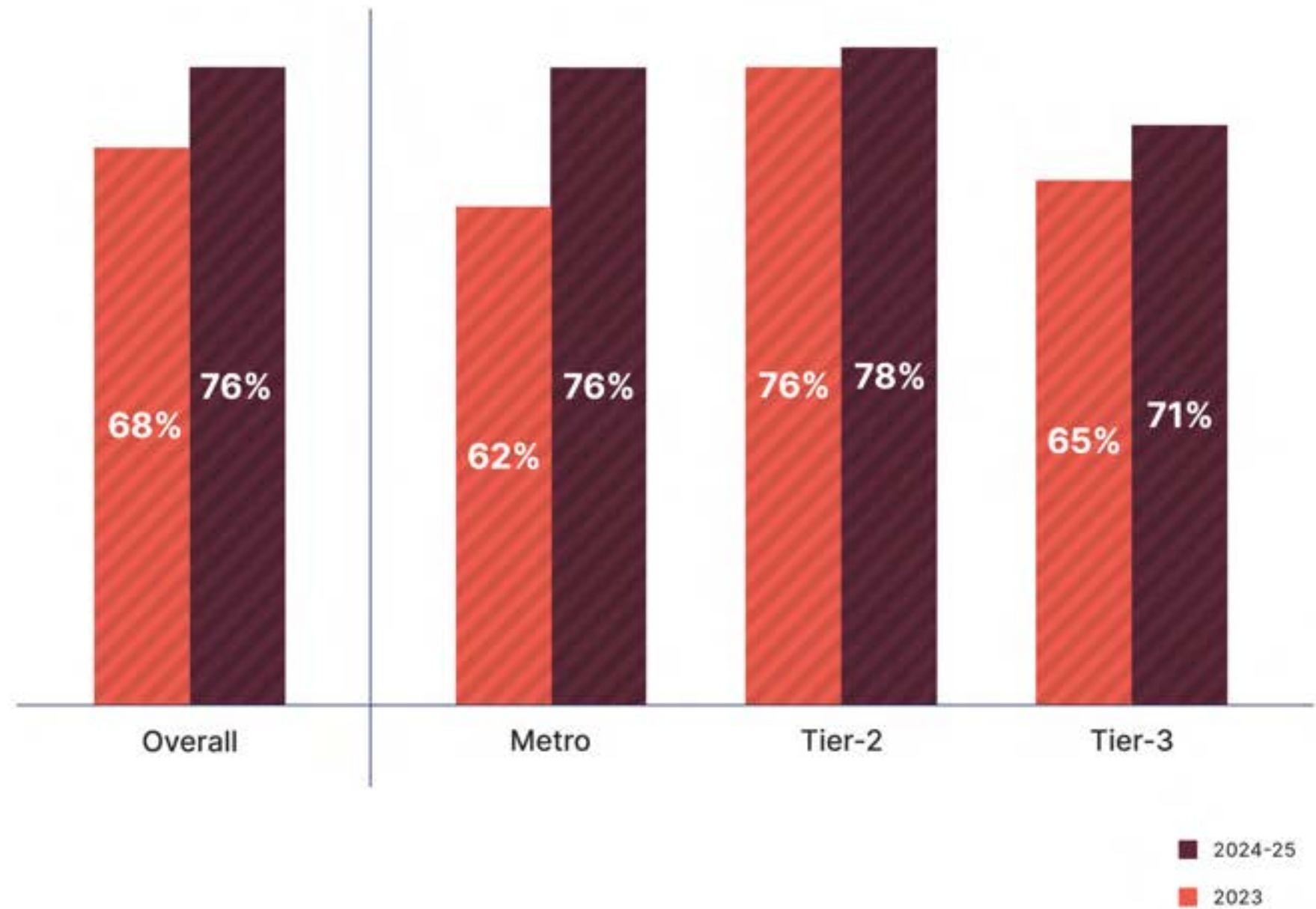


Base: Reimbursement: 2024-25: 668; 2023: 691  
Q. How did you pay the hospital bill since your claim was a reimbursement claim?

Financial stress at claim time has risen across all city tiers between 2023 and 2024-25, with the overall increase driven largely by metros, which saw the sharpest jump of 14 percentage points to 76%. Tier-2 cities record the highest incidence overall at 78%. Tier-3 cities saw a 6 percentage point rise, with 71% of claimants borrowing or liquidating investments in 2024-25. Across tiers, the data makes a case for accessible cashless claims, as reimbursement, by its very nature, pushes claimants into debt or forces them to liquidate investments before they see a rupee back.

This underscores the need for strong and consistent implementation of the "Cashless Everywhere" initiative endorsed by the IRDAI, ensuring that the intent of the policy translates into ground-level access for every policyholder.

## % Respondents Took Loans or Broke Investments, by City Tiers – 2024-25 vs 2023



Base: Reimbursement: 2024-25: 668; Metro: 378; Tier 2: 212; Tier 3: 78  
Q. How did you pay the hospital bill since your claim was a reimbursement claim?



***I paid with credit card for my wife's surgery and almost maxed out my limit. It took over 2 months for the company to give me my reimbursement money. I am a retired person with no incoming income, how was I supposed to sustain. I had to ask money from some relative for some time to avoid paying high interest***

**– Male, 70**

Jaipur

5

# The Reimbursement Drag: Where Process Friction Pulls Down HCX™



73.7

HCX™ for Reimbursement

Reimbursement trails cashless by 13 HCX™ points, weighed down by slower processing, weaker updates, paperwork loops and unclear rejection reasons

Reimbursement posts an **HCX™** of **73.7**, significantly behind cashless at **86.7**. Although reimbursement remains within the 'Moderate' band, its score leaves far less room for comfort, signalling a claim journey that is more effort-heavy and less predictable than cashless. The gap is not just about the final payout; it is about the effort customers must carry through the process as it places the responsibility back on the customer.

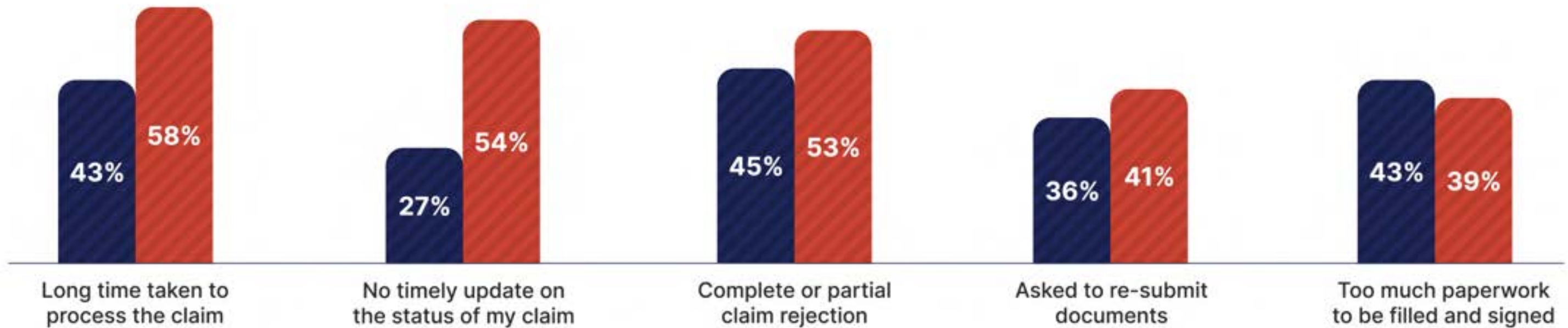
## HCX™ – by Type of Claim – 2024-25



Base: 2024-25: All Respondents: 2,228; Cashless: 1,560; Reimbursement: 668

Note: Please refer to 'Introducing the Health Claims Experience Index (HCX™)' to understand how to read the HCX™ score.

## Top 5 Reasons for Dissatisfaction with Reimbursement, 2024-25 vs 2023



Note: Respondents could select up to 3 options; the sum may exceed 100%

Base: Reimbursement: 2024-25: 211; 2023: 214

Q. Let us know the reasons for your not so good/ bad experience?

■ 2023

■ 2024-25

In reimbursement claims, the process itself becomes an irritant, as claimants are often pushed into it by limited cashless access or immediate financial pressure. Even beyond this, the journey is far from easy for many.

This becomes visible in the reasons for dissatisfaction. Among dissatisfied reimbursement claimants, the biggest pain points remain delay, weak communication, claim rejection and repeated document re-submissions.

Compared to 2023, these concerns intensify on most fronts: processing delays rise from 43% to 58%, lack of timely updates doubles from 27% to 54%, and claim rejection increases from 45% to 53%. The reimbursement journey, therefore, remains slow, opaque and repetitive, with the customer carrying much of the uncertainty even after paying out of pocket.

## The "Why Not?" Problem: The Crisis of Rejection Transparency

The nature of customer dissatisfaction with claim rejection has undergone a dramatic shift, highlighting a new transparency crisis.

Dissatisfaction Driver	2024-25	2023
Not provided a clear reason	73%	53%
Non-disclosure of Pre-existing diseases (PEDs)	15%	33%

Base: 2024-25: 204, 2023: 112  
Q. What was the reason provided for claim rejection?

Dissatisfaction linked to claim rejections due to non-disclosure of Pre-Existing Diseases (PEDs) has plunged for good, from 33% in 2023 to just 15% in 2024-25. However, this progress is undercut by a new issue: the dissatisfaction arising from not being given a clear reason for rejection has surged from 53% to an alarming 73%.

The lack of clarity on rejections remains a critical friction point. Industry must ensure transparency, giving customers clear explanations whenever claims are denied.



*I had gotten a boil on my knee due to continuous rubbing while cleaning the floor, which I had to get surgically removed. I initially filed for a cashless claim which got rejected. I'm not sure of the reason for rejection, not sure if the hospital was not tied up with the insurer or what. I later applied for a reimbursement claim.*

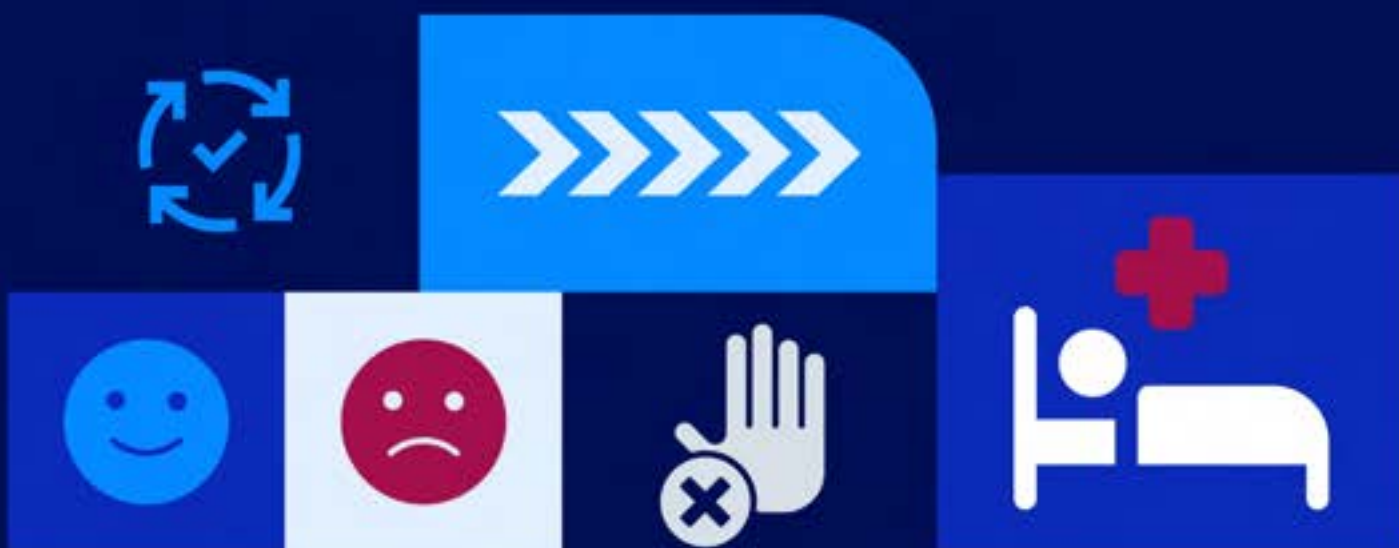


- Female, 44, Mumbai

The reimbursement story, therefore, is not one of failure, but of fragility. The lower HCX™ shows that reimbursement remains a higher-effort, higher-anxiety route, where delays, documentation and unclear decisions can quickly erode trust. This is why improving reimbursement cannot only mean faster payouts; it must also mean clearer communication, simpler documentation and sharper explanation at every point where the customer is asked to wait, resubmit or accept a deduction. Hence, it is the need of the hour that customer feel supported at every stage of the claim journey.

# 6

## The Claim Journey's Weakest Moment: Lack of Rejection Clarity



Across the four stages of a claim process evaluated, the experience is strong at intimation, gradually moderates through the middle stages, and weakens at the post-hospitalization phase

## Highest & Lowest Satisfaction with Processes Across Claim Stages

When viewed across pre-hospitalization, hospital process, insurance provider or intermediary, and post-hospitalization, both claim modes show a similar pattern. Satisfaction is highest at the pre-hospitalization stage, weakens through the middle stages involving hospitals, insurers or intermediary, which involves paperwork and revert speed become key friction points, and falls to its lowest at the post-hospitalization stage, primarily due to limited clarity on the rationale provided for rejections or deductions. Within cashless, satisfaction stays in a relatively narrow band of 76% to 91%. Within reimbursement, the spread is much wider, from 54% to 82%.

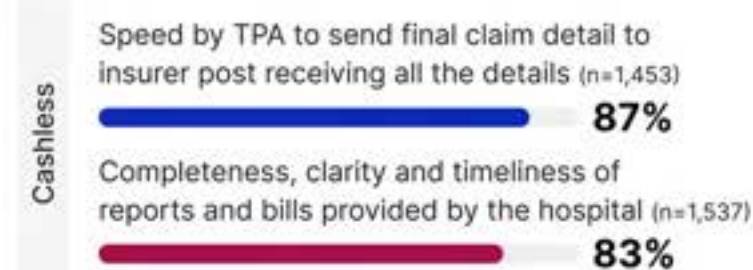
### 1

#### Pre-Hospitalization



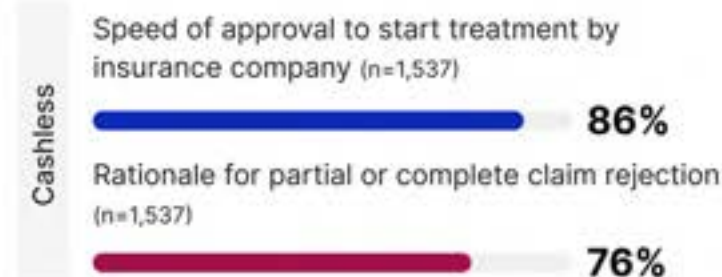
### 2

#### Hospitalization - Hospital Process



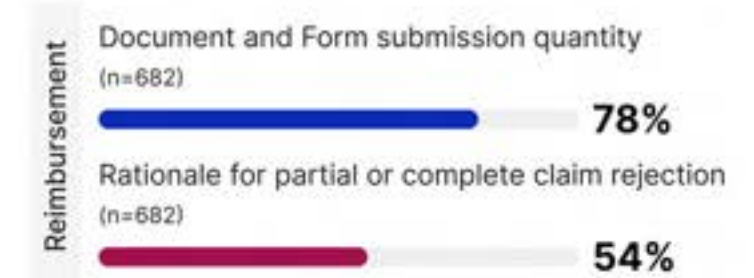
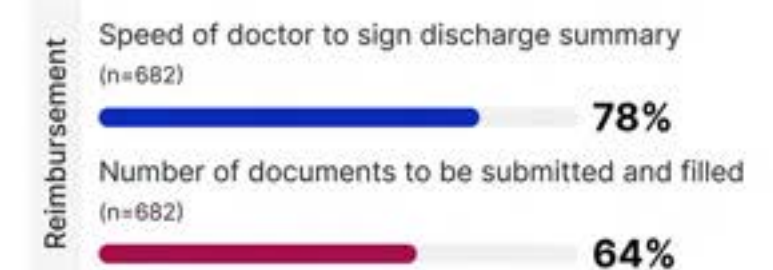
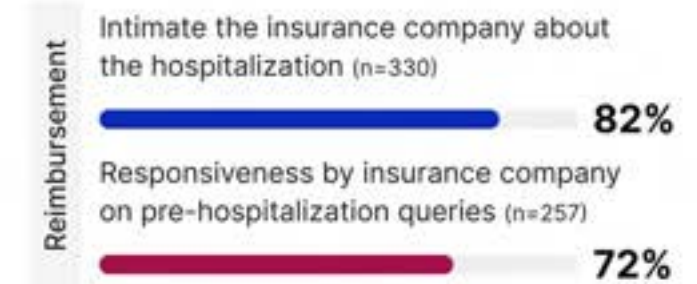
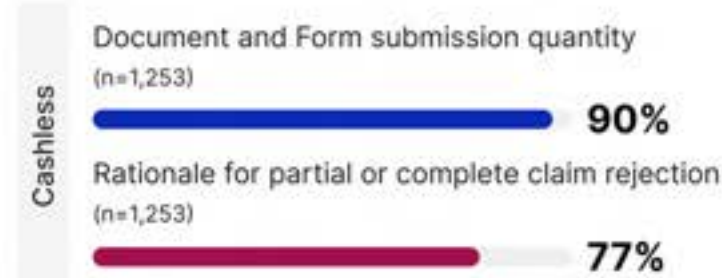
### 3

#### Hospitalization - Insurance Provider / Intermediary



### 4

#### Post Hospitalization



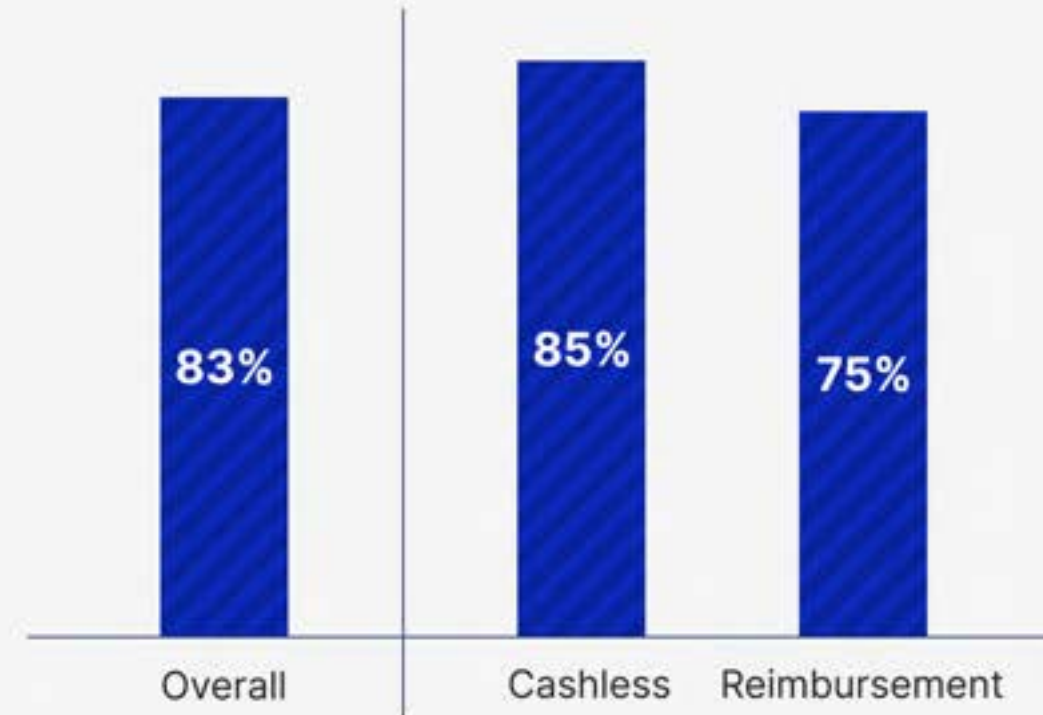
■ Highest satisfaction (T2B) in stage  
 ■ Lowest satisfaction (T2B) in stage

Note: Top 2 Box scores on a 5-point scale, where 1 = extremely dissatisfied and 5 = extremely satisfied. Q. How would you rate your experience on the following processes?

The transparency finding in this report identifies the rationale for rejection as the journey's weakest link. Among cashless claimants in the post-hospitalisation phase, satisfaction with the explanation received dips to 77%, the lowest point in the cashless cycle. The situation is more alarming for reimbursement claimants, where satisfaction plunges to just 54%, marking the lowest experience reading across the entire arc of a claim. In Metros, this figure further erodes to 47%. This lack of clarity on rejections remains a critical friction point; a denied claim without a granular explanation does not just frustrate a customer, it breaks trust in a way that is very hard to rebuild.

Together, these factors make the health claim journey a complex and often overwhelming process to navigate alone. From understanding eligibility and initiating the claim to tracking approvals, managing documentation and decoding rejection decisions, each stage demands time, effort and familiarity with a system that most policyholders encounter only in moments of stress. Naturally, people look for support in their journey, often from the channel they purchased the policy from.

## Satisfaction with On-ground Claim Support - by Claims Mode



Base: 2024-25: All respondents: 2,228; Cashless: 1,560; Reimbursement: 668  
Q. How would you rate your experience on the following processes?

On-ground claim support emerges as a key source of relief during this complex journey, with an uneven overall satisfaction of 83%, cashless at 85% and reimbursement trailing at 75%. The numbers point to support that is serviceable, but with meaningful ground still to cover, particularly for those navigating the reimbursement route. At a moment when policyholders need the most guidance, the opportunity to do better remains.



***My father had cancer and for his treatment, he had to go through 11 chemo therapy sessions. Out of the total bill of Rs.49K, the insurance company made a cashless payment of Rs. 35K to the hospital. Still not sure why the remaining amount was not paid by the insurance company.***

**– Male, 44**

Gaya

7

## What Customers Want Next?



40%+

Seek regular network hospital lists and simpler forms, mostly driven by the North and the South, while the South also wants greater attention to upfront verification and investigation accuracy

Customers' top asks for 2024-25 are clear: regular updates on cashless hospital lists (44%) and simpler claim processes (42%) and forms (41%)

**The regional emphasis differs significantly:**

- The North leans heavily on wanting frequent updates on cashless hospital lists (55%) and simpler forms (49%)

- The South emphasizes on verification significantly more than other regions - 44% want better checks at policy purchase to avoid rejections later, and 45% seek stronger investigation processes to prevent reversals after initial approval.

Improvement Areas	Overall	By Region				Base
		North	East	West	South	
	2,228	515	522	632	559	
List of cashless hospitals should be shared from time to time	44%	55%	39%	41%	42%	
Process should be simplified (e.g. hospital should provide documents to insurance company directly)	42%	31%	37%	50%	46%	
Claims form should be simplified	41%	49%	37%	32%	48%	
Proper verification before policy purchase to avoid claim rejection	39%	32%	38%	39%	44%	
Regular reminders after policy purchase about waiting periods, consumables coverage, etc.	36%	25%	33%	42%	43%	
Better processes for investigation to avoid rejection after initial approval	36%	25%	35%	39%	45%	
Clear rationale should be provided for claim rejection proactively	34%	32%	31%	37%	35%	
Reduction in TAT for claim approval	28%	35%	30%	22%	24%	

Note: Respondents could select up to 3 options; the sum may exceed 100%  
 Q. Which of the following attributes do you feel are important and needs improvement in your claim experience?

Sig higher than Overall for the same year at @95% CI  
 Sig lower than Overall for the same year at @95% CI

Improvement asks vary highly by city tier. Tier-3 customers push hardest for regular network hospital list updates (55% vs 42–43% elsewhere), reflecting cashless access gaps in smaller cities. Metros want simpler hospital-to-insurer handoffs (47%), easing the reimbursement paperwork

burden. Tier-2 customers demand faster claim approval TATs (34% vs 21% in Metros).

These signals point to a common theme: customers now expect clearer information and cleaner processes from the start.

Improvement Areas	Overall	By City Tiers			Base
		Metro	Tier-2	Tier-3	
	2,228	925	1042	261	
List of cashless hospitals should be shared from time to time	44%	43%	42%	55%	
Process should be simplified (e.g. hospital should provide documents to insurance company directly)	42%	47%	39%	33%	
Claims form should be simplified	41%	42%	41%	38%	
Proper verification before policy purchase to avoid claim rejection	39%	37%	41%	32%	
Regular reminders after policy purchase about waiting periods, consumables coverage, etc.	36%	36%	36%	37%	
Better processes for investigation to avoid rejection after initial approval	36%	39%	36%	28%	
Clear rationale should be provided for claim rejection proactively	34%	34%	36%	29%	
Reduction in TAT for claim approval	28%	21%	34%	24%	

Note: Respondents could select up to 3 options; the sum may exceed 100%  
Q. Which of the following attributes do you feel are important and needs improvement in your claim experience?

Sig higher than Overall for the same year at @95% CI  
Sig lower than Overall for the same year at @95% CI

**Claim Form - Part A**  
For Health Insurance Policies Other than Travel & Personal Accident

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)  
All the fields in the Claim Form are mandatory.

**SECTION A - DETAILS OF PRIMARY INSURED:**

a) Policy No:  b) SI No / Certificate No.  c) Company/ TPA ID No:

d) Name:

e) Address:

City:  State:  Pin Code:

f) Phone No:  g) Email ID:

**SECTION B - DETAILS OF INSURANCE HISTORY:**

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

c) If Yes, Company Name:

i) Insurer's Email ID:  ii) Insurer's Phone No:

iii) Policy No.  iv) Sum Insured (Rs.)

d) Have you been hospitalized in the last four years since inception of the contract? Yes  No  e) Date:

ii) Diagnosis:

e) Previously covered by any other Medclaim /Health Insurance: Yes  No

f) If yes, Company Name:

**SECTION C - DETAILS OF INSURED PERSON HOSPITALIZED:**

a) Name:

b) Relationship to Primary insured:  Self  Spouse  Child  Father  Mother  Other

c) Date of Birth:

d) Address:   
(If different from above)

e) Gender:  Male  Female f) Age:  years  months

Occupation:  Service  Self  Employed  Homemaker  Student  Retired  Other

City:  State:  Pin Code:

g) Phone No:  h) Email ID:

**SECTION D - DETAILS OF HOSPITALIZATION:**

a) Name of Hospital where Admitted:

b) Hospital's Email ID:

c) Room Category Occupied:  Day care  Twin sharing  Single Occupancy  3 or more beds per room

d) Hospitalization due to:  Injury  Illness  Maternity

e) Date of Injury / Date Disease first detected / Date of Delivery:  f) Date of Admission:  g) Time:

h) Date of Discharge:  i) Time:

j) If Injury give cause:  Self inflicted  Road Traffic Accident  Substance Abuse / Alcohol Consumption

k) If Medico Legal: Yes  No  l) Reported to police: Yes  No  m) MLC Report & Police FIR attached: Yes  No

n) 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.
vii. Total: Rs.	

**b. Claim for Domiciliary Hospitalization:**  Yes  No (If Yes, provide details in annexure)



*I was sent this form and then tried to find this Certificate Number and Company ID but could not. It had me confused for a very long time, tried searching and asking many people but got no clear answer. Later I called Policybazaar and they informed me that these are not needed for someone like me.*

**- Male, 31**  
Delhi

# Policybazaar Verdict



**At 82.8, the industry sits within the 'Moderate' band — a working foundation, but one that leaves clear room to move.**

Cashless remains the strongest lever: it reduces financial pressure, simplifies the customer's role and performs best when hospitals, TPAs, aggregators and insurers coordinate well.

The reimbursement gap, however, cannot be set aside. At 73.7, it trails cashless not just because customers pay first and wait later, but because the journey remains slow, paperwork-heavy and short on clarity. Delays in processing, lack of timely updates and unexplained rejections continue to erode confidence.

Progress, therefore, must be built on consistency. Broader cashless access, higher amount approved, simpler documentation and more specific rejection communications will determine whether the industry moves from broadly satisfactory to genuinely trustworthy. In a moment of medical stress, the best claim experience is one where the customer does not have to chase the system, fund the uncertainty or decode the decision alone.

# Methodology and Screening Criteria

## Target Audience and Screening Criteria

Respondents met the following criteria:

- **Respondent Age:** 22-60 Years
- **Socio-economic Class:** NCCS A, B, C
- **Claims Experience:** Health insurance claim in the last one year (Aug 2024 - September 2025)
- **Role:** Insurance proposers or attendants directly involved in the claim

Only **hospitalization claims** were included. **OPD claims** (e.g., dialysis, angiography) and treatments not meeting insurance criteria (such as cosmetic surgeries) were excluded.

## Data Collection

- Interviews were conducted using CAPI (Computer-Assisted Personal Interviewing)
- A structured questionnaire was administered
- The questionnaire was translated into regional languages to ensure respondent comprehension and consistency

## Exclusion Criteria

Interviews were rejected if:

- NCCS criteria were not met
- The respondent was not involved in the claim process
- The treatment was not eligible for insurance coverage
- Quality concerns were identified during validation

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## Sampling Approach

A purposive, multi-stage sampling method was followed:

- Cities were divided into 4–5 zones based on size
- Equal starting points were selected across zones
- City-level sample sizes were evenly split across these points
- Respondents were identified through street intercepts, referrals, and nearby medical stores or hospitals
- Representativeness across city tiers, states, and regions was maintained

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## Quality Control

- 30% of interviews per interviewer were quality-checked through physical and telephonic back-checks
- Multiple data consistency checks were conducted during analysis
- Approximately 2% of the sample size were terminated for quality lapses or ineligible treatments

# Appendix

*A sample of the claim forms —  
complex by design, confusing by experience.*

# Sample of a form required to be filled for one claim (1)

**Part A**

1. To be filled in by the Insured.  
2. The issue of this Form is not to be taken as an admission of liability.  
3. To be filled in block letters.

Claim Intimation No.: \_\_\_\_\_

**Section A - Details of Primary Insured**

a) Policy No. : \_\_\_\_\_  
 b) Sl. No./Certificate No.: \_\_\_\_\_ c) Company/TPA ID No.: \_\_\_\_\_  
 d) Name : \_\_\_\_\_  
(Surname) (First Name) (Middle Name)  
 e) Address : \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 City : \_\_\_\_\_  
 State : \_\_\_\_\_ Pin Code : \_\_\_\_\_  
 Phone Number : \_\_\_\_\_  
 E-mail : \_\_\_\_\_

**Section B - Details of Insurance History**

a) Currently covered by any other Medclaim/Health Insurance :  Yes  No  
 b) Date of commencement of first insurance without break : \_\_\_\_/\_\_\_\_/\_\_\_\_ (DD/MM/YYYY)  
 c) If yes, Company Name : \_\_\_\_\_  
 Policy Number : \_\_\_\_\_ Sum Insured (Rs.): \_\_\_\_\_  
 d) Have you ever been hospitalized in the last 4 years since inception of the contract?  Yes  No  
 Date : \_\_\_\_/\_\_\_\_/\_\_\_\_ (DD/MM/YYYY)  
 Diagnosis : \_\_\_\_\_  
 e) Previously covered by any other Medclaim/Health Insurance :  Yes  No  
 f) If yes, Company Name : \_\_\_\_\_

**Section C - Details of Insured Person Hospitalised**

Title :  Mr.  Ms.  
 a) Name : \_\_\_\_\_  
(Surname) (First Name) (Middle Name)  
 b) Gender :  M  F c) Age : \_\_\_\_/\_\_\_\_ (YYYY) d) Date of Birth : \_\_\_\_/\_\_\_\_/\_\_\_\_  
 e) Relationship with Primary Insured :  Self  Spouse  Child  Father  Mother  
 Others (Please Specify) \_\_\_\_\_  
 f) Occupation :  Service  Self Employed  Homemaker  Retired  Student  Others (Please Specify) \_\_\_\_\_  
 g) Address : \_\_\_\_\_  
(if different from above)  
 \_\_\_\_\_  
 \_\_\_\_\_  
 City : \_\_\_\_\_  
 State : \_\_\_\_\_ Pin Code : \_\_\_\_\_  
 Phone Number : \_\_\_\_\_  
 E-mail : \_\_\_\_\_

**Section D - Details of Hospitalisation**

a) Name of Hospital where Admitted : \_\_\_\_\_  
 b) Room Category occupied :  Day Care  Single Occupancy  Twin Sharing  3 or more beds per room  
 c) Hospitalisation due to :  Injury  Illness  Maternity  
 d) Date of Injury/Date Disease first detected/Date of Delivery : \_\_\_\_/\_\_\_\_/\_\_\_\_ (DD/MM/YYYY)  
 e) Date of Admission : \_\_\_\_/\_\_\_\_/\_\_\_\_ (DD/MM/YYYY) f) Time of Admission : \_\_\_\_:\_\_\_\_ (HH:MM)  
 g) Date of Discharge : \_\_\_\_/\_\_\_\_/\_\_\_\_ (DD/MM/YYYY) h) Time of Discharge : \_\_\_\_:\_\_\_\_ (HH:MM)  
 i) If Injury give cause :  Self inflicted  Road Traffic Accident  Substance Abuse/Alcohol Consumption  
 j) If Medico Legal :  Yes  No k) Reported to Police :  Yes  No  
 l) MLC Report & Police FIR attached :  Yes  No m) System of Medicine : \_\_\_\_\_

**Section E - Details of Claim**

a) Details of the treatment expenses claimed

(i) Pre-hospitalization Expenses : Rs. _____	(vi) Others (code) _____ : Rs. _____
(ii) Hospitalization Expenses : Rs. _____	Total : Rs. _____
(iii) Post-hospitalization Expenses : Rs. _____	(vii) Pre-hospitalization period : ____ days
(iv) Health Check-up cost : Rs. _____	(viii) Post-hospitalization period : ____ days
(v) Ambulance Charges : Rs. _____	

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. _____	(v) Pre/Post hospitalization Lump sum benefit : Rs. _____
(ii) Surgical Cash : Rs. _____	(vi) Others _____ : Rs. _____
(iii) Critical Illness Benefit : Rs. _____	Total : Rs. _____
(iv) Convalescence : Rs. _____	

d) Claim Documents Submitted - Checklist

(i) Claim Form Duly signed : <input type="checkbox"/>	(vi) Pharmacy Bill : <input type="checkbox"/>
(ii) Copy of the claim intimation, if any : <input type="checkbox"/>	(vii) Operation Theatre Notes : <input type="checkbox"/>
(iii) Hospital Main Bill : <input type="checkbox"/>	(viii) ECG : <input type="checkbox"/>
(iv) Hospital Break-up Bill : <input type="checkbox"/>	(ix) Doctor's request for investigation : <input type="checkbox"/>
(v) Hospital Bill Payment Receipt : <input type="checkbox"/>	(x) Investigation Reports (including CT/MRI/USG/NPE) : <input type="checkbox"/>
(vi) Hospital Discharge Summary : <input type="checkbox"/>	(xi) Doctor's Prescriptions : <input type="checkbox"/>
	(xii) Others <input type="checkbox"/> _____

**Section F - Details of Bills Enclosed**

S No.	Bill No.	Date	Issued by	Towards	Amount (INR)
1		(DDMMYY)		Hospital Main Bill	
2		(DDMMYY)		Pre-hospitalization Bills: ___Nos	
3		(DDMMYY)		Post-hospitalization Bills: ___Nos	
4		(DDMMYY)		Pharmacy bills	
5		(DDMMYY)			
6		(DDMMYY)			
7		(DDMMYY)			
8		(DDMMYY)			
9		(DDMMYY)			
10		(DDMMYY)			

In case of more details, please attach a separate sheet.

**Section G - Details of Primary Insured's Bank Account**

a) PAN	:																			
b) Account Number	:																			
c) Bank Name & Branch	:																			
d) Cheque/DD payable details	:																			
e) IFSC Code	:																			

**Section H - 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/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 :  /  /  (DDMMYY)

Signature of the Insured : \_\_\_\_\_

Place : \_\_\_\_\_

**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) SI 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 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 Hospitalised 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 Hospitalised</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 with 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	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 Hospitalisation</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>		
Claim Made for	Select the event for which the claim is made	Tick Yes or No
a) Details of Treatment Expenses	Enter the amount claimed as treatment expenses	In rupees (Do not enter paise values)
b) Claim for Domiciliary Hospitalisation	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 amounts in rupees		



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.	License 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 Medicaclaim / Health Insurance?	Indicate whether currently covered by another Medicaclaim / 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 Medicaclaim / Health Insurance?	Indicate whether previously covered by another Medicaclaim / 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

SECTION E - DETAILS OF CLAIM		
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
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
d) 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
e) 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.		

# Sample of a form required to be filled for one claim (3)

**Claim form for health insurance policies other than travel and personal accident - PART A**

**TO BE FILLED IN BY THE INSURED**  
(TO BE FILLED IN BLOCK LETTERS)  
The issue of this Form is not to be taken as an admission of liability

**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 A**

**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 \_\_\_\_\_

**SECTION B**

**DETAILS OF INSURED PERSON HOSPITALIZED:**

a) Name: \_\_\_\_\_

b) Gender: Male  Female  Third Gender  c) Age: Years \_\_\_\_\_ Month \_\_\_\_\_ d) Date of Birth: \_\_\_\_\_

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

(Please Specify) \_\_\_\_\_

f) Occupation: Service  Self Employed  Homemaker  Student  Retired  Other

(Please Specify) \_\_\_\_\_

g) Address (if different from above): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Pin Code: \_\_\_\_\_ Phone No: \_\_\_\_\_ Email ID: \_\_\_\_\_

**SECTION C**

**DETAILS 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 Abuse / Alcohol Consumption  j) If Medico legal:  YES  NO

ii. Reported to police:  YES  NO iii. MLC Report & Police FIR attached:  YES  NO j) System of Medicine: \_\_\_\_\_

**SECTION D**

**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 Of 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  Hospital Discharge Summary  Investigation Reports (Including CT/ MRI / USG / HPE)

Copy of the Claim intimation if any  Pharmacy Bill  Doctor's Prescriptions

Hospital Main Bill  Operation Theatre Notes  Others

Hospital Break-up Bill  ECG

Hospital Bill Payment Receipt  Doctor's request for investigation

**DETAILS OF BILLS ENCLOSED:**

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

**SECTION F**

**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: \_\_\_\_\_

**SECTION G**

**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: \_\_\_\_\_

**SECTION H**

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	License number as allotted by IRDAI 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 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 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
<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, Female or Third Gender
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)
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Indicate which bills are enclosed with the amounts in rupees		
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c) Bank Name and Branch	Enter the bank name along with the branch	Name of the Bank in full
d) Cheque/ DO payable details	Enter the name of the beneficiary the cheque/ DD should be made out to	Name of the individual/ organization in full
e) 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>		



Research Partner: White Canvases Consulting



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