

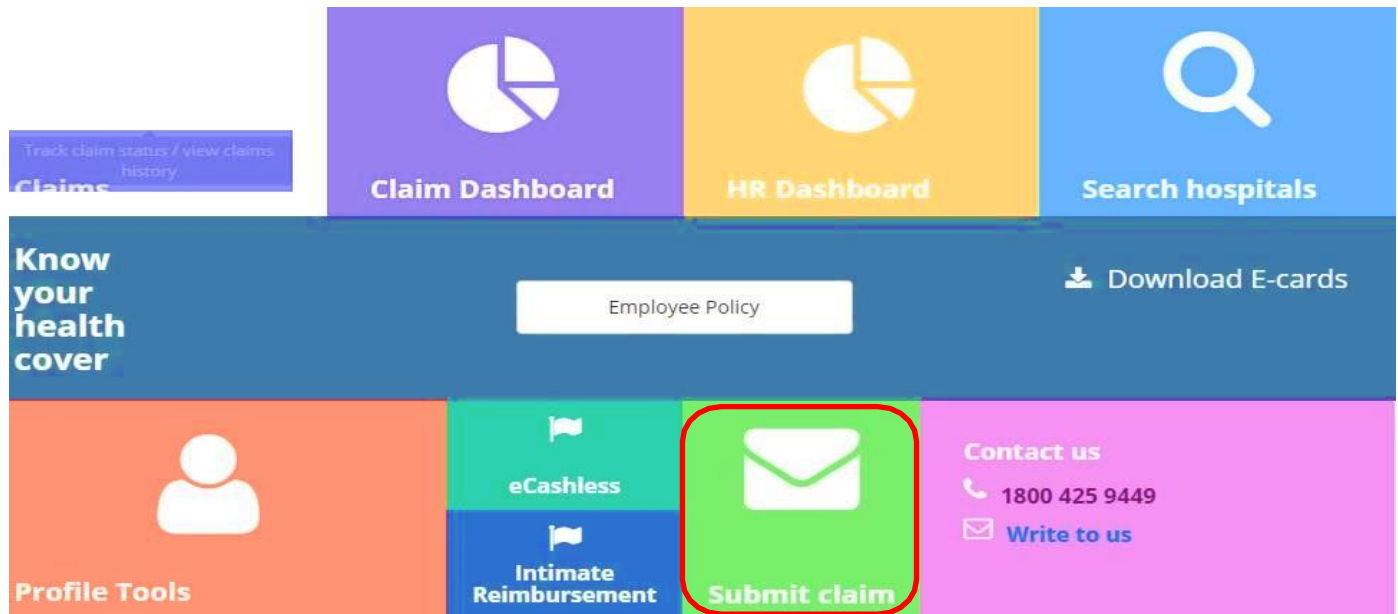
# Online Claim Submission Process Flow

## (Step By Step Guide)

- Log on to Url - <https://portal.mediassist.in> - MediAssist Employee portal.

(Your username will be as <application\_id>@NATIONALTRUST.Com and password will be your date of Birth of Beneficiary e.g. DD-MM-YYYY)

- You can also download the **Mediassist App** from Android/Apple/Window store in a phone [Username - <application\_id>@NATIONALTRUST.Com and password will be DD-MM-YYYY (Date of Birth of the Beneficiary)]



- Click on Submit claim option as highlighted in above screen shot.
- On 1st Page, fill the details to generate the claim form.

1 **USER DETAILS**    2 Hospitalization details    3 KYC details    3 Declaration and claim submission

**Beneficiary Details**                      **Employee Name : Test Employee**                      **Employee ID : 1**

<b>Patient name*</b>	<input type="text" value="Test Employee"/>	<b>Relationship with employee</b>	<input type="text" value="Self"/>
<b>E-mail *</b>	<input type="text" value="hamza.zaidi@mediassist.in"/>	<b>Mobile Number*</b>	<input type="text" value="7349122713"/>
<b>Date Of Admission*</b>	<input type="text" value="04/21/2021"/>	<b>Date Of Discharge*</b>	<input type="text" value="04/30/2021"/>

**Bank Details**

Bank/Branch/Location	IFSC Code	A/C No	A/C Holder Name	Action
ICICI BANK LIMITED GACHIBOWLI, HYDERABAD ICICI BANK LTD., PLOT NO.74&75, VINAYAK NAGAR, GACHIBOWLI, HYDERABAD - 500 032, HYDERABAD DIST., ANDHRA PRADESH.	ICIC0001114	111401513162	test	<input type="button" value="Upload Cheque Leaf"/>

Click on edit to upload new or update cheque leaf and bank details

Bank details given by an employee at the time of submitting final documents will be considered for his claim processing.

## Details to be filled on "1.USER DETAILS" are...

- Select Name of the patient.
  - Relationship will auto populate based on the name of the patient.
  - Official Email ID and phone to be filled
  - Select date of admission and date of discharge. (In case of OPD, Domiciliary claims, mention the bill generated date in both columns)
  - Update your account details
  - Then click on "Save and Next".
  -
- **On 2<sup>nd</sup> page you need to update**
    1. For hospitalization & pre-post reimbursements - Hospital details
    2. OPD - hospital/clinic/ test centre details
    3. Domiciliary - Institute/clinic/tele consultation name

### Claim Details

State*	Telangana	City*	Hyderabad
Hospital Name*	Asjan Institute Of Gastroenterolo	Hospital Address*	H.No.6-3-661, Somajiguda, Hyderabad
The selected hospital is a Network Hospital.Please provide reason for choosing the same for a Reimbursement claim instead of Cashless claim			
Reason*	Not aware of cashless process	Pre Hospitalization Amount	Calculated based on bill dates & DOA/DI
Nature of Illness/Disease/Accident*	Fever of Unknown Origin	Post Hospitalization Amount	12000
Total Amount Claimed	12000	Hospitalization Amount	Calculated based on bill dates & DOA/DI

### Medical Expenses Breakup

**Please note:**  
\* Please select the correct hospital admission date and discharge date before providing bill details. If admission date or discharge date is changed after entering the bill details, your existing bill details will be lost.  
The Pre Hospitalization/Post Hospitalization/Hospitalization amounts are based on bill dates and DOA/DOD.

Serial No.	BillNo	Bill Date(MM/DD/YYYY)	Bill Amount(In INR)	Remarks	
					Add
1	1123	5/3/2021	12000	post hospitalization	Remove

Previous Save & Next

Click on "**Save and Next**" once all the details are filled.

On 3rd Page, employee KYC documents are to be updated (one time activity)

1 User details 2 Hospitalization details **3 KYC DETAILS** 3 Declaration and claim submission

### Complete your KYC now

As per IRDA guidelines, KYC is a mandatory requirement for claim processing. Please authenticate yourself to fill in the required details.

#### ID Proof of the beneficiary

Upload Front & Back of any of these documents

Government/MNC Employee ID

Government/MNC Employee ID

#### Address Proof of the beneficiary

Upload Front & Back of any of these documents

Valid lease agreement along with rent receipt

Valid lease agreement along with rent receipt

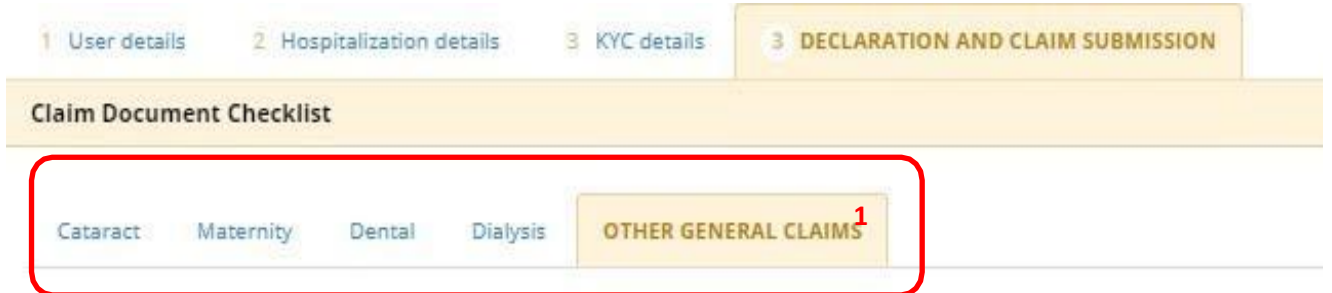
Previous Save & Next

**You will have to upload:**

- Photo ID Proof of the Employee
- Address Proof of the Employee

- After Moving to the final Page "Declaration and Claim Submission"

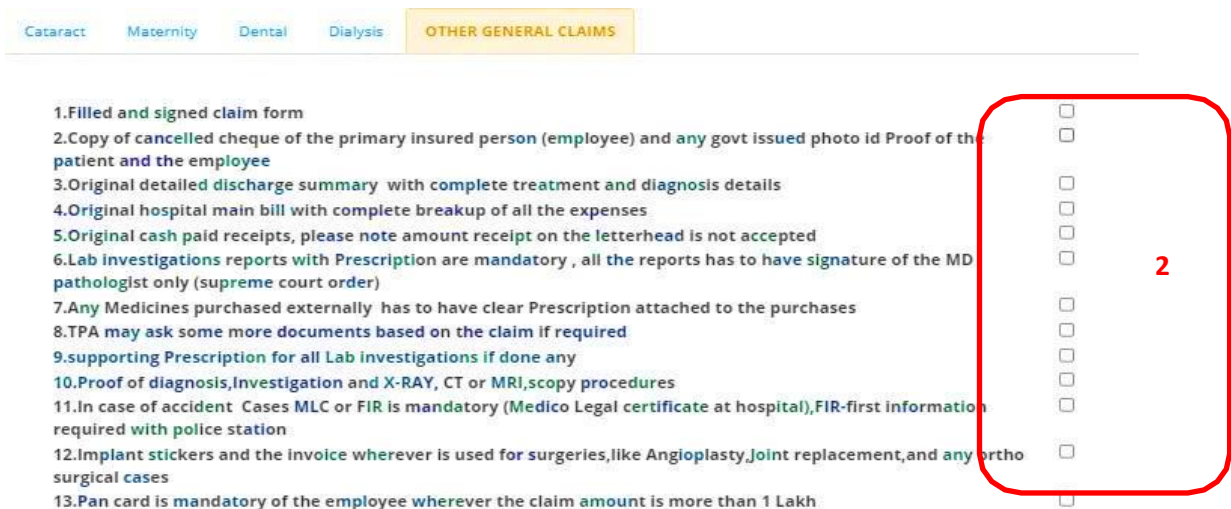
1. You will have to Select the ailment type.



1.Filled and signed claim form

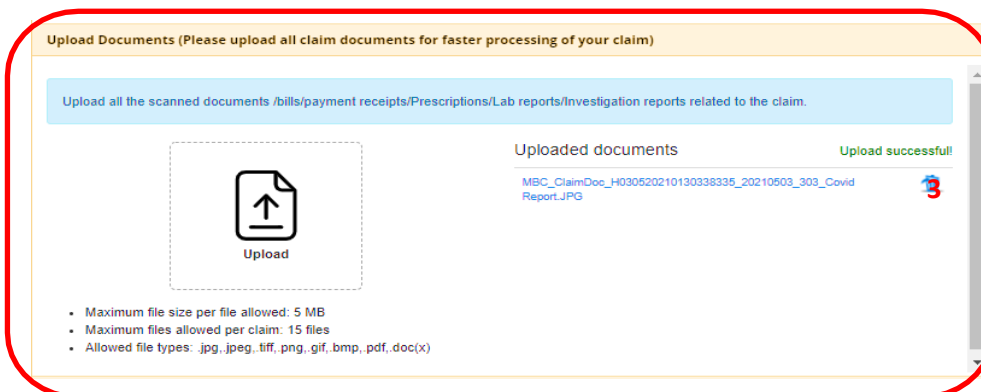
2.Copy of cancelled cheque of the primary insured person (employee) and any govt issued photo id Proof of

2. Click on the documents that you will be uploading.



**\*\*Online Claim form will be auto-generated based on the details filled in previous pages**

3. Upload the softcopy of the documents.



- Acknowledge the declaration of submitting the physical documents will not be used for claiming from any other policy.

Safeguard your Sum Insured amount against fraudulent activity by identifying unauthorized activities related to your insurance account. Authenticate a claim before it is registered under your insurance account. Count me in!

#### 4 Declaration

- I have attached the required soft copy of the document. Once the restrictions are lifted & situation gets under control, I will be in position to deliver the original documents to you. Request you to consider the same & process the claim on submitted documents. I also declare that these documents will not be used for claiming under any other policy and shall submit the same as and when it is called for or immediately after COVID 19 restriction are eased or lifted whichever is earlier. If any information & documents found to be misused by me in any manner the recovery of the claim amount, if any, will be borne by me.

#### Notes

- Click **submit** to successfully generate the claim form.

#### Claim Form

**Medi Assist** **Liberty General Insurance.**

CLAIM FORM - PART A' to 'CLAIM FORM FOR HEALTH INSURANCE POLICY

The issue of this Form is not to be taken as an admission of liability (To be filled in block letters)

**DETAILS OF PRIMARY INSURED** Section A

a) Policy No.: 4211-500101-20-7000285-00-000 b) St. No./Certificate No.:  
c) Company / TPA ID (MA ID) No.: 1 / 4033118734 d) Name: TEST EMPLOYEE  
e) Address:  
City: State: 5 Pin Code:  
Phone No.: 7343122713 Email ID: INAYAT.IRFAN@MEDIASSISTINDIA.COM

**DETAILS OF INSURANCE HISTORY** Section B

a) Currently covered by any other Mediciam / Health Insurance:  Yes  No b) Date of commencement of first Insurance without break:  
c) If yes, company name: Policy No.: 4211-500101-20-7000285-00-000  
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 Mediciam / Health insurance:  Yes  No  
f) If yes, company name:

**DETAILS OF INSURED PERSON HOSPITALIZED:** Section C

a) Name: TEST EMPLOYEE  
b) Gender:  Male  Female c) Age Years: Months:  
d) Date of birth:  
e) Relationship to Primary insured:  Self  Spouse  Child  Father  Mother  Other (Please Specify):  
f) Occupation:  Service  Self Employed  Home Maker  Student  Retired  Other (Please Specify):

An Auto-generated mail will be triggered to your registered Email ID containing the claim form.

# Thank you