

## **Claim Form - Part B**

## To Be Filled In By the Hospital

The issue of this Form is not to be taken as an admission of liability Please include the original preauthorization request form in lieu of PART A (To be filled in block letters) All the fields in the Claim Form are mandatory

1.	DETAILS OF HOSPITAL					
a.	Name of the hospital:					
b.	Hospital ID:					
c.	Hospital Email ID:					
d.	Type of Hospital:	Network No	n Network (if non netwo	ork fill section E)		
e.	Name of the treating doctor:			f. Qualification	1:	
g.	Registration No. with State Code.:			h. Phone No.	:	
2.	DETAILS OF THE PATIE	ENT ADMITTED				
a.	Name of the Patient:					
b.	IP Registration Number:				c. Gender: Male	Female
d.	Age:	Y Y Years M M Mon	nths e. Date of Birth:	D D M M Y Y Y	7	
f.	Date of Admission:	D D M M Y Y Y	Υ	g. Time:		
h.	Date of Discharge:	D D M M Y Y Y	Υ	i. Time:		
j.	Type of Admission:	Emergency Pla	nned Day Care	Maternity		
k.	If Maternity	i) Date of Delivery:	M M Y Y Y	ii) Gravida Status:		
	Status at time of	Discharge to home	Discharge to anothe	r hospital Deceased		
l.		Discharge to nome				
m.	discharge  Total claimed amount:	Rs.				
m.	discharge Total claimed amount:	Rs.				
m.	discharge Total claimed amount:  DETAILS OF AILMENT					
m.	discharge Total claimed amount:  DETAILS OF AILMENT  a)	Rs.	Description	b)	ICD 10 PCS	Description
m.	discharge Total claimed amount:  DETAILS OF AILMENT  a)  Primary Diagnosis:	Rs. DIAGNOSED (PRIMARY)		b) i. Procedure 1:	ICD 10 PCS	Description
m.  i. ii.	discharge Total claimed amount:  DETAILS OF AILMENT  a)  Primary Diagnosis:  Additional Diagnosis:	Rs. DIAGNOSED (PRIMARY)		b) i. Procedure 1: ii. Procedure 2:	ICD 10 PCS	Description
m. i. ii.	discharge Total claimed amount:  DETAILS OF AILMENT  a)  Primary Diagnosis: Additional Diagnosis: . Co-morbidities:	Rs. DIAGNOSED (PRIMARY)		b) i. Procedure 1: ii. Procedure 2: iii. Procedure 3:	ICD 10 PCS	Description
m. i. ii.	discharge Total claimed amount:  DETAILS OF AILMENT  a)  Primary Diagnosis:  Additional Diagnosis:	Rs. DIAGNOSED (PRIMARY)		b) i. Procedure 1: ii. Procedure 2:	ICD 10 PCS	Description
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i. ii. iii	discharge Total claimed amount:  DETAILS OF AILMENT  a)  Primary Diagnosis: Additional Diagnosis: . Co-morbidities: . Co-morbidities:	RS. DIAGNOSED (PRIMARY)  ICD 10 Codes	Description  No b) Pre	b) i. Procedure 1: ii. Procedure 2: iii. Procedure 3: iv. Details of Procedure:	ICD 10 PCS	Description
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m. 3. i. ii. iii. iv	discharge Total claimed amount:  DETAILS OF AILMENT  a) Primary Diagnosis: Additional Diagnosis: . Co-morbidities: . Co-morbidities: Pre-authorization obtain If authorization by netwo	RS. DIAGNOSED (PRIMARY)  ICD 10 Codes  ed: Yes  ork hospital not obtained, give	Description  No b) Prescreason:	b) i. Procedure 1: ii. Procedure 2: iii. Procedure 3: iv. Details of Procedure:		Description
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m.  i. ii. iii. iv  c)  d) i.	discharge Total claimed amount:  DETAILS OF AILMENT  a)  Primary Diagnosis: Additional Diagnosis: Co-morbidities: Co-morbidities: Pre-authorization obtain If authorization by network Hospitalization due to inj If Yes, give cause	RS.   DIAGNOSED (PRIMARY)  ICD 10 Codes  ed: Yes   Yes	Description  No b) Precreason:	i. Procedure 1: ii. Procedure 2: iii. Procedure 3: iv. Details of Procedure: e-authorization Number:	otion No	
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Duly filled and signed Claim Form Part A  All previous consultation papers (prior to hospitalization)  Duly filled and signed Claim Form Part B for a Hospitalization Claim  Proposer's Bank Account Details-Cancelled Cheque Leaf with Proposer name pre-printed OR Bank Passbook 1st page  Hospital Final Bill with breakup  Legal Heir / Succession Certificate in case of Proposer's Death	Duly filled and signed Claim Form Part A	Duly filled and signed Claim Form Part A   All previous consultation papers (prior to hospitalization)   Duly filled and signed Claim Form Part B for a Hospitalization Claim   Proposer's Bank Account Details-Cancelled Cheque Leaf with Proposer name pre-printed OB Bank Passbook is ta page   Hospital Final Bill with breakup   Legal Heir / Succession Certificate in case of Proposer's Death   Discharge Summary / Day-care Summary   Affidavit - NOC from other Legal Heirs on a Stamp Paper certified by a Public Notary (in case of Settlement to one Legal Heir)   In case of Death: Death Summary and Death Certificate   Nominee / Legal Heir Bank Account Details-Cancelled Cheque Leaf / Passbook / Bank Statement (in case of Proposer's Death)   Indoor Case papers (Hospital progress notes and nursing charts)   Pharmacy / Investigation / Diagnostic Bills with Prescriptions / Diagnostic Claim (if submission is Devond 30 days from date of discharge/event/last treatment date)   Doctor Consultation Bills and Papers   Invoice / Sticker for the implants used in the treatment   All Bill Payment Receipts   In case of Accident:   Medico Legal Case (MLC) / Accident Report (AR)   First Information Report (FIR)   Police Final Report    5. Addiress of the   Hospital:   Care   State:   Pincode:   City:   State:   Pincode:   Pincode:   Doctor Consultation Report (FIR)   Pincode:   Doctor Case   Pincode:   P	4.	. CLAIM DOCUME	ENTS	SUE	зміт	TED	- CI	HEC	K LI	ST:																												
Duly filled and signed Claim Form Part B for a Hospitalization Claim  Proposer's Bank Account Details-Cancelled Cheque Leaf with Proposer name pre-printed OR Bank Passbook 1st page  Hospital Final Bill with breakup  Legal Heir / Succession Certificate in case of Proposer's Death  Discharge Summary / Day-care Summary  Affidavit - NOC from other Legal Heirs on a Stamp Paper certified by a Public Notary (In case of Settlement to one Legal Heir)  Nominee / Legal Heir Bank Account Details-Cancelled Cheque Leaf / Passbook / Bank Statement (in case of Proposer's Death)  In case of Death: Death Summary and Death Certificate  Nominee / Legal Heir Bank Account Details-Cancelled Cheque Leaf / Passbook / Bank Statement (in case of Proposer's Death)  Indoor Case papers (Hospital progress notes and nursing charts)  Pharmacy / Investigation / Diagnostic Bills with Prescriptions / Diagnostic Compared to Pharmacy / Investigation / Diagnostic Bills with Prescriptions / Diagnostic Bills	Duly filled and signed Claim Form Part B for a Hospitalization Claim    Duly filled and signed Claim Form Part B for a Hospitalization Claim   Proposer's Bank Account Details-Cancelled Cheque Leaf with Proposer name pre-printed OR Bank Passbook 1st page   Hospital Final Bill with breakup   Legal Heir / Succession Certificate in case of Proposer's Death   Discharge Summary / Day-care Summary   Affidavit - NOC from other Legal Heirs on a Stamp Paper certified by a Public Notary (in case of Settlement to one Legal Heir)   In case of Death: Death Summary and Death Certificate   Nomine / Legal Heir Bank Account Details-Cancelled Cheque Leaf / Passbook / Bank Statement (in case of Proposer's Death)   Indoor Case papers (Hospital progress notes and nursing charts)   Pharmacy / Investigation / Diagnostic Bills with Prescriptions / Diagnostic   Pharmacy / Investigation / Diagnostic Bills with Prescriptions / Diagnostic Cancelled Cheque Leaf / Passbook / Bank Statement (in case of Proposer's Death)   Pharmacy / Investigation / Diagnostic Bills with Prescriptions / Diagnostic Bills with Pre	Duly filled and signed Claim Form Part B for a Hospitalization Claim    Droposer's Bank Account Details-Cancelled Cheque Leaf with Proposer name pre-printed OR Bank Passbook 1st page   Hospital Final Bill with breakup   Discharge Summary / Day-care Summary   Discharge Summary / Day-care Summary   Discharge Summary / Day-care Summary   Affidavit - NOC from other Legal Heirs on a Stamp Paper certified by a Public Notary (In case of Settlement to one Legal Heir)   In case of Death: Death Summary and Death Certificate   Nominee / Legal Heir Bank Account Details-Cancelled Cheque Leaf / Passbook / Bank Statement (in case of Proposer's Death)   Indoor Case papers (Hospital progress notes and nursing charts)   All investigation reports including CT / MRI / USG / HPE / ECG / X-Ray / MRI / CT Reports and Films   Doctor Consultation Bills and Papers   Invoice / Sticker for the implants used in the treatment date)   Doctor Consultation Bills and Papers   In Card issued by Employer (in case of Group Policy)   In case of Accident: Medico Legal Case (MLC) / Accident Report (AR)   First Information Report (FiR)   Police Final Report   Address of the Hospital:																																						
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All investigation reports Including CT / MRI / USG / HPE / ECG / X-Ray / MRI / Reason for delayed submission of claim (if submission is beyond 30 days from date of discharge/event/last treatment date)  Doctor Consultation Bills and Papers   Invoice / Sticker for the implants used in the treatment    All Bill Payment Receipts   ID Card issued by Employer (in case of Group Policy)  Proposer's ID Proof:   In case of Accident:   Medico Legal Case (MLC) / Accident Report (AR)    First Information Report (FIR)    Police Final Report    5. ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)  a. Address of the   Hospital:   Pin Code:    City:   State:   Pin Code:    D. Phone No.:   C. Registration No. with State Code:    D. Hospital PAN:   e. Number of Inpatient beds:    F. Facilities available in the hospital:   OT:   Yes   No    ICU:   Yes   No    No   ICU:   Yes   Yes	All investigation reports including CT / MRI / USG / HPE / ECG / X-Ray / MRI / Reason for delayed submission of claim (if submission is beyond 30 days from date of discharge/event/last treatment date)  Doctor Consultation Bills and Papers   Invoice / Sticker for the implants used in the treatment    All Bill Payment Receipts   ID Card issued by Employer (in case of Group Policy)    Proposer's ID Proof : PAN Card & Aadhaar Card (if CKYC not registered). If CKYC registered: CKYC form and CKYC number   In case of Accident: Medico Legal Case (MLC) / Accident Report (AR)    First Information Report (FIR)    Police Final Report    S. ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)    a. Address of the Hospital:   Pinal Code:   Phone No.:   Pinal Code:   Pinal Code:    b. Phone No.:   C. Registration No. with State Code:   Pinal Code:    d. Hospital PAN:   Pinal Code:   Pinal Code:    f. Facilities available in the hospital: OT:   Ves   No   ICU:   Yes   No    Others:   Others:   Others:   Others:   Others:   Others:    Others:	All investigation reports Including CT / MRI / USG / HPE / ECG / X-Ray / MRI / CT Reports and Films from date of discharge/event/last treatment date)  Doctor Consultation Bills and Papers   Invoice / Sticker for the implants used in the treatment date)  Doctor Consultation Bills and Papers   Invoice / Sticker for the implants used in the treatment    All Bill Payment Receipts   ID Card issued by Employer (in case of Group Policy)    Proposer's ID Proof:   PAN Card & Aadhaar Card (If CKYC not registered), If CKYC registered: CKYC form and CKYC number   In case of Accident:   Medico Legal Case (MLC) / Accident Report (AR)    First information Report (FIR)   Police Final Report    5. ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)    a. Address of the   Hospital:   Pin Code:    b. Phone No:   C. Registration No. with State Code:    d. Hospital PAN:   e. Number of Inpatient beds:    f. Facilities available in the hospital:   OT:   Yes   No    g. Others:   No   ICU:   Yes   No    Others:   Others:   Others:   Others:    6. DECLARATION BY THE HOSPITAL (PLEASE READ VERY CAREFULLY)		In case of Death:	: Death	n Sur	mmar	y and	d De	ath (	Cert	ifica	te																							e Le	eaf /			
CT Reports and Films  from date of discharge/event/last treatment date)  Doctor Consultation Bills and Papers  Invoice / Sticker for the implants used in the treatment  In Card issued by Employer (in case of Group Policy)  Proposer's ID Proof:  PAN Card & Aadhaar Card (if CKYC not registered).  If CKYC registered: CKYC form and CKYC number  First Information Report (FIR)  Police Final Report  5. ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)  a. Address of the Hospital:  City:  State:  D. Phone No.:  C. Registration No. with State Code:  d. Hospital PAN:  e. Number of Inpatient beds:  f. Facilities available in the hospital:  OT:  Yes  No	CT Reports and Films	CT Reports and Films		Indoor Case pape	ers (Ho	spit	al pro	gres	ss no	tes a	and	nur	sing	cha	rts)					F	har	macy	/ / In	vest	igat	ion ,	' Dia	gno	stic	Bill	ls wi	ith F	res	crip	tior	ıs / [	Diag	nost	tic	_
All Bill Payment Receipts    ID Card issued by Employer (in case of Group Policy)   Proposer's ID Proof:   PAN Card & Aadhaar Card (If CKYC not registered).   If CKYC registered: CKYC form and CKYC number   In case of Accident:   Medico Legal Case (MLC) / Accident Report (AR)   First Information Report (FIR)   Police Final Report	All Bill Payment Receipts   ID Card issued by Employer (in case of Group Policy)   Proposer's ID Proof: PAN Card & Aadhaar Card (if CKYC not registered). If CKYC registered: CKYC form and CKYC number   In case of Accident: Medico Legal Case (MLC) / Accident Report (AR) First Information Report (FIR) Police Final Report  5. ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)  a. Address of the Hospital: City: State: D. Phone No.: C. Registration No. with State Code: d. Hospital PAN: e. Number of Inpatient beds: f. Facilities available in the hospital: OT: Yes No ICU: Yes No Others:	All Bill Payment Receipts   D Card issued by Employer (in case of Group Policy)				ts In	cludin	g CT	/ MI	RI / L	JSG	/ HF	PE / I	ECG	/ X-	-Ray	/ MI	RI/																n is	bey	ond/	130	days	5	
Proposer's ID Proof: PAN Card & Aadhaar Card (If CKYC not registered). If CKYC registered: CKYC form and CKYC number  PAN Card & Aadhaar Card (If CKYC number  In case of Accident: Medico Legal Case (MLC) / Accident Report (AR) First Information Report (FIR) Police Final Report  5. ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)  a. Address of the Hospital: City:  City:  Description: City:	Proposer's ID Proof: PAN Card & Aadhaar Card (IF CKYC not registered). IF CKYC registered: CKYC form and CKYC number    In case of Accident:   Medico Legal Case (MLC) / Accident Report (AR)   First Information Report (FIR)   Police Final Report    State:	Proposer's ID Proof: PAN Card & Aadhaar Card (IF CKYC not registered). If CKYC registered: CKYC form and CKYC number  S. ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)  a. Address of the Hospital: City: D. Phone No: C. Registration No. with State Code: D. Phone No: D. Pacilities available in the hospital: OT: Yes No ICU: Yes No  G. DECLARATION BY THE HOSPITAL (PLEASE READ VERY CAREFULLY)		Doctor Consultat	tion Bi	lls aı	nd Pa <sub>l</sub>	pers												] [	nvoi	ce/	Stick	er fo	r th	ne im	plaı	ntsı	usec	l in	the	trea	atme	ent						
PAN Card & Aadhaar Card (If CKYC not registered).  If CKYC registered: CKYC form and CKYC number  Medico Legal Case (MLC) / Accident Report (AR) First Information Report (FIR) Police Final Report  5. ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)  a. Address of the Hospital:  City:  State:  Pin Code:  Description No. with State Co	PAN Card & Aadhaar Card (If CKYC not registered).  If CKYC registered: CKYC form and CKYC number  Medico Legal Case (MLC) / Accident Report (AR)  First Information Report (FIR)  Police Final Report  5. ADDITIONAL DETAILS IN CASE OF NON NETWORK HOSPITAL (ONLY FILL IN CASE OF NON-NETWORK HOSPITAL)  a. Address of the Hospital:  City:  City:  City:  C. Registration No. with State Code:  d. Hospital PAN:  F. Facilities available in the hospital:  OT:  Yes  No  ICU:  Yes  No  Others:	PAN Card & Aadhaar Card (IF CKYC not registered). If CKYC registered: CKYC form and CKYC number    Medico Legal Case (MLC) / Accident Report (AR)		All Bill Payment I	Receip	ts														]	D Ca	rd is	sued	by E	mp	loye	r (in	cas	e of	Gro	oup	Poli	су)							
a. Address of the Hospital:  City: State: Pin Code:  b. Phone No.: c. Registration No. with State Code: d. Hospital PAN: e. Number of Inpatient beds: f. Facilities available in the hospital: OT: Yes No ICU: Yes No	a. Address of the Hospital:  City: State: Pin Code:  b. Phone No.: c. Registration No. with State Code:  d. Hospital PAN: e. Number of Inpatient beds:  f. Facilities available in the hospital: OT: Yes No  Others:	a. Address of the Hospital:  City: State: Pin Code:  D. Phone No.: C. Registration No. with State Code:  d. Hospital PAN: e. Number of Inpatient beds:  F. Facilities available in the hospital: OT: Yes No  Others:  G. DECLARATION BY THE HOSPITAL (PLEASE READ VERY CAREFULLY)		PAN Card & Aadh	naar Ca							).								۱ F	/ledi irst	co Le Info	egal ( rmat	ase ion F	(ML Rep			den	t Re	por	rt (A	.R)								
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We hereby declare that the information furnished in this Claim Form is true & correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited.  Date:	statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited.			Place:		+		ㅡ	$\dashv$				$\neg$																			Sion	ıatı.	re a	and '	Seal	l ∩f +	ho L	loc.	r
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Authority:

GUIDANCE FOR	FILLING CLAIM FORM - PART B (To be filled in by	the hospital)
DATA ELEMENT	DESCRIPTION	FORMAT
	SECTION A - DETAILS OF HOSPITAL	
a) Name of Hospital	Enter the name of hospital	Name of hospital in full
b) Hospital ID	Enter ID number of hospital	As allocated by the TPA
c) Type of Hospital	Indicate whether In network or non network Hospital	Tick the right option
d) Name of treating doctor	Enter the name of the treating doctor	Name of doctor in full
e) Qualification	Enter the qualification of the treating doctor	Abbreviations of educational qualifications
f) Registration No. with State Code	Enter the registration number of the doctor along with the state code	As allocated by the Medical Council of India
g) Phone No.	Enter the phone number of doctor	Include STD code with telephone number
	SECTION B - DETAILS OF THE PATIENT ADMITTED	
a) Name of Patient	Enter the name of hospital	Name of hospital in full
b) IP Registration Number	Enter insurance provider registration number	As allotted by the insurance provider
c) Gender	Indicate Gender of the patient	Tick Male or Female
d) Age	Enter age of the patient	Number of years and months
e) Date of Birth	Enter date of birth of the patient	Use dd-mm-yy format
f) Date of Admission	Enter date of admission	Use dd-mm-yy format
g) Time	Enter time of admission	Use hh:mm format
h) Date of Discharge	Enter date of discharge	Use dd-mm-yy format
i) Time	Enter time of discharge	Use hh:mm format
j) Type of Admission	Indicate type of admission of patient	Tick the right option
k) If Maternity		
Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format
Gravida Status	Enter Gravida status if maternity	Use standard format
I) Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
m) Total claimed amount	Indicate the total claimed amount	In rupees (Do not enter paise values)
SEC	TION C - DETAILS OF AILMENT DIAGNOSED (PRIMA	ARY)
a) ICD 10 Code		
Primary Diagnosis	Enter the ICD 10 Code and description of the primary diagnosis	Standard Format and Open text
Additional Diagnosis	Enter the ICD 10 Code and description of the additional diagnosis	Standard Format and Open text
Co-morbidities	Enter the ICD 10 Code and description of the co-morbidities	Standard Format and Open text
b) ICD 10 PCS		
Procedure 1	Enter the ICD 10 PCS and description of the first procedure	Standard Format and Open text
Procedure 2	Enter the ICD 10 PCS and description of the second procedure	Standard Format and Open text
Procedure 3	Enter the ICD 10 PCS and description of the third procedure	Standard Format and Open text
Details of Procedure	Enter the details of the procedure	Open text
c) Pre-authorization obtained	Indicate whether pre-authorization obtained	Tick Yes or No
d) Pre-authorization Number	Enter pre-authorization number	As allotted by TPA
e) If authorization by network hospital not obtained, give reason	Enter reason for not obtaining pre-authorization number	Open text
f) Hospitalization due to injury	Indicate if hospitalization is due to injury	Tick Yes or No
Cause	Indicate cause of injury	Tick the right option
If injury due to substance abuse/alcohol consumption, test conducted to establish this	Indicate whether test conducted	Tick Yes or No
Medico Legal	Indicate whether injury is medico legal	Tick Yes or No
Reported To Police	Indicate whether police report was filed	Tick Yes or No

FIR No. Enter first information report number As issued by police authorities  If not reported to police, give reason Enter reason for not reporting to police Open Text  SECTION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST  Indicate which supporting documents are submitted
SECTION D - CLAIM DOCUMENTS SUBMITTED-CHECK LIST  Indicate which supporting documents are submitted
Indicate which supporting documents are submitted
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SECTION E - DETAILS IN CASE OF NON NETWORK HOSPITAL
a) Address Enter the full postal address Include Street, City and Pin Code
b) Phone No. Enter the phone number of hospital Include STD code with telephone number
c) Registration No. with State Code Enter the registration number of the doctor along with the state code As allocated by the Medical Council of India
d) Hospital PAN Enter the permanent account number As allocated by the Income Tax department
e) Number of Inpatient beds Enter the number of inpatient beds Digits
f) Facilities available in the hospital Indicate facilities available in the hospital Tick the right option. If others, please spec
SECTION F - DECLARATION BY THE HOSPITAL
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign and stamp