

Claim Adjudication

What is Claim Adjudication?

Claim Adjudication is the process by which a health insurance company **reviews, verifies, and decides** whether a submitted claim should be approved, partially approved, or rejected according to policy terms.

It ensures that claims are **valid, medically necessary, and covered** under the policy conditions.

In India, the process follows regulations issued by the **Insurance Regulatory and Development Authority of India (IRDAI)**.

Simple Example

Riya submits a reimbursement claim of **₹75,000** after hospitalization.

The insurer reviews:

- Policy coverage
- Medical reports
- Bills and receipts
- Waiting periods and exclusions

After verification:

- ₹68,000 is approved
- ₹7,000 is rejected (non-medical items)

This decision-making process is called **claim adjudication**.

Why is Claim Adjudication Important?

Prevents Fraud

Ensures only genuine and medically necessary claims are paid.

Protects Policyholders

Ensures fair and consistent claim decisions.

Ensures Policy Compliance

Claims are settled according to policy terms and coverage limits.

Maintains Insurance Sustainability

Controls unnecessary payouts, helping keep premiums stable.

How Does Claim Adjudication Work?

Step 1: Claim Submission

The policyholder or hospital submits claim documents to the insurer or TPA.

Step 2: Document Verification

The insurer checks:

- Policy validity
- Coverage eligibility
- Waiting periods
- Sum insured availability

Step 3: Medical Evaluation

Medical experts review:

- Diagnosis
- Treatment necessity
- Hospitalization requirement

Step 4: Policy Terms Check

The insurer evaluates:

- Exclusions

- Sub-limits
- Co-payment or deductible
- Coverage limits

Step 5: Decision

The insurer decides:

- **Approved** → Full payment
- **Partially Approved** → Some expenses rejected
- **Rejected** → Claim denied with reason

Step 6: Settlement

Payment is made to:

- Hospital (cashless claim), or
- Policyholder (reimbursement claim)

Types of Claim Decisions

Approved Claim

All eligible expenses are covered as per policy.

Partially Approved Claim

Some expenses are not covered (e.g., consumables or non-medical items).

Rejected Claim

Claim denied due to policy violations or exclusions.

What is Checked During Adjudication?

- Policy status (active or lapsed)
- Waiting period completion
- Coverage of illness/treatment

- Hospital eligibility
- Medical necessity
- Fraud or misrepresentation
- Previous claims history

Key Features of Claim Adjudication

Evidence-Based Process

Decisions are based on documents and medical records.

Time-Bound Process

Insurers must process claims within timelines defined by IRDAI.

Transparency

Insurers must provide reasons for claim rejection.

Grievance Redressal Available

Policyholders can appeal if dissatisfied with the decision.

Claim Adjudication vs Claim Settlement

Feature	Claim Adjudication	Claim Settlement
Meaning	Evaluation of claim	Payment of approved claim
Stage	Before payment	After approval
Purpose	Decide eligibility	Pay eligible amount

Common Reasons for Claim Rejection

- Policy inactive or premium unpaid
- Waiting period not completed
- Treatment excluded under policy

- Incomplete documentation
- Non-disclosure of medical history
- Treatment not medically necessary

Documents Required for Adjudication

- Claim form
- Hospital bills and receipts
- Discharge summary
- Doctor's prescription
- Diagnostic test reports
- ID proof and policy details

Common Mistakes to Avoid

- Submitting incomplete documents
- Hiding pre-existing illnesses
- Delaying claim submission
- Not reading policy exclusions
- Claiming non-medical expenses

Legal / Policy Aspects

As per IRDAI guidelines:

- Insurers must provide clear reasons for rejection.
- Claims must be processed within specified timelines.
- Policyholders can file complaints through insurer grievance cells or the Insurance Ombudsman.

Final Word

Claim adjudication is the backbone of the health insurance claim process. It ensures that claims are genuine, policy-compliant, and medically necessary. Understanding this process helps policyholders submit proper documentation and improves the chances of smooth and timely claim settlement.