IN-PATIENT MEDICAL EXPENSES INSURANCE
CLAIM FORM

NOTE:
This form is to be supported with paid receipts, prescriptions and discharge summary* of the hospital in original.

POLICY PARTICULARS:
Emp No.: _____
Policy No.: _____
Name of Assured: _____
Name of Person requiring medical attention: _____
Category/Serial no. in the list of policy: _____
Age of Person hospitalised: _____

DETAILS OF ILLNESS:
Date of illness first noticed: _____
Date of recovery: _____
Description of illness: _____
Has the claimant suffered from this illness before? YES/NO
If yes, please give date(s) and details: _____
_____

DETAILS OF HOSPITAL:
Name of Hospital attended: _____
Name of medical practitioner consulted: _____
Period of confinement: From: _____ To: _____
Were any drugs prescribed: Yes/No _____
If yes, please list the drugs prescribed and administered: _____
_____

OTHER INSURANCE:
Is the patient entitled to payment under any other insurance in respect of this ailment? Yes/No
If yes, please give details: _____

AMOUNT OF CLAIM:
Please list in the column below all expenses claimed and attach original (not photocopies) of all relevant paid receipt supported by relevant prescriptions and discharge summary*

Name of expenses	Amount
Total	

*Discharge summary means a concise description of the patient's hospitalisation entered into the medical record, including the reasons for admission, findings of laboratory testing and other diagnostic procedures, the discharge diagnostic provided by the attending physician upon the patient's discharge from the hospital and instructions for the patient.

DECLARATION BY THE INSURED PERSON & ASSURED:

(a) To be signed by the Insured Person

I declare that to the best of my knowledge and belief the statements contained herein are true and that all relevant information has been disclosed.

Date: _____ Signature: _____

(b) To be signed by an official of the Assured

I confirm that at the date of claims the member of whose behalf this claim is made, was an eligible employee in terms of the policy.

Date: _____ Signature: _____

(c) Declaration by the attending Doctor

I confirm having treated Mr/Mrs/Miss: _____

_____

between the dates _____ and _____
and that the details shown on this form are consistent with my own knowledge of the patient.

Date: _____ Signature: _____

NOTE:
For speedy settlement of the claim, we request you to please fill in each and every column with as much details as possible. Please do not leave any column blank.

FOR OFFICIAL USE ONLY

i. Is the person covered under the policy? Yes/No _____
ii. What is the insured maximum limit
Per ailment Rs. _____
R/B-Limit Rs. _____
PC-Limit (if concerned) Rs. _____

iii. Are the bills/prescriptions attached in order? Yes/No. _____
iv. Is the amount claimed within the limit Yes/No. _____
v. Amount claimed: _____
vi. Amount approved: _____
vii. Signature of approver: _____