

(c) Registration No.

6. (a) Name and Address of the Hospital/Nursing Home/Clinic : _____
Pin Code _____
State/U.Territory _____

(b) Date of Admission : Date Month Year

(c) Date of Discharge : Date Month Year

7. If the claim is for Domicilliary Hospitaliation

Please indicate

(a) Date of Commencement of treatment : Date Month Year

(b) Date of completion of treatment : Date Month Year

(c) Name & Address of attending Medical Practitioner :

(d) Telephone No.

(e) Registration No.

I have incurred on the treatment of Disease/illness/Accident referred to above, the expenses as per the details given by me in the Schedule of Expenses given overleaf.

In support of the above claim, I enclose the following documents (Please indicate by ►)

1. Bill, Receipt and Discharge certificate/card from the Hospital.
2. Cash Memos from the Hospital/Chemist(s), supported by the proper prescription.
3. Receipt and Pathological test reports from a pathologist supported by the note from the attending medical Practitioner/surgeon demanding such pathological test.
4. Surgeon's certificate stating nature of operation performed and Surgeon's bill and receipts.
5. Attending Doctor's/Consultant's /Specialist's/ Aneasthetist's bill and receipt and certificate regarding diagnosis.
6. In case of Domiciliary Hospitalisation, receipt from a qualified nurse who attended the patient at his/her residence duly supported by a certificate from attending Medical practitioner.
7. Certificate from the attending Medical practitioner giving reasons for allowing treatment home.
8. Certificate from the attending Medical Practitioner/Surgeon that the Patient is fully cured.

I hereby warrant the truth of the foregoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppression or concealment, my right to claim reimbursement of the said expenses shall be absolutely forfeited, I further declare that, in respect of the above treatment, no benefits are admissible under any other Medical Scheme or Insurance.

Dated at _____ tjos _____ of _____ 200

Signature of the Claimant

FOR OFFICE USE ONLY:

DATE OF CLAIM

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Policy No. _____ Scheme A/B _____ Category of Benefits _____ Claim No.

SCHEDULE OF EXPENSES INCURRED BY THE CLAIMANT		FOR OFFICE USE ONLY	
Details of Expenses claimed under Hospitalisation/Domiciliary Hospitalisation (To be supported by Bills/Receipts Cash memos etc.)	Amount Claimed (1)	Amount not Payable (2)	Net Payable (1)-(2)-(3)
1. (A) HOSPITALISATION BENEFIT: (i) Room Board, Nursing expenses (including Boarding to be provided by the Hospital) for _____ days _____ <input type="text"/> <input type="text"/>		<input type="text"/> <input type="text"/> <input type="text"/>	
(ii) I.C. Unit For _____ days _____ <input type="text"/> <input type="text"/>		<input type="text"/> <input type="text"/> <input type="text"/>	
(B) Hospitalisation Benefits other than Room, Board & Nursing Expenses & ICCU(including Pre & Post Hospitalisation) <input type="text"/> <input type="text"/>		<input type="text"/> <input type="text"/> <input type="text"/>	
1. Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists fees. <input type="text"/> <input type="text"/>		<input type="text"/> <input type="text"/> <input type="text"/>	
2. Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines & Drugs, Diagnostic materials & X-ray dialysis, Chemotherapy, cost of Pacemaker, artificial limbs & cost of Organs and similar other expenses. <input type="text"/> <input type="text"/>		<input type="text"/> <input type="text"/> <input type="text"/>	
		<input type="text"/> <input type="text"/> <input type="text"/>	
		<input type="text"/> <input type="text"/> <input type="text"/>	

