CLAIM NO :- CORP / CL /

STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED

Corporate Office : 1, New Tank Street, Valluvarkottam High Road, Chennai - 600 034.

CLAIM FORM FOR MEDICAL INSURANCE

Issuance of this form does not amount to admission of liability under the policy. Customer ID

Please furnish the following information correctly to enable the Company to process your claim

Name of the Insured — First Name | Middle Name | Last Name

Name of the person for whome the claim is made — First Name | Middle Name | Last Name

Relationship with the Insured

Address for Communication

City/Taluk | District | State | Pincode

STD Code | Phone No. | Fax | Cell

Policy Number | Period of Insurance : From | To

Sum Insured | Previous Policy No: | Period :

ID Card No. | E-mail :

Nature of Disease/ Illness Contracted or Injury Sustained :

Date of Injury Sustained for Disease / Illness First Detected — D D M M Y Y

Name of the Hospital

Address

City / Taluk | District | State | Pincode

Date & time of admission | Date & time of Discharge

Name of the Medial Practitioner

Address

City/Taluk | District | State | Pincode

Qualification | Regn. No.

Have you been insured under any mediclaim Scheme of any other insurance Company. If YES, XEROX, Copies of previous year's policies must be enclosed. Y N

Date of commencement of very first insurance for the claimant with continuous insurance Coverage : From To

Have you preferred any claim for the same insured under the Mediclaim Policy earlier, If so give details viz :

(a) Previous claim No & Office

(b) Diagnosis

(c) Whether Settled [Y] [N] Repudiated [Y] [N]

(d) Amount of settlement

(e) Admitted on Date Time

(f) Discharged on Date Time

DETAILS OF CURRENT CLAIM BILLS

Financial Details : Bill Amount Claim Amount

I have incurred the above expensed for the treatment of the disease/illness/accident and herewith as per schedule mentioned below:

Date	Bill No.	Description	Bill Amount	Amount Claimed	Claim type (Pre- Hospitalization/ Post-Hospitalization/Hospitalization)
		GRAND TOTAL			

*If required, additional sheet to be attached

In support ot the claim, I enclose the following documents

Claim Form Duly Signed [Y] [N]

Pre-authorization form [Y] [N]

Claim Notification [Y] [N]

Discharge Summary [Y] [N]

Hospitalization Bills [Y] [N]

Doctors Surgery Certificate if any [Y] [N]

Surgery/Consultation Bills if any [Y] [N]

Operation Theatre Pharmacy Bills [Y] [N]

Medicines Bills with Dr's Prescription [Y] [N]

Pre-Hospitalization Bills : No(s) .....Bill Amount..... [Y] [N]

Hospital Payment Receipt [Y] [N]

Investigation Report with Dr's request [Y] [N]

1) MRI Yes/No. 2) CT Scan Yes/No [Y] [N]
3) ECG Yes/No. 4) X-ray Yes/No
5) US Scan Yes/No.

Lab Reports with Dr's request No(s) .....of [Y] [N]
Rep.....other if any

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 for feited. I further declare that, in respect of the above treatment, no benefits are admissible under any other rMedical Scheme or insurance.

I also consent and authorize Star Health And Allied Insurance Company to seek medical information from any Hospital/ Medical Practitioner who has any time attended on the insured person.

I hereby declare that I have included all bills/receipts for purpose of this claim and that I will not be making any supplementary claim in respect thereof.

Date :

Signature of Claimant

MEDICAL CERTIFICATE TO BE FILLED IN BY THE TREATING DOCTOR

1.	Name of the Patient & Age	
2.	Admission Date and Time	Discharge Date And Time
3.	Name of Surgeon / Physician	
4.	Diagnosis	
5.	Date of First Consultation (Prior to hospitalisation)	
6.	(a) With What compliants was the patient admitted for:	
	(b) Since when was the patient suffering from the said complaints	
7.	Past History of the Patient (if any) with the duration of illness	
.8.	Whether the present ailment is a complication of Pre-existing disease?	
	If yes, please specify the disease (or) complication of any previous surgery done? If yes, please specify details.	
9.	Whether the disease/disorder is congential in nature?	
10.	Nature of Surgery/treatment given for present ailment	
11.	(a) Whether Hospital/Nursing Home is Registered, if yes, Regn. No.	
	(b) No. of in - patient beds in the Hospital (including ICU)	
	(C) Whether the Hospital is having fully equipped Operation Theatre of its own/qualified nurses round the clock/Qualified doctors round the clock?	

Signature of the Doctor with Seal

Date

Hospital Seal :