

HOSPITALIZATION CLAIM FORM FOR REIMBURSEMENT

Issuance of this form does not amount to admission of any liability under the claim on the part of the insurers. Please give the following information correctly & completely.

(TO BE FILLED IN BLOCK LETTERS)

CLAIM CONTROL NO: _____

1. NAME OF INSURED _____ TEL. _____
2. POLICY NO: _____
3. DETAIL OF THE CLAIMANT:
(In respect of whom the claim is made)
 - a. Name of Claimant: _____
 - b. Relationship with insured: _____
 - c. Present age: _____
4. a) Nature of Disease/Illness contracted of injury suffered: _____

b) Date of injury, or Disease/ Ailment contracted/ Detected, for which the expenses are claimed herby
 - i) When 1st detected: _____
 - ii) When cured: _____
 - iii) If not cured, give complete history _____

5. Name & address of the hospital/nursing home/clinic admitted to
 - i) Date & time of admission: _____
 - ii) Date & time of discharge: _____
6. Total amount claimed: _____

I have on the treatment of disease/ Illness / injury referred to above. In support of the above claim, I enclose the following documents: **(Please tick the followings)**

- a) Discharge Summary of the Hospital/ Nursing home.
- b) Cash Memo/ Bills supported by proper prescription.
- c) Receipt, Pathological test reports supported with prescription.
- d) Hospital bill with receipt of payment.
- e) Breakup of each heads of hospital bill.
- f) Any other detail/ documents which substantiate the claim.
- g) Hospital Declaration Form (Over leaf to be filled by the hospital)

I hereby warrant the truth of the foregoing particulars in every respect & I agree that if I have made or shall make any false or untrue statement or concealment my right to claim reimbursement of the 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.

Signature of Insured

Signature of Claimant