HOSPITALISATION CLAIM FORM

Issuance of this form does not amount to admission of any liability under ther claim on the part of the insurers

Policy Holder Information				Patient Information		
Name:				Name:		
Card ID No.				Relation		
Address:				UHIDof Provider Tel: # Policy Holder- E-mail:		
City:	State:		Pin:			
Provider Information						
Name:				Provider Information Number (UPIN/MCI NO.):		
Address:				City :	State:	Pin:
Claim Information						
Admission Date		Time:		Notes:		
Patient Status:						
First Occurance Date:						
Discharge Date:		Time:				
Patient Paid Amount:						
Principal Diagnosis:						
Other Diagnosis:						
Procedure Code:				Disease Code:		

Serviceline Information

S.No.	Service Description	Amount	Discount	Net Amount	Patient Paid Amount	Balance Due	Ramarks
	Room Charges						
	ICU/CCU/Nursery Charges						
	Doctor's Fee						
	Lab Investigation						
	Radiology						
	Other Investigation						
	Specical Procedure						
	Pharmacy Service						
	OT/ Labour Room Service						
	Misc.						

List of Enclosures (Please Tick)	Comments/Remarks / Objections
☐ Pre authorisation / First Admission Report ☐ Discharge Summary ☐ Hospitalizaion Bills with breakups ☐ Investigation Reports ☐ Consultation bills with Receipt ☐ If Surgery, Surgery bills with Receipt ☐ Medicine bills with prescriptions ☐ OT Pharmacy Bills ☐ Others	

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, suppression 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.

Provider Representative		Policy Holder/Patient
Name:	Date:	Name:
		Date:
Signature:		Signature: