

**SUPPLEMENTARY CLAIM FORM**

<b>Policy Holder Information</b>			<b>Patient Information</b>		
Policy No.			Name:		
Name:			Relation:		
Card ID:					
Address:			UHID of Provider:		
			Tel.:		
			E-mail:		
City:	State:	Pin:	Discharge Date:		
<b>Claim Information</b>					
Admission Date:			Time:		
First Occurrence date:			Diagnosis:		
S. No.	Name of Hospital/ Clinic/ Doctor	Service/ Product	Bill No.	Bill Date	Amount Claimed/ * Claim Type
<b>Total Amount:</b>			<b>Comments/ Remarks/ Objections</b>		
<input type="checkbox"/> Pre authorization/ first Admission Report <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Hospitalization Bills with breakups <input type="checkbox"/> Investigation Reports <input type="checkbox"/> Consultation bills with Receipt <input type="checkbox"/> If Surgery, Surgery bills with Receipt <input type="checkbox"/> Medicine bills with prescriptions <input type="checkbox"/> OT Pharmacy Bills <input type="checkbox"/> Others  _____ _____ _____					
<b>Provider Representative</b>			<b>Policy Holder/ Patient</b>		
Name			Name		
Date			Date		
Signature			Signature		