1.1. CLAIM FORM FOR IN PATIENT TREATMENT
(TO BE COMPLEDED BY THE INSURED)

I ……………………………………………………………………………………………………..policyholder of policy No……………………………………….wish to submit a claim for reimbursement of expenses related to the illness/ injury prescribed in the informative form for inpatient treatment.

Patient details

Name:	D.O.B.
Address:	
Telephones:	I.D. No.
e-mail address:	
Details for the illness/ injury :	
Hospital:	Doctor:

Payment
Choose:

○ Payment to the Policyholder

○ Issue a cheque to the hospital that treated me (The company is not committed to any hospital for any amount)

Reimbursement by other provider
Please inform us if you are receiving any reimbursement by any other provider (i.e. other insurance company, medical fund etc.)

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Policyholder's Signature……………………………………………………..Date…………………………….

Declaration and Authorization
I hereby declare that all information given in this form and in the Informative form for in-patient treatment are true and complete and authorize the company or any Authorized Company for Claims Handling to get any information in respect of my physical and mental health from any person or institution. I also authorize sharing of such information for the purpose of this claim settlement.

Patient's Signature…………………………………………………………….

Date……………………………………………

TO PROCEED WITH THE EXAMINATION OF YOUR CLAIM, THE LABORATORY TEST RESULTS SHOULD BE SUBMITTED

Warning: All supporting documentation (originals) must be provided along with the claim forms

Supporting Documentation for in-patient treatment

1. Claim forms (fully completed)
2. Payment settlement
3. Discharge note
4. Medical Expert's Advice
5. Operating theater records (If applicable)
6. Laboratory tests/ analysis's outcomes (If applicable)
7. Medical history/ Doctors reports
8. Medicines Card
9. Vitals Card
10. Medical & Nursing instructions card
11. Ambulance charge (If applicable)
12. Anesthesiologist's fees
13. Assistant surgeon's fees
14. Doctor's fees
15. Histological examination (If applicable)
16. M.R.I. (If applicable)
17. X-RAYS (If applicable)
18. E.C.G. (If applicable)
19. CT SCANS (If applicable)
20. Blood tests or Urine tests (If applicable)
21. Biopsy (If applicable)
22. Physiotherapy (If applicable)
23. Hospital/ Clinic/ Doctors invoices
24. Affirmation of contribution by any Fund or Organization (If applicable)
25. Consumables invoice
26. Medicines invoices
27. Receipts of payments (If applicable)