MDINDIA HEALTHCARE SERVICES (TPA) PVT. LTD. 904, Meridian Towers, 9th Floor, Near Rajkumar Cinema, Udhana Darwaja, Ring Road, Surat – 395002 Tel.No. 0261- 2343009 Fax No. 0261 – 2345335 Email: surat@mdindia.com –Website: www.mdindia.com



<u>CLAIM FORM</u>								
	National Insurance Company The New India Assurance Company							
	Oriental Insurance Company	The United	l India Insurance	Company				
1.	Current Policy no.	$\overline{}$						
2.	MDIndia ID No.: MDI5-							
3.	Corporate Name : Employee Code :							
	Name & Address of the Policy Holder:							
5.	5. Name of the Patient:							
6.	6. Present Contact Address:							
	7. Contact No. (Resi. / Office): Mobile No.:							
8. Have you preferred any claim for the same <u>Insured under</u> the Mediclaim scheme earlier, if so give details viz								
Sr. No.	Particulars	Claim 1	Claim 2	Claim 3	Claim 4			
(a)	Policy Number							
(b)	Date of Admission							
(c)	Date of Discharge							
(d)	Diagnosis							
(e)	Whether settled / repudiated							
(f)	Claim Amount (if settled): Rs .							
9.	Since when the person covered un-			_ yrs.				
10.	If the claim is of Domiciliary Hosp	pitalization please inc	dicate					
	a) Date of Commencement of the treatment							
	b) Date of Completion of treatment							
	c) Name & Address of attending Medical Practitioner							
	_	gistration No		Qualification				

11. Details of Expenses incurred by the Claimant

SR. NO.	DATE	BILL No	PARTICULARS	AMOUNT CLAIMED
			GRAND TOTAL:	

NOTE: Please attach the sheets if Necessary

In support of the claim, I enclose the following documents

Sr. No.	Particulars	Yes / No Tick		Sr. No.	Particulars		Yes / No Tick	
1	Policy Schedule / Policy Copy			8	Prescriptions*			
2	Discharge Card / Summary*			9	Pre Hospitalization Medical Bills*			
3	Final Hospital Bill*			10	Post Hospitalization Medical Bills*			
4	Surgeon's Certificate (In all cases of surgery explaining the procedure)			11	Medical Reports*& MLC / FIR (for accident cases)			
5	Attending Doctor's / Consultant's / Specialist's / Anesthetist's bill receipt and certificate regarding diagnosis *			12	Hospital Payment Receipt*			
6	Certificate from attending Medical Practitioner giving reasons for allowing treatment at home.*			13	Indoor Case Papers (preferably for all claims above 1 lakh)			
7	Certificate from attending Medical Practitioner /Surgeon that the patient is fully cured.*			14	Previous Policy Copies, if any			

* These documents to be submitted as original.

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

I hereby declare that the above information is true & correct to the best of my knowledge and belief. If I have made any false,

fraud or untrue statement, suppression or concealment, my right to claim reimbursement of the expenses shall be forfeited.

I also consent and authorize MDINDIA / 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, except the post Hospitalization claim if any.

Signature of Policy Holder

MEDICLAIM MEDICAL REPORT (MMR)

CERTIFICATE FROM ATTENDING DOCTOR OF CLAIMANT FROM THE NURSING HOME/HOSPITAL

1. Name of Patient:-							
2.	Age: DOB:/ Sex: M F						
3.	Are you a family doctor of patient?:- Yes / No Since: yrs						
4.	Who referred the case to you?						
5.	When did the patient approach you for the first time in connection with present disease suffered?						
	Date of First Consultation:						
6.	Details of previous history of disease / surgery (if any) of patient?						
7.	Is the patient suffering from Diabetes, Hypertension (Blood Pressure), Kidney problems, Cancer T.B., Heart Problem and AIDS or other disease? If yes (Since how long he or she may be suffering from the same.):-						
9.]	Present disease suffered (Diagnosis):-						
10.	Duration of present disease suffered (i.e. since how long he or she may be suffering from present disease before approaching you):-						
11.	. Is the present disease suffered connected to previous disease or Diabetes, Hypertension (Blood Pressure), Surgery or other existing disease? :-						
12.	Is disease suffered Acute or Chronic? :						
13.	B. Whether the disease is caused due to any congenital defects (Yes/No)?						
14.	4. Whether the patient had any complications during or after pregnancy (Yes/No)?						

(Yes/No):	ectly or indirectly due to the use of alcohol or drugs						
16. Could the patient have been aware the illness	ss or disease of which treatment is being taken now?						
If yes since when? (Approx. period of illness):-							
Date when the illness / injury was sustained	Date when the illness / injury was sustained:						
17. Is the disease suffered requires hospitalizati	on? :- Yes / No						
a) Nature of treatment given :-Open	rative / I.V.Fluid / Injection / Oral Treatment / Other Parenteral Treatment						
b) Indoor case no. of the patient Ho	ospital / Nursing home:						
18. Date of Admission:	Time of admission:						
19. Date of Discharge:	Time of discharge:						
20. Is your hospital registered with local authority? If yes, please attaché xerox copy of certificat Registration Number of Hospital:							
21. No. of total beds in your Nursing Home / H	ospital:						
patient:-	e (if any) connected to present disease suffered by the						
23. "Whether the patient is fully cured or not?"	Yes / No						
Certified that the details furnished above are true to th hospital.	e best of my knowledge and as per the records available at this						
Doctor's Name:	Qualification: Registration No:						
Contact No:							
Date://	Signature of Attending Doctor						
(With rubber stamp and regis	stration no. of your Nursing Home / Hospital)						
Name of Policy Holder:							
Date:/							

Signature of Policy Holder