



7.	(a) Name &Address of the attending Medical Practitioner	: .....
	(b) Qualification & Telephone No.	: .....
	(c) Registration No.	: ..... .....
8.	(a) Name & Address of the Hospital / Nursing Home / Clinic	: .....
		Pin Code .....
		State /U. Territory .....
	(b) Date of Admission	: .....
	(c) Date of Discharge	: .....
9.	If the claim is for Domiciliary Hospitalisation, Please indicate	: .....
	(a) Date of Commencement of treatment	:
	(b) Date of Completion of treatment	: .....
	(c) Name & Address of attending Medical Practitioner	: .....
	(d) Telephone No.	: .....
	(e) Registration No.	: .....

I have incurred on the treatment of disease / illness accident referred to above, the expenses as per the details given by me in the Schedule of Expenses given overleaf.

In support of the above claim , I enclose the following documents (Please indicate by ) :-

1. Bill Receipt and Discharge Certificate / Card from the Hospital.
2. Cash Memos from the Hospital / Chemist(s) , supported by the proper prescription.
3. Receipt and pathological test reports from a pathologist supported by the note from the attending Medical Practitioner / Surgeon demanding such Pathological Tests.
4. Surgeon's certificate Stating nature of operation performed and surgeon's bill and receipt.
5. Attending Doctor's / Consultant's / Specialist's / Aneasthetist's bill and receipt and certificate regarding diagnosis.
6. In case of domiciliary Hospitalisation , receipt from a qualified nurse who attended the patient at his / her residence duly supported by a certificate from attending Medical Practitioner.
7. Certificate from the attending Medical Practitioner giving reasons for allowing treatment at home.

8. Certificate from the attending Medical Practitioner / Surgeon that the patient is fully cured.

I hereby warrant the truth of the foregoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppression or concealments, my right to claim reimbursement of the said expenses shall be absolutely fortified. I further declare that, in respect of the above treatment, no benefits are admissible under any other Medical Scheme or Insurance.

Dated .....this .....day of .....200

Signature of the Claimant

FOR OFFICE USE :

Date of Claim

CLAIM NO. CL

POLICY NO. SCHEME A/B  
CATEGORY OF BENEFIT.....

SCHEDULE OF EXPENSES INCURRED BY THE CLAIMANT	TO BE FILLED IN BY THE CLAIMANT	FOR OFFICE USE ONLY			
		Amount Available (2)	Amount Payable (3)	Amount not payable (1-3) (4)	Balance benefit to the credit (2-3) (5)
Details of expenses claimed under Hospitalisation / Domiciliary Hospitalisation (To be supported by Bills / Receipt , Cash Memo etc.)	Amount Claimed (1)				

<b>I.</b> <b>(A) HOSPITALISATION BENEFITS:</b> (a) Room , Board, Nursing Expenses For ....days.....@ .....per day  (b) I.C.Unit For ....days .....@ ....per day					
<b>(B) Hospitalisation Benefits other than          Room Board &amp; Nursing expenses &amp;          ICCU (including Pre &amp; Post          Hospitalisation)</b>  1. Surgeon , Anaesthetist, Medical Practitioner , Consultants , Specialists fees  2. Anaesthesia , Blood , oxygen , Operation Theatre charges , Surgical Appliances , Medicines & Drugs , Diagnostic, Materials & X-Ray , Dialysis , Chemotherapy , Radiotherapy , cost of Pacemaker artificial limbs & cost of Organs and similar other expenses.					
<b>II.</b> <b>DOMICILIARY HOSPITALISATION :</b>  1. Medical Practitioners, Consultants & Specialists fees for visits etc.  2. Blood , Oxygen , Diagnostic materials , X-ray , Employment of qualified Nurses, Medicines and Drugs and similar expenses.					
<b>III.</b> <b>COST OF HEALTH CHECK-UP</b>					
<b>TOTAL RS.</b>					
Date : Place:					
Signature of the Claimant					
Checked By :	<b>FOR OFFICE USE ONLY</b> Total amount payable under the claim      Rs.....  Less : Advance on account payable, if any      Rs. ....  Net amount payable      Rs. ....				
Approved By:	In case entire claim is not admissible , reasons thereof				
Passed for payment of Rs. ....					
<b>COMPETENT AUTHORITY</b>					