SOW 20000 - 10-2003

Form No. Medi. - 6 w.e.f. 1-10-02

THE NEW INDIA ASSURANCE Co. LTD.

REGD. & HEAD OFF. : NEW INDIA ASSURANCE BLDG.,
87, M.G. ROAD, FORT, MUMBAI-400 001.

CLAIM NUMBER		

MEDI-CLAIM FORM

FOR OFFICE USE

Issuance of this form does not amount to admission of any liability under the policy on the part of the insurer. Please give the following information correctly and completely to enable us to process your claim promptly. If claim is under Personal Accident Insurance, please complete a Personal Accident Claim Form. (All date to be entered as Datel MonthlYear

1. a) Name of the Insured (in whose name policy issued) :	
2. Details of the Insured Person : (in respect of whom claim is made) a) Name & Relationship with the Insured : b) Personal Complete Age c) Occupation d) Residential Address	
3. Policy Number (In full)	
4. Nature of Disease / illness / injury sustained	
5. Date on which injury sustained / Diseases first Contracted	
6. a) Name & Full Address of the attending Medical Practitioner b) Qualification & Telephone No. c) Registration No.	Pin Code State/U. Territory
7. a) Name & Full Address of the Hospital / Nursing Home / Clinic b) Date of Admission c) Date of Discharge	Pin Code State/U. Territory
8. If the claim is for Domic;ary Hospitalisation, Please irlcicate a) Date of Commencement uj Treatment b) Date of Completion of Treatment c) Name & Address of attending Medical Practitioner d) Telephone No. 8) Registration No.	Pin Code State/U. Territory

THE NEW INDIA ASSURANCE COMPANY LIMITED

ANNEXURE "A"

TO BE ATTACHED WITH CLAIM FORM AND CLAIM PAPERS

CERTIFICATE FROM ATTENDING TREATING DOCTOR TO NURSING HOME/HOSPITAL

DOCTOR OF CLAIMANT

1. Name of Patient :
2. Age :
3. Are you family doctor of patient :
4. Who referred the case to you :
5. When the patient approached you for the first time in connection with present disease suffered :
6. Details of Previous history of disease of patient (IF Any) :
7. Is the patient suffering from Diabities, Hypertension, Blood Pressure, Kidney Problem, Cancer, T.B. and Heart Problem or other disease. If yes (Since how long He/She may be suffering from the same) :
8. Present disease suffered :
9. Duration of present disease suffered i.e. since how long He/She may be suffering from present disease before approaching you) :
10. Is the present disease suffered is Connected to previous history of Hypertension, Diabites, Blood Pressure and other existing disease :

9. Are you at present covered under any other similar type of scheme like P.A. Cancer Insurance. Mediclaim (Individual or Group), Health Insurance etc. If Yes, please give particulars of each.

a) Is this the first year of coverage under Mediclaim Policy ? YES / NO

If no, since when have you been continuously Insured under Mediclaim Policy. Give details:

b) (i) Is this the first claim under this Policy? YES / NO please

(ii) If no, quote Previous claim number and details:

In support of the above claim, I enclose 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 / Anaesthetist'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.

Summary of expenses incurred for which original bills / receipts / cash memos are enclosed.

Total of Hospital Bills	Rs. _____
Consultant's / Surgeon's/Anaesthetist's Fees	Rs. _____
Diagnostics Tests	Rs. _____
Medicines purchased from chemists	Rs. _____
Other expenses-not included above	Rs. _____
GrandTotal	Rs. _____

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 CONCEALMENT, my right to claim reimbursement of the said expenses SHALL BE ABSOLUTELY FORFEITED. I further declare that, in respect of the above treatment, no benefits are admissible under any other Medical Scheme of Insurance.

I ALSO CONSENT AND AUTHORISETHETHIRP PARTYADMINSITRATOR SEEK MEDICAL INFORMATION FROM ANY HOSPITAL / MEDICAL PRACTITIONER WHO HAS AT ANYTIME ATTENDED ON ME.

I authorise TPA to make payment of the claim admissible as per terms, conditions and limitations of the policy to the hospital on my behalf for full and final settlement of Hospital bills.

I also authorise TPA to receive payment from Insurance Company as reimbursement of hospital bills incurred on my treatment.

Dated at .....this .....day of 20

_____

Signature of the Claimant

11. Is the disease suffered Acute / Chronic :

12. Could the patient be remained oblivious of illness / disease for which now treatment is being taken for :

13. Is the disease suffered requires Hospitalisation
    (a) Nature of treatment given : Operative/I.V. Fluids/Injection/oral Treatment/Other Parental treatment

    (b) Indoor Case No. Of the Patient in Hospital/Nursing Home :

14. Date of admission :

15. Date of discharge :

16. Is your hospital registered with local authorities under Mumbai Nursing Home Act Section 25. If yes, please Attach Xerox Copy of certificate Otherwise claim will be considered as "NO CLAIM" :

17. No. of total beds in your Nursing Home/Hospital

18. Other comments you would like to Make (if any) connected to present Disease suffered by the patient :

DOCTOR'S NAME

SIGNATURE OF ATTENDING DOCTOR
(With rubber stamp and Reg. No. of your Nursing Home/Hospital

Doctors IMA Reg. No.

Qualification