STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED

Corporate Office : 1, New Tank Street, Valluvarkottam High Road, Chennai - 600 034.

CLAIM FORM FOR MEDICAL INSURANCE

Issuance of this form does not amount to admission of liability under the policy.

Customer ID

PLEASE FURNISH THE FOLLOWING INFORMATION CORRECTLY TO ENABLE THE COMPANY TO PROCESS YOUR CLAIM
CLAIM FORM SHOULD BE COMPLETE IN ALL RESPECTS INCOMPLETE WOULD DELAY THE PROCESSING
COMPLETE THE FORM IN CAPITAL LETTERS

Name of the Insured — First Name | Middle Name | Last Name

Name of the person for whom the claim is made — First Name | Middle Name | Last Name

Relationship with the Insured

Address for Communication

City/Taluk | District | State | Pin Code

STD Code | Phone | Cell

Policy Number | E-mail

Period of Insurance : From | To | Sum Insured

Previous Policy No/s. with Star Insurance : From | To | ID Card No.

With any other insurers : From | To

A) Nature of Disease/ Illness Contracted :

Brief History of Disease/Illness : | Date D D M M Y Y | Time

B) In case of injury

(i) When did the accident happen

(ii) Where did the accident happen

(iii) Brief Particulars of the accident

(iv) Whether the said accident was reported to the Police?

(v) If Yes, please furnish the FIR copy with particulars

(vi) If accident was not reported, Reason for not reporting

(vii) MLC/AR copy from the hospital.

Name of the Hospital

Address

City/Taluk | District | State | Pin Code

Date & Time of admission | Date & Time of discharge | Tel

CLAIM FORM SHOULD BE COMPLETE IN ALL RESPECTS INCOMPLETE FORM WOULD DELAY THE PROCESSING

Name of the Medical Practitioner

Address

City/Taluk | District | State | Pin Code

Qualification | Regn. No. | Tel

Name of the Family Doctor

Address

City/Taluk | District | State | Pin Code

Qualification | Regn. No. | Tel

Have you been insured under any mediclaim Scheme of any other insurance Company.
If YES, XEROX, Copies of previous year's policies must be enclosed.

Date of commencement of very first insurance for the claimant with continuous insurance Coverage.

Have you preferred any claim for the same insured under the Mediclaim Policy earlier, If so give details viz :

(a) Previous claim No & Office

(b) Diagnosis

(c) Whether Settled [Y] [N] Repudiated [Y] [N]

(d) Amount of settlement

(e) Admitted on Date [D D M M Y Y] Time

(f) Discharged on Date [D D M M Y Y] Time

DETAILS OF CURRENT CLAIM BILLS

Financial Details : Bill Amount Claim Amount

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

Date	Bill No.	Description	Bill Amount	Amount Claimed	Claim type (Pre-Hospitalization/ Post-Hospitalization/Hospitalization)
		Grand Total			

*If required, additional sheet to be attached

CLAIM FORM SHOULD BE COMPLETE IN ALL RESPECTS INCOMPLETE FORM WOULD BY DELAY THE PROCESSING

In support of the claim, I enclose the following documents

Claim Form Duly Signed	Y N	Pre-Hospitalization Bills : No(s) ..... Bill Amount	Y N
Pre-authorization request form	Y N	Hospital Payment Receipt	Y N
Author / Enhancement	Y N	Investigation bill / Report with Dr's request	Y N
Claim Notification	Y N	1) MRI Yes/No 2) CT Scan Yes/No	Y N
Discharge Summary	Y N	3) ECG Yes/No 4) X-ray Yes/No	
		5) USG Scan Yes/No	
Main Hospitalization Bill	Y N		
Doctors Surgery Certificate if any	Y N	Lab Reports with Dr's request No(s)..... of Rep..... other if any	Y N
Surgery/Consultation Bills if any	Y N	Bank Name/Place	
Operation Theatre Pharmacy Bills	Y N		
Medicines Bills with Dr's Prescription	Y N	Account Number	

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 or insurance.

I also consent and authorize Star Health And Allied 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.

Date :

Signature of Claimant

CLAIM FORM SHOULD BE COMPLETE IN ALL RESPECTS INCOMPLETE FORM WOULD BY DELAY THE PROCESSING

MEDICAL CERTIFICATE TO BE FILLED IN BY TREATING DOCTOR

1. Name of the Patient	Age :
2. Admission Date and Time	Discharge Date and Time
3. Name of Surgeon / Physician	
4. Diagnosis	
5. (a) Date of First Consultation of the Doctor	
(b) Previous Consultation before hospitalisation	
6. (a) With What complaints was the patient admitted for:	
(b) Since when was the patient suffering from the said complaints	
7. Past History of the Patient (if any) with the duration of illness	
8. Whether the present ailment is a complication of Pre-existing disease?	
If yes, please specify the disease (or) complication of any previous surgery done? If yes, please specify details.	
9. Whether the disease/disorder is congential in nature?	
10. Nature of Surgery/treatment given for present ailment	
11. (a) Whether Hospital/Nursing Home is Registered, if yes, Regn. No.	
(b) No. of in - patient beds in the Hospital (including ICU)	
(c) Whether the Hospital is having fully equipped Operation Theatre of its own/qualified nurses round the clock/qualified doctors round the clock?	

SPC120311 50k

Signature of the Doctor with Seal

Date

Hospital Seal :