



Claim Form

(For reimbursement of expenses)

Claim No.

Date

(For official use only)

Please provide the following information fully to enable us to process your claim appropriately.

1. Policy number (In full)

2. Name of the Policy Holder (In whose name policy is issued)

3. Details of the Insured Person

a. Name of patient

b. Relationship with Policy Holder Self Spouse Son Daughter c. Date of birth

d. Current address

City District

State Pin code

Phone No. STD code Landline No. Mobile No.

4. Nature of illness contracted or injury suffered

5. Date on which injury was sustained/disease or illness first detected

6. Details of the attending Doctor

a. Name

b. Address of the doctor

City District

State Pin code

c. Qualification d. Phone No.

e. Registration number

7. Details of the Hospital

a. Name

b. Address of hospital

City District

State Pin code

Contact No c. Registration No.

c. In-patient bill no.

d. Date of admission e. Date of discharge

8. **Type of Hospitalisation** Planned Emergency

9. Details of expenses

Expense Head	Amount (Rs.)
In-patient Treatment	
Pre-Hospitalisation	
Post-Hospitalisation	
Domiciliary Treatment	
Emergency Ambulance	
Medicine bills from outside hospital	
Diagnostic tests from outside hospital	
Out-patient Expenses	
Other expenses not included above	
Total Claimed Amount	

10. Have these expenses been paid by you? Yes No

11. Number of document(s) submitted including this claim form

12. Please enclose the following documents

- (i) Original bills, receipts and discharge certificate/card from the hospital/doctor.
- (ii) Original bills from chemists supported by proper prescription.
- (iii) Original investigation test reports and payment receipts.
- (iv) Original medical practitioner/doctor's referral letter advising hospitalisation.
- (v) Details of any other insurance policy that may respond to the claim.

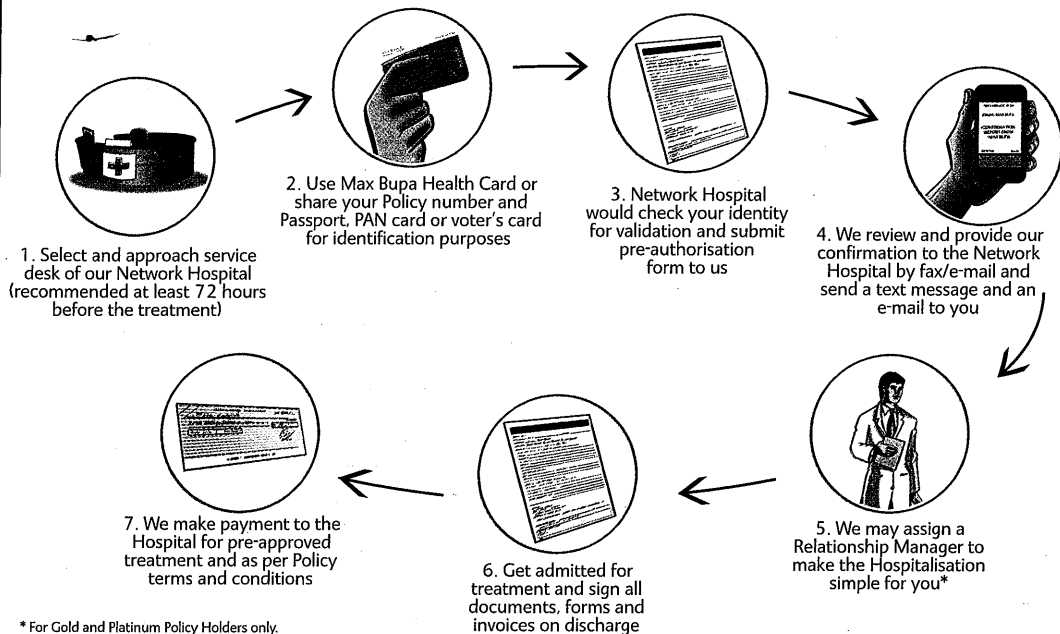
13. Are you presently covered under any other type of insurance (individual or group health insurance)? Yes No

If yes, please give the details as follows:

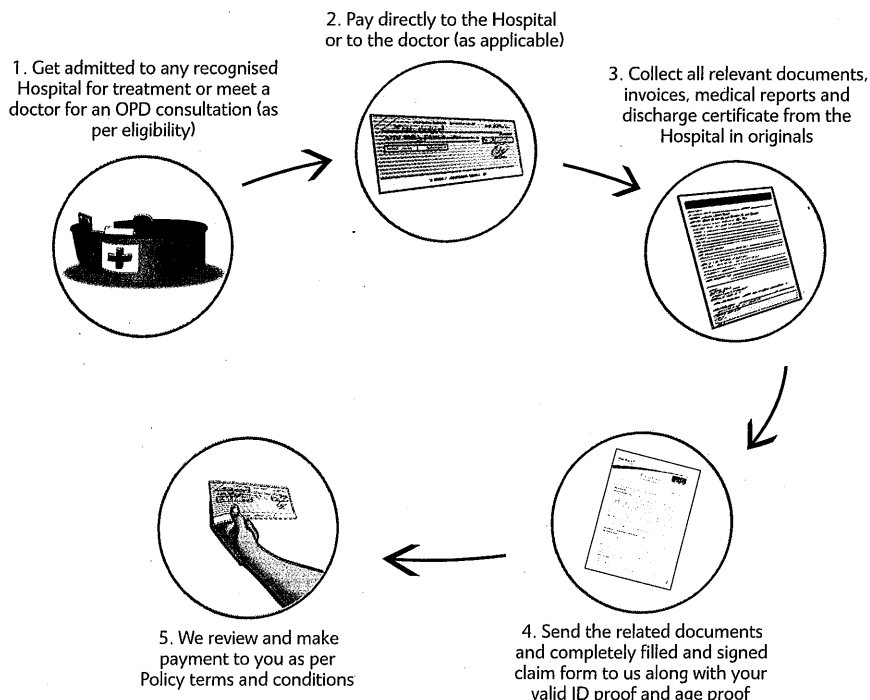
Name of Insurance Company	Policy Number	Start Date	End Date	Sum Insured

Cashless Hospitalisation For Network Hospitals

Planned Hospitalisation



Reimbursement Claims Process



For more information and 24 x7 assistance :

Call : 1800 3010 3333

Visit : www.maxbupa.com

Max Bupa Health Insurance Company Limited

Registered Office: Max House, 1 Dr. Jha Marg, Okhla, New Delhi-110 020.

Corporate Office: D-1, 2nd Floor, Salcon Ras Vilas, District Centre, Saket, New Delhi-110 017. Insurance is the subject matter of solicitation.

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