

CLAIM FORM

(Issuance of this form does not amount to admission of any liability under the policy on the part of the Insurers)

Vipul ID No. : _____

Name & Address of the Insured :

(in whose name policy is issued)

Details of Insured Person :

(in respect of whom claim is made)

a) Name & relationship of the Insured :

b) Present completed Age :

c) Contact Address :

e) Mobile / Phone No. :

f) **Bank A/C No. :**

g) **Bank Name. :**

h) E-mail Address :

i) I.P. No. :

j) File No. :

Name of Insurance Company :

Policy No. : _____

Serial No. of the Schd./Certificate No.: _____

AILMENT / DISEASE / INJURY

Date of Injury sustained of disease / illness first detected :- _____

Name of the Hospital : _____

a) Have you been Insured under any Mediclaim Scheme earlier (held with any Insurance Co.) If yes Xerox copies of Previous years' policies MUST be enclosed. : _____

b) Date of Commencement of very first Insurance for this Insured person with continuous Insurance coverage: _____

Have you proffered any claim for the same insured under the Mediclaim scheme earlier, if so give details viz :

(a) Previous Claim File Ref. No. / Office : _____

(b) Diagnosis : _____

(c) Whether Settled / Repudiated : _____

(d) Amount (if settled) : Rs. _____

PRESENT HOSPITALISATION DETAILS:

Admitted On : Date _____ Time _____ Discharged On : Date _____ Time _____

Total Amount Claimed Rs.: _____

If the claim is of Domiciliary Hospitalization please indicate

a) Date of Commencement of the treatment: _____

b) Date of Completion of treatment: _____

c) Name & Address of attending Medical Practitioner with Telephone No. & Registration No.: _____

Signature of the Claimant



MEDICAL CERTIFICATE TO BE FILLED IN BY THE DOCTOR

1. Name of the Patient & Age	
2. Admission Date and Time	Discharge Date and Time
3. Name of Surgeon / Physician	
4. Diagnosis	
5. Date of first consultation (Prior to 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 congenital 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?	

Signature of the Doctor with seal

Date