CLAIM FORM FOR NIRAMAYA HEALTH INSURANCE SCHEME

Notes: This form is issued without admission of liability and must be completed and returned to the insurance company for processing the claim.

Claim No (to be allotted by the insurer): _____Policy No: _____

1. Details of the Claimant:
Name in Full:_____
Present Age: _____ Years, Relationship with the patient _____

Telephone No.:_____
Residential Address:_____
_____
_____

2. Details of the Patient:
Name in Full: _____Age: _____Years, Disability: _____
Son / daughter of: _____BPL Card No._____
Residential Address:
_____
_____
_____

3. Permanent Business or Occupation: (If more than one state all)_____

4. (a) Name & address of the hospital where the treatment was conducted:
_____
_____
(b) Name, address & qualification of the doctor who conducted the treatment
_____
_____
_____

(5) Nature of claim: OPD/ IPD
a) Date/s: _____
b) Details of disease _____
c) Date of Admission: _____ Time: _____
d) Date of Discharge: _____ Time: _____

(6) Total Claimed Amount:

(7) If the claim is for domiciliary hospitalization, please indicate:

a) Date of commencement of treatment_____

b) Date of completion of treatment_____

c) Name & address of attending Medical Practitioner_____

d) Qualification_____

e) Telephone No._____

8. Are you insured elsewhere? If so, give details:
(a) Name of the Company and Sum Insured: _____
(b) The amount you are entitled to Claim under above policy: _____

In support of the above claim, I enclose following documents {Please indicate by (✓)}

1. Bills, Receipt and Discharge Certificate / card from the Hospital/Nursing Home. (In original)
2. Cash memos from the Hospital / Chemist(s), supported by the proper prescription.(In original)
3. Receipt and Pathological test reports from a Pathologist supported by the note from the attending Medical Practitioner / Surgeon demanding such Pathological tests. (In Original)
4. Surgeons certificate stating nature of operation performed and surgeon's bill and receipt. (In Orginal)
5. Attending Doctor's / Consultant's / Specialist's / Anesthetist's bill and receipt and certificate regarding diagnosis, whichever is prescribed & thereby expenses incurred (In Original)
6. If any transportation bill then pls. submit the bill. (In original)

Declaration:
I HEREBY DECLARE that the particulars are true to best of my knowledge and warrant the truth of the foregoing particulars in every
respect, and I agree that if I have made, or if shall make any false or untrue statement, suppression or concealment, my right to compensation shall be absolutely forfeited.

Place:
Date: **Signature of Insured**

Important:
Since it is a pre-requisite for admission of claims under the policy that the Hospital / Nursing Home / Clinic where the Insured Person was admitted, is registered with Local Authorities, it is necessary for the claimant to ensure that the Hospital / Nursing Home / Clinic indicates the same on the Bill-cum-Receipt issued by them.

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