

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. :** _____ **Cancelled Chq. No** _____
- f) **Account Holder Name***: _____
- g) **Bank A/C No (12-17 Digit)*:** _____ **Bank IFSC Code*** _____
- h) **Account Type***: Savings Account Current Account Other (Please Specify) _____
- i) **Bank Name***: _____
- j) **Bank Address***: _____
- k) **E-mail Address:** _____
- l) I.P. No. : _____
- m) File No. : _____

NOTE: * Banking details and Cancelled Cheque are compulsory as per latest guidelines of Insurance Companies for claim payment would be made electronically (NEFT/RTGS) only.

Name of Insurance Company:

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

AILMENT / DISEASE / INJURY

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

Name of the Hospital : _____

a) Have you been Insured under any Medclaim 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 Medclaim 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 or genetic in nature?	
10. Nature of Surgery/treatment given for present ailment	
11. Whether Hospital/Nursing Home is Registered, a) if yes, Registration No. of the Hospital b) If not ,No. of in-patient beds in the Hospital (including ICU) and Whether the hospital is having fully equipped Operation Theatre of its own/ qualified & registered nurses Round the clock / Qualified & registered doctors round the clock?	

Signature of the Doctor with seal

Date