

TO BE FILLED IN BY THE INSURED

The issue of this Form is not to be taken as an admission of liability
 (To be filled in block letters)

SECTION A
DETAILS OF PRIMARY INSURED:

a) Name of the Insured:

b) Gender.: ☐ Male ☐ Female ☐ Third Gender

c) DOB: Age (Years) /(Months)

d) Phone No: STD Code: Landline No.

e) Address:

f) Member ID.:

g) Policy Number:

h) Plan Type:

i) Identity proof:

j) Address proof:

SECTION B
DETAILS OF CLAIM:

a) Requested Services:
 (List of services the claim is for, in case of multiple services availed at the same facility on the same date. If services were availed at different facilities on different dates, different claims need to be filed)

b) Requested amount.:

c) Visit Type OPD/IPD:

d) Reimbursement request Created at place:

a. Facility Name:

b. Facility address:

e) Invoice Number:

f) Documents needed.:
 1. Invoice 2. Prescription 3. Lab report 4. Radiology report

SECTION C
DETAILS OF BILLS ENCLOSED:

Sl. No	Bill No	Date	Issued by	Bill Heads (as applicable)	Amount (Rs)
1.				Consulting Doctor's Fees	
2.				Pharmacy / Medicine charges	
3.				Investigation charges	
4.				Others (Kindly Specify)	
5.					
6.					
7.					
8.					



DETAILS OF PRIMARY INSURED'S BANK ACCOUNT:

a) PAN:

b) Account Number:

c) Bank Name and Branch:

d) IFSC Code:

e) Cheque/ DD Payable Details:

DECLARATION BY THE INSURED:

Place:

Signature of the Insured: