CLAIM FORM

Please complete all the pages without fail. Do not put 'Dots' (.) Or Dashes (-)

Name of the Insurance Company			
Policy No		Sl. No/ Certificate No	
Medi Assist ID No			
Name & Address of the Primary Insured			
Details of the Insured Person Hospitalised			
a) Name			
b) Relationship		c) Age	
d) Address			
e) Phone No		f) Mobile No	
g) E-mail Address, if any			
Ailment / Disease/ Injury			
Date of Injury sustained/ disease detected			
If Injury, narration how it occurred			
Name of the Hospital where treated			
Name of the treating Doctor			
Qualification		Registration No	
Admission	Date: Time:	Discharge	Date: Time:
Total Amount Claimed		Rs.	
Date of commencement of first Insurance for the person (without break)			
Have you been covered with any other Mediclaim / Health Insurance?		Yes	No
If 'Yes' please attach a photocopy of the Policy			
Have you preferred any claim for the same ailment earlier?		Yes	No
If 'Yes', Claim No		Status: Settled / Denied	
If the Claim is for Domiciliary hospitalisation, please indicate			
Date of Commencement of treatment			
Date of completion of treatment			
Name of the treating Doctor		Qualification	
Address of the Doctor			
Reason for not hospitalizing patient			

Date: **Signature of the Claimant**

Please send this claim form duly completed with all enclosures to:

MEDI ASSIST INDIA PRIVATE LTD.,
#49, "Shilpa Vidya" Buildings, 1st Main, Sarakki Industrial Layout, 3rd Phase J.P.Nagar, Bangalore - 560078.
Phone: 26584811 **Fax:** 26538793 **Toll Free:** 1800 4259 449

I have incurred the following expenses for the treatment of the disease / ailment / injury detailed overleaf:

To be filled by the Claimant					Medi Assist Use Only	
Bill No	Date	Issued by	Towards	Amount	Disallowed	Reason

In support of the above claim, I submit the following documents:

Claim form Duly Signed	Yes	No	Pre-hospitalisation Bills ___No	Yes	No
Copy of Claim Intimation	Yes	No	Post-hospitalisation Bills ___No	Yes	No
Hospital Discharge Summary	Yes	No	Hospital Payment Receipt	Yes	No
Surgeon's Certificate, if any	Yes	No	Investigation Reports	Yes	No
Surgery/ Consultation Bills	Yes	No	Doctor's Reference for Investign	Yes	No
Hospital Main Bill	Yes	No	MRI	Yes	No
Hospital Break - up Bill	Yes	No	CT Scan	Yes	No
Doctor's Prescriptions	Yes	No	ECG	Yes	No
Pharmacy Bills	Yes	No	USG Scan	Yes	No
Any other (Pl. specify):					

Please note:

1. You can submit **original or xerox** copies of Discharge Summary / Prescriptions & all Diagnostic / Lab Reports but they should be **duly certified** by either the Hospital or the Insurer. Uncertified copies will not be accepted.
2. Please submit xerox **copies of the Insurance Policy** – current as well as previous

---

I hereby declare that the information furnished in this Claim Form is true & correct to the best of my knowledge & belief. If I have made any false or untrue statement, suppression or concealment of any material fact, my right to claim reimbursement shall be forfeited.

I also consent & authorise Mediassist India Pvt Ltd., to seek necessary medical information from any hospital / Medical Practitioner who has attended on the person against whom this claim is made.

I hereby declare that I have included all the Bills / receipts for the purpose of this claim & that I will not be making any supplementary claim except the Post - hospitalisation claim, if any.

Date: **Signature of the Claimant**

MEDI ASSIST INDIA PRIVATE LTD.,
#49, "Shilpa Vidya" Buildings, 1st Main, Sarakki Industrial Layout, 3rd Phase J.P.Nagar, Bangalore - 560078.
Phone: 26584811 **Fax:** 26538793 **Toll Free:** 1800 4259 449

MEDICAL CERTIFICATE TO BE FILLED IN BY THE DOCTOR TREATING THE PATIENT

1	Name of the Patient			Age	___Yrs
2	Hospitalistion Period	Date of Admn		Date of Discharge	
3	Diagnosis				
4	Date of first consultation (Prior to Hospitalisation)				
5	Presenting complaints on admission				
6	Since when was the patient suffering from these?				
7	Past history of the Patient, if any, with duration of the ailment/s				
8	Whether the present ailment is a complication of any pre - existing ailment?	Yes		No	
9	If 'Yes', please specify the Disease or complication of any previous surgery done & the details thereof				
10	Whether the Disease / Defect / Disorder is Congenital in nature?				
11	Nature of Treatment given or Surgery performed for the present ailment / injury				
12	If the claim is for **Maternity**, number of living children **excluding the new born**				
13	Whether the Hospital is registered with Local Authorities? If 'Yes' please furnish Registration No				
14	Number of In-patient beds in the hospital (including ICU)				
15	Whether the hospital has fully equipped OT of its own?				
16	Whether qualified nurses employed round the clock?				
17	Whether under the supervision of a Registered Medical Practitioner round the clock ?				

Date:

Signature of the Doctor with Seal

To

____

____

____

Dear Sir/s,

Re: AUTHORISATION TO M/s. MEDI ASSIST INDIA PVT. LTD.,

I have undergone treatment for ____ from _________________ to _________________ in your hospital under Inpatient No:___________.

I hereby authorise M/s. Medi Assist India Pvt. Ltd., who are my TPA for the Mediclaim policy I have, to seek any medical information / records from you or from the Medical Practitioners who has attended on me in connection with the above ailment.

In case they seek any such information / records kindly oblige. I have no objection whatsoever in this regard.

Thanking you,

Yours faithfully,

(Signature of the Claimant)

Date:

Address of the Insured:

____

____

____