



**HOSPITALIZATION CLAIM FORM FOR REIMBURSEMENT**

*Issuance of This Form Does Not Amount To Admission of Any Liability under the Claim On The Part Of the Insurers*

*Please Give The Following Information Correctly & Completely  
(To Be Filled In Block Letters)*

CLAIM CONTROL NO: \_\_\_\_\_

1. NAME OF INSURED: \_\_\_\_\_

2. POLICY NO: \_\_\_\_\_

3. DETAIL OF THE CLAIMANT:  
(in respect of whom the claim is made)

a. Name of claimant: \_\_\_\_\_

b. Relationship with insured: \_\_\_\_\_

c. Present age: \_\_\_\_\_

4. a) Nature of Disease/Illness contracted or injury suffered: \_\_\_\_\_

b) Date of Injury, or Disease/Aliment contracted/Detected, for which the expences are Claimed hereby

i) When 1<sup>st</sup> detected: \_\_\_\_\_

ii) When Cured: \_\_\_\_\_

iii) If not Cured, give complete history \_\_\_\_\_

5. Name & Address of the hospital/Nursing Home/Clinic admitted to

i) Date & Time of admission: \_\_\_\_\_

ii) Date & Time of discharge: \_\_\_\_\_

6. Total Amount Claimed: \_\_\_\_\_

I have on the treatment of Disease/Illness/Injury referred to above. In support of the above claim, I enclose the following documents: **(Please tick the followings)**

- a. Discharge Summary of the Hospital/Nursing Home
- b. Cash Memo/Bills supported by proper prescriptions
- c. Receipt, Pathological tests reports supported with prescriptions.
- d. Hospital Bill with receipt of payment.
- e. Breakup of each heads of hospital bill.
- f. Any other detail/documents which substantiate the claim
- g. Hospital Declaration Form (Over leaf to be filled by the hospital)

I hereby warrant the truth of the foregoing particulars in every respect & I agree that if I have made or shall make any false or untrue statement or concealment may right to claim reimbursement of the expences shall be absolutely forfeited. I further declare that in respect of the above treatment no benefits are admissible under any other medical scheme or insurance.

Signature of Insured

Signature of claimant



## CERTIFICATE

(TO BE FILLED BY THE HOSPITAL/NURSING HOME/CLINIC AUTHORITY)

This is to certify that \_\_\_\_\_

was admitted under my treatment from \_\_\_\_\_ at \_\_\_\_\_ to \_\_\_\_\_ at \_\_\_\_\_ and

detail information is as under: -

1. Name of Hospital/Nursing Home \_\_\_\_\_

2. Whether the same is registered with the local authority or not \_\_\_\_\_

3. If so, Registration No \_\_\_\_\_

4. If not answer the following queries: -

A. No of inpatient beds in the Hospital/Nursing Home: \_\_\_\_\_

B. Whether you have fully equipped operation theater of your own: Yes/No

C. Whether you have fully qualified Nursing Staff  
in your employment round the clock: Yes/No

D. Whether you have qualified Doctor in Charge round the clock Yes/No

5. Date/ Time of Admission \_\_\_\_\_

6. Date/Time of Discharge \_\_\_\_\_

7. History of present illness with duration of the presenting complaints:

(a). What is the exact nature of complaint with  
which the patient first presented(seen) \_\_\_\_\_

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(b). Since how long he/she has been suffering  
for the same. \_\_\_\_\_

8. Past History of the disease \_\_\_\_\_

Signature of Doctor

OR

Hospital Authorities

(Seal of Hospital)