


Supplementary Claim Form				
				
<b>Policy Holder Information</b>			<b>Patient Information</b>	
Policy No.			Name:	
Name:			Relation:	
Card ID:			UHID of Provider:	
Address:			Tel:	
			E-mail:	
City	State:	Pin:		
<b>Claim Information</b>				
Adm Date:                      Time			Discharge Date:	
First Occurance Date:			Diagnosis	
S.No.	Name Of Hospital / Clinic / Doctor	Service /Product	Bill No.	Bill Date
<b>Total Amount:</b>			<b>Comments/ Remarks</b>	
<input type="checkbox"/> Pre authorisation / First Admission Report <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Hospitalizaion Bills with breakups <input type="checkbox"/> Investigation Reports <input type="checkbox"/> Consultation bills with Receipt <input type="checkbox"/> If Surgery, Surgery bills with Receipt <input type="checkbox"/> Medicine bills with prescriptions <input type="checkbox"/> OT Pharmacy Bills <input type="checkbox"/> Others  _____ _____ _____				
<b>Provider Representative</b>			<b>Policy Holder /Patient</b>	
Name			Name	
Date			Date	
Signature			Signature	

