

REIMBURSEMENT CLAIM FORM

		FILLED BY THE INSURED s not to be taken as an admission of liability	(To be Filled in block letters
Nankit Healthcare TPA Ltd.	DETAII	S OF PRIMARY INSURED:	
) Policy No.:		b) Sl. No/ Certificate no.	
Company / TPA ID (MA ID)No:			
) Name: SURN	AME		L E N A M E
e)Address:			
City:			
Pin Code	Phone No:		
		LS OF INSURANCE HISTORY:	
) Currently covered by any other Mediclair		ate of commencement of first Insurance without break:	YYYY
) If yes, company name:		Policy No.	
dum insured (Rs.)	d) Have you been hospitalized in the	e last four years since inception of the contract? Yes No	Date: M M Y Y
Diagnosis:		e) Previously covered by any other M	lediclaim /Health insurance : : Yes No
If yes, company name:			
) Name: SURN	DETAILS OF I	INSURED PERSON HOSPITALIZED:	
) Gender Male Femal	c) Age years Y Y Monti	ths M M d) Date of Birth D D M M Y Y Y	
e) Relationship to Primary insured: Sel	Spouse Child Fath		
	Employed Home Maker Stude		
) Address (if diffrent from above) :			
City:			
Pin Code	Phone No:		
		AILS OF HOSPITALIZATION:	
a) Name of Hospital where Admited:			
) Room Category occupied:	Day care Single occupancy	Twin sharing 3 or more beds per room	
) Hospitalization due to: Injury	Illness Maternity	as upone or injury / Ligan Disease first detected /Date of Delivery:	M M Y Y Y
) Date of Admission:		d) Date of injury / Date Disease first detected /Date of Delivery: D D	V h) Time:
	M Y Y f) Time H H	M H g) Date of Discharge: D D M M Y	Y h) Time: H H : M H
) If injury give cause: Self inflicted			Y h) Time: H H : M H Yes No
If injury give cause: Self inflicted Reported to Police	M Y Y f) Time H H Road Traffic Accident iii. MLC Report & Police FIR attached	M H g) Date of Discharge: D D M M Y Substance Abuse / Alcohol Consumption I) If Medico legal Yes No j) System of Medicine: —DETAILS OF CLAIM:	Yes No
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	GUIDANCE F	OR FILLING CLAIM FORM - PART A (To be filled in by the insured	d)
	DATA ELEMENT	DESCRIPTION	FORMAT
		SECTION A - DETAILS OF PRIMARY INSURED	
1)	Policy No.	Enter the policy number	As allotted by the Insurance Company
)	SI. No/ Certificate No.	Enter the social Insurance number or the certificate number of social health insurance scheme	As allotted by the oraganization
)	Company TPA ID No.	Enter the TPA ID No.	Licence number as allotted by IRDA and printe in TPA documents.
)	Name	Enter the full name of the policyholder	Surname, First name, Middle name
)	Address	Enter the full postal address	Include Street, City and Pin code
		SECTION B -DETAILS OF INSURANCE HISTORY	
)	Currently covered by any other Mediclaim / Health Insurance?	Indicate whether currently covered by another Mediclaim / Health Insurance	Tick Yes or No
)	Date of commencement of first Insurance without break	Enter the date of commencement of first Insurance	Use dd-mm-yy-forrmat
)	Company Name	Enter the full name of the Insurance Company	Name of the organization in full
	Policy No.	Enter the policy number	As allotted by the Insurance Company
	Sum insured	Enter the total sum insured as per the policy	In rupees
)	Have you been Hospitalized in the last four years since Inception of the contract?	Indicate whether hospitalized in the last four years	Tick Yes or No
	Date	Enter the date of Hospitalization	Use mm-yy format
	Diagnosis	Enter the diagnosis details	Open Text
	Previously covered by any other Mediclaim / Health Insurance?	Indicate whether previously covered by another mediclaim / Health Insurance	Tick Yes or No
	Company Name	Enter the full name of the Insurance Company	Name of the organization in full
	SEC	TION C -DETAILS OF INSURED PERSON HOSPITALIZED	
)	Name	Enter the full name of the patient	Surname, First name, Middle name
)	Gender	Indicate Gender of the patient	Tick Male or Female
	Age	Enter age of the patient	Number of years and months
	Date of Birth	Enter Date of Birth of patient	Use dd-mm-yy format
)	Relationship to primary Insured	Indicate relationship of patient with policyholder	Tick the right option, if others, please specify
	Occupation	indicate occupation of patient	Tick the right option. If others, please specify.
)	Address	Enter the full postal address	Include Street, City and Pin code
)	Phone No	Enter the phone number of patient	Include STD code with telephone number
)	E-mail ID	Enter e-mail address of patient	Complete e-mail address
_		SECTION D - DETAILS OF HOSPITALIZATION	
)	Name of Hospital where admited	Enter the name of hospital	Name of hospital in full
)	Room category occupied	indicate the room category occupied	Tick the right option
)	Hospitalization due to	indicate reason of hospitalization	Tick the right option
)	Date of injury/Date Disease first detected / Date of	Enter the relevant date	Use dd-mm-yy format
_	Delivery Date of admission		Use dd-mm-yy format
)		Enter date of admission Enter time of admission	Use hh-mm- format
_	Time Date of discharge		
	Date of discharge	Enter date of discharge	Use dd-mm-yy format Use hh-mm- format
)	Time If injury give cause	Enter time of discharge indicate cause of injury	Tick the right option
I)	If injury give cause	indicate cause of injury indicate whether injury is medico legal	Tick Yes or No
	Reported to Police	indicate whether police report was filed	Tick Yes or No
	MLC Report & Police FIR attached	indicate whether MLC report and Police FIR attached	Tick Yes or No
	System of Medicene	Enter the system of medicine followed in treating the patient	Open Text
	Cystem of Medicene	SECTION E - DETAILS OF CLAIM	Open text
)	Details of Treatment Expences	Enter the amount claimed as treatment expences	In rupees (Do not enter paise values)
)	Claim for Domiciliary Hospitalization	indicate whether claim is for domiciliary hospitalization	Tick Yes or No
)	Details of Lump sum/ Cash benifit claimed	Enter the amount claimed as lump sum / cash benefit	In rupees (Do not enter paise values)
)	Claim documents Submitted-Check List	indicate which supporting documents are submitted	Tick the right option
		SECTION F - DETAILS OF BILLS ENCLOSED	die rigin opnori
die	ate which bills are enclosed with the amount in rupees		
	SECTION	ON G - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT	
)	PAN	Enter the permanent account number	As allotted by the Income Tax Department
)	Account Number	Enter the Bank account number	As allotted by the Bank
)	Bank Name and Branch	Enter the Bank name along with the branch	Name of the Bank in full
)	Cheque/ DD payable details	Enter the name of the beneficiary the cheque / DD should be made out to	Name of the individual / organization in full
)	IFSC Code	Enter the IFSC code of the Bank branch	IFSC code of the Bank branch in full
-,			

SECTION H - DECLARATION BY THE INSURED

Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.

Place:

Signature of the Insured

(IMPORTANT: PLEASE TURN OVER)