Vipul MedCorp TPA Private Limited

Form No. 3 Rev: 1

CLAIM FORM

(Issuance of this form does not amount to admission of any liability under the policy on the part of the Insurers)

Vipul ID No. : _____

Name & Address of the Insured : _____
(in whose name policy is issued)

Details of Insured Person (in respect of whom claim is made)**:**

a) Name & relationship of the Insured : _____

b) Present completed Age : _____

c) Contact Address : _____

e) **Mobile / Phone No.** : _____

f) **Account Holder Name***: _____

g) **Bank A/C No (12-17 Digit)*:** _____ **Bank IFSC Code*** _____

h) **Account Type***: Savings Account ☐ Current Account ☐ Other (Please Specify) _____

i) **Bank Name***: _____

j) **Bank Address***: _____

k) **E-mail Address**: _____

l) I.P. No. : _____

m) File No. : _____

NOTE: * Banking details and Cancelled Cheque are compulsory for United India Insurance Company Ltd as per their guidelines.

Name of Insurance Company:

Policy No. :_____ Serial No. of the Schd./Certificate No.: _____

AILMENT / DISEASE / INJURY

Date of Injury sustained or disease / illness first detected :- _____

Name of the Hospital : _____

a) Have you been Insured under any Mediclaim Scheme earlier (held with any Insurance Co.) If yes Xerox copies of Previous years' policies MUST be enclosed. : _____

b) Date of Commencement of very first Insurance for this Insured person with continuous Insurance coverage: _____

Have you proffered any claim for the same insured under the Mediclaim scheme earlier, if so give details viz :

(a) Previous Claim File Ref. No. / Office : _____

(b) Diagnosis : _____

(c) Whether Settled / Repudiated : _____

(d) Amount (if settled) : Rs. _____

PRESENT HOSPITALISATIN DETAILS:

Admitted On : Date _____ Time _____ Discharged On : Date_____ Time _____

Total Amount Claimed Rs.: _____

If the claim is of Domiciliary Hospitalization please indicate

a) Date of Commencement of the treatment: _____

b) Date of Completion of treatment: _____

c) Name & Address of attending Medical Practitioner with Telephone No. & Registration No.: _____

_____

Signature of the Claimant

I have incurred the above expenses for the treatment of the disease / illness / accident and herewith as per schedule mentioned below:-

Schedule of Expenses incurred by the Claimant

				CLAIM TYPE (PRE-HOSPITALIZATION / POST-HOSPITALIZATION / HOSPITALIZATION)
DATE	**BILL NO.**	**DESCRIPTION**	**AMOUNT CLAIMED**	
		GRAND TOTAL		

* If required, additional sheet to be attached

In support of the claim, I enclose the following documents

	Yes / No			Yes / No	
Claim Form Duly Signed	☐	☐	Pre-Hospitalization Bills : No(s)____ Bill Amount _____	☐	☐
Vipul Pre-Authorization Form	☐	☐	Post-Hospitalization Bills : No(s)____ Bill Amount _____	☐	☐
Claim Notification	☐	☐	Hospital Payment Receipt	☐	☐
Discharge Summary	☐	☐	Investigation Report with Dr's request	☐	☐
Hospitalization Bills	☐	☐	1. MRI Yes / No 2. CT Scan Yes / No	☐	☐
Doctors Surgery Certificate if any	☐	☐	3. ECG Yes/ No 4. X-ray Yes / No 5. US Scan Yes / No	☐	☐
Surgery / Consultation Bills if any	☐	☐	Lab Reports with Dr's request No (s)_____ of Rep _____	☐	☐
Operation Theatre Pharmacy Bills	☐	☐	Others if any		
Medicines Bills with Dr's prescription	☐	☐			

Previous Policy Numbers if any :

I hereby warrant the truth of the foregoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppression or concealment, my right to claim reimbursement of the said expenses 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

I also consent and authorize Vipul MedCorp / Insurance Company to seek the treatment papers/medical information from any Hospital / Medical Practitioner who has any time attended on the insured person.

I hereby declare that I have included all bills / receipts for purpose of this claim and that I will not be making any supplementary claim in respect thereof, except the post Hospitalization claim if any.

Date : **Signature of the Claimant**

Vipul MedCorp TPA Private Limited

MEDICAL CERTIFICATE TO BE FILLED IN BY THE DOCTOR

1. Name of the Patient & Age	
2. Admission Date and Time	Discharge Date and Time
3. Name of Surgeon / Physician	
4. Diagnosis	
5. Date of first consultation (Prior to hospitalisation)	
6. (a) With what complaints was the patient admitted for:	
(b) Since when was the patient suffering from the said complaints	
7. Past History of the Patient (if any) with the duration of illness	
8. Whether the present ailment is a complication of Pre-existing disease?	
If yes, please specify the disease (or) complication of any previous Surgery done? If yes, please specify details.	
9. Whether the disease/disorder is congenital or genetic in nature?	
10. Nature of Surgery/treatment given for present ailment	
11. Whether Hospital/Nursing Home is Registered, a) if yes, Registration No. of the Hospital b) If not ,No. of in-patient beds in the Hospital (including ICU) and Whether the hospital is having fully equipped Operation Theatre of its own/ qualified & registered nurses Round the clock / Qualified & registered doctors round the clock?	

Signature of the Doctor with seal Date