

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 HOSPITALISATION 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

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

* If required, additional sheet to be attached

In support of the claim, I enclose the following documents

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

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



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