



Health Insurance Claim Form

Organization Name _____ Credit Letter/Card No _____

Employee Name _____ Designation _____

Employee Code HR (Necessary) _____ Contact No. _____

Office Address _____

Patient Name _____ Age _____

Relation With Employee _____ Sex _____

Out Door Treatment (OPD)

Note: Please attach detailed bill, original prescriptions, lab reports and receipts

Name Of Clinic/Hospital And Doctor _____

Consultation Fee _____ Cost Of Medicine _____

Cost Of Investigation/Lab Test _____ Total Cost _____

Specialized Investigation

Name Of Hospital/Institution _____

Referring Specialist/Consultant _____

Cost Of Investigation/Procedure _____

Please tick whichever is applicable

CT Scan (Computerized Tomography)

MRI (Magnetic Resonance Imaging)

Thallium Scan

Angiography

Endoscopy

Date Of Intimation _____ Date Of Approval _____

Hospitalization Treatment

Name Of Hospital _____

Name Of Treating Physician/Surgeon _____

Date Of Admission _____ Date Of Discharge _____

Please tick whichever is applicable

1. Medical

2. Surgical

3. Maternity

Please mention if normal, C-Section, D&C, abortion etc

Antenatal

Natal

Postnatal

Total Cost Of Hospitalization _____

Room Charges _____ No. Of Days _____

O.T./Lab room Charges _____

Cost Of Surgeon _____

Cost Of Anesthetist _____

Investigation And Lab Charges _____

Consultant/M.O. Visit Charges _____

Other (Name & Cost) _____

Employee Signature

Name Signature And Seal Of Doctor/Hospital

Employer Signature

For Premier Use Only

Total amount Of Claim _____

Approved Amount _____

Not Payable Amount _____

Signature Of Authorized Person _____ Date _____