

CLAIM FORM



(Issuance of this form does not amount to admission of any liability under the claim on the part of the insurance.)

Name of the Insurance Company:

Address of the Policy issuing Office:

EMSL's ID No. :

Policy No.:

1. Name of the Insured (In whose name policy is issued):

2. Details of the insured Person (In respect of whom claim is made):

(a) Name & relationship to the insured:

(b) Present completed age:

Phone No.:

(c) Occupation:

Mobile No.:

(d) Residential address:

(e) E-Mail – I.D.

3. Nature of Disease/illness contracted or injury suffered:

4. Date of injury sustained or Disease/ illness first detected:

5. (a) Name & Address of the Hospital/ Nursing Home/Clinic: G.C GUPTA HOSPITAL, 372-373, HUDA, SEC-11, PANIPAT

(b) Date of Admission:

(c) Date of Discharge:

6. (a) Name and Address of the attending Medical Practitioner :

(b) Qualification:

Telephone No.:

(c) Registration No.:

7. Have you been insured under any Mediciam Scheme earlier:

(Whether with us or any other Insurance Co.) If yes, photo copies of Previous year's Insurance policies must be enclosed

8. Date of Commencement of very first insurance for this insured:
person with continuous Insurance Cover

9. If the claim is for Domiciliary Hospitalization,:

Please indicate

(a) Date of Commencement of treatment:

(b) Date of Completion of treatment:

(c) Name & Address of attending Medical:
Practitioner

10. Total Amount Claimed: Rs.

I have incurred on the treatment of disease/illness/accident referred to above the expenses as per the details given by me in the Schedule of Expenses given overleaf.

In support of the above claim, I enclose the following documents:

Claim Form Duly Signed:

Yes/No

Pre Hospitalization bills ___ Nos. Yes/No

EMSL Pre-Authorization Certificate:

Yes/No

Post Hospitalization bills ___ Nos. Yes/No

Claim Intimation Letter

Yes/No

Hospital Payment receipt Yes/No

Discharge Summary

Yes/No

Hospitalization Bill Yes/No

