Insured Contact No. M : _____ R : _____

CLAIM NUMBER		

MEDI-CLAIM FORM

Issuance of this form does not amount to admission of any liability under the policy on the part of the insurer. Please give the following information correctly and completely to enable us to process your claim promptly. If claim is under Personal Accident Insurance, please complete a Personal Accident Claim Form. (All date to be entered as Date/Month/Year

1.	a) Name of the Insured (In whose name policy issued) :	
2.	Details of the Insured Person : (In respect of whom claim is made) : a) Name and Relationship with the Insured : b) Personal Completed Age : c) Occupation : d) Residential Address :	
3.	Policy Number (In full) :	
4.	Nature of Disease / illness / injury : Sustained / How did accident occur?	
5.	Date on which injury sustained / Disease first : Contracted	
6.	a) Name & Full Address of the attending : Medical Practitioner b) Qualification & Telephone No. : c) Registration No. :	Pin code _____ State / U. Territory _____
7.	a) Name & Full Address of the attending : Medical Practitioner b) Date of Admission : c) Date of Discharge :	Pin code _____ State / U. Territory _____
8.	If the claim is for Domiciliary : Hospitalization, Please indicate a) Date of Commencement of Treatment : b) Date of Competition of Treatment : c) Name & Address of attending Medical Practitioner : d) Telephone No. : e) Registration No. :	Pin code _____ State / U. Territory _____

9. Are you at present covered under any other similar type of scheme like P.A Cancer Insurance. Mediclaim (Individual or Group), Health Insurance etc. If yes, please give particulars of each.

a) Is this the first year of coverage under Mediclaim Policy? YES / NO
If no, since when have you been continuously Insured under Mediclaim Policy. Give details:

b) (I) Is this the first claim under this policy? YES / NO
(II) If no, please quote Previous claim number and details:

In support of the above claim, I enclose following documents (Please indicate by ✓)

1. Bill, Receipt and discharge certificate / card from the Hospital.
2. Cash Memos from the Hospital / Chemist(s), supported by the proper prescription.
3. Receipt and pathological test reports from a Pathologist supported by the note from the attending Medical Practitioner / Surgeon demanding such Pathological tests.
4. Surgeon's certificate stating nature of operation performed and Surgeon's bill and receipt.
5. Attending Doctor's / Consultant's / Specialist's / Anesthetist's bill and receipt and certificate regarding diagnosis.
6. In case of Domiciliary Hospitalization receipt from a qualified nurse who attends the patient at his/her residence duly supported by a certificate from attending Medical Practitioner.
7. Certificate from the attending Medical Practitioner giving reasons for allowing treatment at home.
8. Certificate from the attending Medical Practitioner / Surgeon that the Patient is fully cured.

Summary of expenses incurred for which original bills / receipts / cash memos are enclosed.

Total of Hospital Bills	Rs._____
Consultant's / Surgeon's / Anesthetist's Fees	Rs._____
Diagnostics Test	Rs._____
Medicines purchased from chemists	Rs._____
Other expenses not included above	Rs._____
Grand Total	Rs._____

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 of Insurance.

I ALSO CONSENT AND AUTHORISE THE THIRD PARTY ADMINISTRATOR SEEK MEDICAL INFORMATION FROM ANY HOSPITAL / MEDICAL PRACTITIONER WHO HAS AT ANY TIME ATTENDED ON ME.

I authorize TPA to make payment of the claim admissible as per terms, conditions and limitations of the Policy to the hospital on my behalf for full and final settlement of Hospital bills.

I also authorize TPA to receive payment from Insurance Company as reimbursement of hospital bills Incurred on my treatment.

» Please Mention Insured's Bank Details

Bank Name …… A/c. No. ……

Dated at ……. This …….. day of …… 200

Signature of the Claimant

MEDICAL CERTIFICATE

To be filled in by the Treating Doctor

1. Name of Patient : _____
2. Age : _____ Sex : M ☐ F ☐
3. Are you a family doctor of patient? Yes / No Since : _____ yrs
4. Who referred the case to you?

   _____
5. Details of previous history of any illness (if any) of patient? _____

   _____
6. Nature of Disease / illness / Injury Sustained : _____

   _____
7. Duration of present disease suffered (i.e. since how long he or she may be suffering from present disease before approaching you) : _____

   _____
8. Is the present disease suffered connected to previous disease or Diabetes, Hypertension (Blood Pressure), Surgery or other existing disease? : _____

   If yes. Since how long? _____
9. Is disease suffered Acute or Chronic? : _____
10. Whether the disease is caused due to any congenital defects (Yes/No)? _____
11. Whether the patient had any complications during or after pregnancy (Yes/No)? _____
12. Whether the disease/injury is caused directly or indirectly due to use of alcohol or drugs (Yes / No) : _____
13. Could the patient have been aware of the illness disease of which treatment is being taken now?

    If yes When? (Approx period of illness) : _____

    Date when the illness / injury was sustained : _____
14. Is the disease suffered requires hospitalization ? : Yes / No
    a) Nature of treatment given : Operative / I.V. Fluid / Injection / Oral Treatment / Other Parenteral Treatment
    b) Indoor case no. of the patient Hospital / Nursing Home :
15. Date of Admission : _____ Time of Admission : _____

16. Date of Discharge : _____ Time of Discharge : _____
17. Is your hospital registered with local authority? If yes; please attach Xerox copy of certificate
    Registration Number of Hospital : _____
18. No. of total beds in your Nursing Home / Hospital : _____
19. Other comments you would like to make (if any) connected to present disease suffered by the
    Patient :_____
    _____
20. "Weather the patient is fully cured or not?" Yes / No

Certified that the above information are true to the best of my knowledge and as per the records available at this hospital

Doctor's Name : _____ Qualification : _____ Registration No : _____

Contact No : _____ _____

Signature of Attending Doctor

(with rubber stamp and registration no. of your Nursing Home / Hospital)

Name of Policy Holder :_____

Date :____ /_____ /_____

_____

Signature of Policy Holder

ANMOL MEDICARE LTD.

STATEMENT OF BILLS

NAME			
D.0.A.		D.O.D.	
POLICY NO.			
PERIOD :	FROM:	TO:	

SR. NO	DESCRIPTION	BILL NO.	DATE	AMOUNT
A DOCTORS & HOSPITAL BILLS				
		SUBTOTAL (A)		
B LABORATORY, X-RAY & INVESTIGATION BILL				
		SUBTOTAL (B)		
C CHEMIST BILLS				
		SUBTOTAL(C)		
		TOTAL RS. [A+B+C]		
TOTAL RS. IN WORDS				

Anmol Medicare	ANMOL MEDICARE FORM FOR ELECTRONIC SYSTEM

Policy Number

Policy Holder's Name

Address

TELEPHONE NO Email ID

UHID No

Claim No

Name of Account Holder

Name Of Bank

Branch Name

Branch Address

SB/CD

Account No

MICR Code Cancelled Cheque **Y** **N**

IFSC Code

1)Please enclose the cancelled cheque of your bank account for our record, your banker should be a participant of NEFT/RTGS Facility.

2) By Submission of the above, I authorize Anmol Medicare (TPA) Ltd./National Insurance Co. Ltd. To settle the claim under reference through direct Payment By NEFT/RTGS. I hereby declare & confirm that the particulars given above are correct & complete. I agree that I shall not hold TPA/Insurance Company responsible for delay or non receipt of the payment for any reason whatsoever after issue of the instructions for payment by Insurer/TPA based on the above.

DATE:

Place:

Signature of the Policy Holder