DOMICILIARY TREATMENT - CLAIM FORM

(To be filled in block letters)

DETAILS OF PRIMARY INSURED:

Policy No: Emp ID:

ID Card No:

Emp Name:

Mobile No: Personal Email:

DETAILS OF PATIENT:

Name:

Gender: Male ☐ Female ☐ Age: years months

Relationship to Primary Insured: Self ☐ Spouse ☐ Child ☐ Father ☐ Mother ☐ Other.....

DETAILS OF CLAIMS:

Name of Treating Doctor:

Commencement of Treatment: Date Treatment end Date

Treatment For:

CLAIM DOCUMENTS SUBMITTED- Check List:

Documents	Total Number of Documents Submitted
☐ Claim Form Duly Signed	
☐ Illness Certificate by Treating Doctor	(Illness Certificate by Treating Doctor with treatment duration)
☐ Pharmacy Prescriptions by Doctor	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15
☐ Pharmacy Bills Cash Memo	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15
☐ Investigation Prescriptions By Doctor	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15
☐ Investigation Bills Cash Memo	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15
☐ Investigation Reports	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15
☐ Doctor Consultancy Charges Cash Receipts	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15

DETAILS OF BILLS ENCLOSED:

Sr. N	Date	Particulars	Amount Claimed in Rs.
		Total Amount in Rs.	

DECLARATION BY THE INSURED:

I hereby declare that the above information is true & correct to the best of my knowledge and belief. If I have made any false, fraud or untrue statement, suppression or concealment, my right to claim reimbursement of the expenses shall be forfeited. I also consent and authorize MDINDIA / Insurance Company to seek medical information from any Hospital Medical Practitioner who has any time attend 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: Place: Signature of Policy Holder