National Insurance Company Limited

Regd. Office 3, Middleton Street, Post Box 9229, Kolkata 700 071

BARODA HEALTH POLICY CLAIM FORM

1. **Name and address of the Insured**
   (Bank of Baroda account Holder in whose Name the policy is issued)

   Type of Account:

   Account No.:

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

   (a) name and relationship to the insured:
   (b) completed age at present:
   (c) Occupation:
   (d) Residential address:

3. **Policy No**.

4. **Nature of disease /illness contracted or Injury suffered:**

5. **Date of injury sustained or disease illness first detected:**

6. **(a) Name and address of the Medical practitioner:**

   (b) Qualification & Telephone No.

   (c) Registration No.

7. **(a) Name and address of the Hospital/ Nursing Home/Clinic:**

   (b) Date and time of admission:

   (c) Date and time of Discharge:

I have incurred on the treatment of disease/illness/accident referred to above, the expense as per the details given by me in the Schedule of Expense given overleaf. In support of the above claim, I enclose the following documents (please indicate by √) -

- ☐ Bill Receipt and Discharge Certificate/card from the Hospital.
- ☐ Cash Memos from the Hospital/Chemist(s), supported by the proper Prescription.
- ☐ Receipt and Pathological test reports from Pathologist supported by the note form the attending Medical Practitioner/Surgeon demanding such Pathological test.
- ☐ Surgeon's Certificate stating nature of operation performed and Surgeon's Bill and receipt.
- ☐ Attending Doctor's/Consultant's/Anaesthetist's bill and receipt and certificate regarding diagnosis.
- ☐ In case of Domiciliary Hospitalisation, receipt from a qualified nurse who attended the patent at his/her residence duly supported by a certificate from attending Medical Practitioner.
- ☐ Certificate from the attending Medical Practitioner giving reasons for allowing treatment at home.
- ☐ Certificate from the attending Medical Practiioner/Surgeon that the Patient is fully cured.

I hereby warrant the truth of the foregoin particulars in every respect and I agree that if I have made or shall make any false o 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.

Place :

Date :

Signature of the Claimant

For Office Use

Date of Claim:

Policy No……. Claim No

SCHEDULE OF EXPENSES INCURRED BY THE CLAIMANT			FOR OFFICE USE ONLY
Details of expenses claimed under Hospitalisation / Domicialiary Hospitalisation (To be supported by Bills/Receipts,Cash Memo etc.)	For Office Use only	Amount Claimed (1)	Amount Payable (2)
(a) Room, Board, Nursing Expenses For ……. Days …….. (b) I.C. Unit For ……. Days …… (c) Surgeon and Anaesthesist Fees (d) Anaesthesia, Blood, Oxygen, Operation theatre, Surgical Appliance. (e) Diagnostic Material & X-Ray (f) Medical Practitioners, Consultants and Specialities Fees for Consultations/visits….. (g) Medical and Drugs: (a) Supplied by Hospital (b) Purchased from Chemists (h) Ambulance Charges (i) Out of Pocket Expenses in case of Hospitalisation to Children upto age of 12 years. (A declaration from parent to be submitted)			

SCHEDULE OF EXPENSES INCURRED BY THE CLAIMANT			
	For Office Use Only		
II. DOMICILIARY HOSPITALISATION: (a) Anaesthesia, Blood & Oxygen (b) Diagnostic Materials & X-Rays (c) Medicines and Drugs (d) Medical Practitioners, Consultants and Specialists fees for Consultations/visits (e) Employment of a qualified nurse to attend to the patient at his/her residence			
		Total Rs.	
Date : Place : Signature of the Claimant			
FOR OFFICE USE ONLY Passed for Payment of Rs……. Prepared by: Checked by: Approved by: COMPETENT AUTHORITY			