Claim No.

NATIONAL INSURANCE COMPANY LIMITED

Registered & Head Office : 3, Middleton Street, Kolkata 700 071.

Hospitalisation And Domiciliary Hospitalisation Benefit Policy

CLAIM FORM

Issuance of this Form does not amount to admission of any liability under the claim on the part of the insurers. YOU ARE ADVISED TO FILL EACH AND EVERY COLUMN OF THIS CLAIM FORM and give all information correctly and completely to enable theTPA company to process your claim promptly

PARAMOUNT HEALTH SERVICES PVT LTD (IRDA License No. 006)

Elite Auto House, 54-A, 2nd Floor, M. Vasanji Road, Mumbai – 400 093 Tel: 022 – 5662 0808. Fax: 022 – 28259743

1. Name of the Insured : _____
   (In whose name policy is issued) (SURNAME) (NAME) (FATHER'S / HUSBAND'S NAME)
2. Details of the insured person (in respect of whom claim is made)
   a) Name & relationship to the insured : _____
   b) Present completed Age : _____
   c) Occupation : _____
   d) Residential Address : _____
   e) Telephone Number : _____
   f) E-Mail Address : _____
3. Policy No. in Full : _____
   Policy Period : From _____ To _____
4. Nature of Disease/ Illness contracted Or Injury suffered : _____
5. Date of injury sustained or Disease/ Illness first detected ___ ___ ___ ___ ___ ___ ___ ___
   (Date) (Month) (Year)
6. a) Name & Address of the attending Medical Practitioner _____
   _____
   b) Qualification & Telephone No. _____
   c) Registration No. _____
7. a) Name & Address of the Hospital/ _____
   Nursing home/clinic _____
   b) Date of Admission : ___ ___ ___ ___ ___ ___ ___ ___
   (Date) (Month) (Year)
   c) Date of Discharge : ___ ___ ___ ___ ___ ___ ___ ___
   (Date) (Month) (Year)
8. If the claim is for Domiciliary Hospitalization Please Indicate
   a) Date of Commencement of treatment : ___ ___ ___ ___ ___ ___ ___ ___
   (Date) (Month) (Year)
   b) Date of Completion of treatment : ___ ___ ___ ___ ___ ___ ___ ___
   (Date) (Month) (Year)
   c) Name & Address of attending Medical Practitioner : _____
   d) Telephone No. : : _____
   e) Registration No. : _____
9. Are you at present covered under any other similar type of scheme like P.A. Cancer Insurance, Mediclaim (Individual/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 given space below.

   _____

I have incurred Rs. _____ on the treatment of disease/illness/accident referred to above, as per the details given by me in the Schedule of Expense given below.

Details of Hospital/Nursing Home/Clinic Bill

No.	Particulars	Amount ₹
1	Room Charges	
2	Pathology Charges	
3	Surgeon Charges	
4	Anesthesia Charges	
5	Consultation Fees	
6	Medicines (from Chemist)	
7	Others	
	Attach separate Sheet if necessary	
	TOTAL ₹	

In support of the above claim, I enclose the 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/Specialists/ Anesthetist's bill and receipt and certificate regarding diagnosis.
6) In case of Domiciliary Hospitalisation, receipt from a qualified nurse who attended 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.

I hereby warrant the truth of the foregoing particulars in every respect and I agree that if 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 authorize the third party administrator to 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 the TPA to receive payment from Insurance Company as reimbursement of hospital bill incurred on my treatment.

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Dated at _____ this _____day of _____ 201 ___ Signature of the Claimant

1	Name of Account Holder	
2	Bank Name	
3	Full Bank Account No.	
4	IFSC Code	
5	Account Type (Savings/Current)	
6	Bank Address	
7	Mobile No.	
8	Email Id	
9	Cancelled chq. Leaf	

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Signature of the Insured Person (Proposer)

W.E.F. 16/08/2011, all Health claims will be paid through ELECTRONIC TRANSFER (NEFT / RTGS), hence it is mandatory to give alongside details to TPAI

ANNEXURE - A Form

CERTIFICATE FROM ATTENDING DOCTOR OR NURSING HOME / HOSPITAL DOCTOR OF CLAIMANT

1. Name of Patient : 2. Age :

3. Are you family doctor of Patient : 4. Who referred the case to you :

5. When the patient approached you for the first time in connection with present disease :

6. Details of previous history of disease of patient with duration :

7. If the patient is suffering from Diabetes, Hypertension, Blood Pressure, Kidney problem, Cancer, T. B. and Heart problem Or other disease. If yes, specify **Duration :**

8. Present disease suffered :

9. Duration of present disease suffered :

10. Previous admission for same illness : Yes / No

11. Is the disease suffered Acute / Chronic :

12. Is the disease suffered requires Hospitalization :

(a) Nature of the treatment given : Operative / I. V. Fluids / Injection / Oral Treatment / Other Parental treatment

(b) Indoor Case No. of Patient :

13. Date of admission : 14. Date of discharge :

15. Is your hospital registered with local authorities : If yes, Please attach Xerox copy of certificate

16. No. of beds in your Nursing home / Hospital : Attach Xerox Copy of Attested Certificate of No. of Beds

17. Other comments you would like to make connected to present disease suffered by the Patient :

18. Income Tax Permanent Account No. of
Hospital / Nursing Home :
Treating Doctor :
Family Physician :
Any Specialist :
Laboratories/Radiologist/Anethetician :

DOCTOR'S NAME :

SIGNATURE OF ATTENDING DOCTOR (with rubber stamp and Reg. No. of your Nursing Home / Hospital)

Qualification :

Authorization (To be Signed by the Claimant)

TO WHOM SO EVER IT MAY CONCERN

I hereby authorize Paramount Health Services (T.P.A.) Pvt. Ltd. / their representative / Medical referee appointed / deputed by the company to verify/check and/or collect the documents from the Hospital / Doctor or from any other concerned person / authorities, as may be required to settle / decide the above claim, for which I have no objection.

Date :

Place : (Signature of the Insured / Claimant)

YOUR LINK TO GOOD HEALTH