

**HERITAGE HEALTH SERVICES PVT. LTD.  
TPA FOR  
THE ORIENTAL INSURANCE COMPANY LIMITED**



Regd. Office: Oriental House, P.B. No. 7037, A-25/27, Asaf Ali Road, New Delhi - 110 002

Issuing Office Code:

**HOSPITALISATION AND DOMICILIARY HOSPITALISATION BENEFIT POLICY  
CLAIM FORM**

Claim No:

Issuance of this form does not amount to admission of any liability of under the policy on the part of the insurers  
Please give the following information correctly and completely to enable us process your claim promptly.

*All dates to be entered as Date / Month / Year*

1.

*(in whose name policy is issued)*

2. Details of the Insured person:

*(in respect of whom claim is made)*

(a) Name & Relationship with the Insured: .....

(b) Present Completed Age:.....

(c) Occupation:.. ..

(d) Residential Address: ..... Pin.....

(e) Phone No:

3. Policy Number (in Full) :

4. Card No.:

DO/B0 .....

5. Nature of Disease/illness contracted or injury sustained:

6. Date on which injury was sustained/Disease Or illness first detected:

(b) Qualification..... Phone No.:.....

(c) Registration No.:.....

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

(d) Name & Address of the Hospital/Nursing Home.....

8. (a) Hospital/Nursing Home / Clinic ..:

Address: .....

(b) Date of Admission:

(c) Date of Discharge:

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:.....

Pin Code : ..... State/ U. Territory:.....

(d) Telephone No.:.....

(e) Registration No.....

9. Are you at present covered under any other similar type of scheme like PA Cancer Insurance, Medclaim (Individual or Group), Health Insurance, etc? If Yes. Please give particulars of each

(a) Is this the first year of coverage under Medclaim Policy? Yes / No.

If no, since when have you been continuously insured under Medclaim 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 the following original documents (Please indicated by)

1. Bill Receipt and Discharge certificate/card from the Hospital.
2. Cash Memos from the Hospitals (s) / Chemists (s), supported by proper prescriptions.
3. Receipt and Pathological test reports from Pathologist supported by the note from the attending Medical Practitioner/ Surgeon recommending such Pathological tests.
4. Surgeons certificate stating nature of operation performed and Surgeons' 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 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 attending Medical Practitioner giving reasons for allowing treatment at home.
8. Certificate from 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 Bill	RS .....
Room Rent	RS .....
Consultant's / Surgeon's / Anesthetist's Fees	RS .....
Diagnostics Tests	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 or insurance.

I ALSO CONSENT AND AUTHORISE 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 TPA to receive payment from insurance company 'as reimbursement of hospital bills incurred on my treatment.

Dated at ..... This ..... day of, .....200 .....

Phone No. :

Signature of the Claimant

