

HERITAGE HEALTH SERVICES PVT. LTD.  
TPA FOR

UNITED INDIA INSURANCE CO. LTD  
(Govt. of India Undertaking)

CONTROLLING DIVISION:  
HOSPITALISATION AND DOMICILIARY HOSPITALISATION BENEFIT POLICY

CLAIM FORM

ISSUING OFFICE:

CLAIM NO.

Issuance of this form does not amount to admission of any liability under the Policy on the part of the Insurers. Please give the following information correctly and completely to enable the Company to process your claim promptly. If the claim is under Personal Accident Insurance, Please complete a Personal Accident Claim Form.

FOR OFFICE  
USE ONLY

1. Name of the Insured:

SURNAME

INITIALS

(in whose name policy is issue)

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:..... Pin:...

(e) Phone no:...

3. (a) Policy No.

(b) Card No.

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

Pin Code

State/U. Territory

(b) Qualification & Telephone No.

(c) Registration No.

7. (a) Name & Address of the Hospital!  
Nursing Home/Clinic

Pin Code

State/U. Territory

(b) Date of Admission

(c) Date of Discharge

8. If the claim is for Domiciliary Hospitalisation, please indicate

(a) Date of Commencement of treatment

Date      Month      Year

(b) Date of Completion of treatment

(c) Name & Address of attending Medical Practitioner

Date      Month      Year

Pin Code  
State/U. Territory

(d) Telephone No.

(e) Registration No.

I have incurred on the treatment of Disease /Illness / Accident referred of above, the expenses as per the details given by me in the Schedule of Expenses given overleaf.

In support of the above claim, I enclose the following documents (please indicate by) : 121

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/Consultants/Specialist's/Anesthetist's professional bill and receipt and certificate regarding diagnosis on their letterhead / printed receipt.
6. In case of Domiciliary Hospitalisation or 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 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 Medicaid Scheme or insurance.

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

FOR OFFICE USE ONLY:

Signature of the Claimant

Date of Claim

Date      Month      Year

