CHRONIC REIMBURSEMENT - CLAIM FORM

TO BE FILLED BY THE INSURED [illegible]

DETAILS OF PRIMARY INSURED : EMPLOYEE/PENSIONER

No. : [illegible]

GPF/PPF/PRN/PPO no. :

Emp Name :

Address :

District :

State :

Pin Code :

Phone :

Email ID :

DETAILS OF THE PATIENT

Name :

Gender : MALE ☐ FMALE ☐ Age (years) ☐ (months) ☐ Date of Birth : ☐ ☐ ☐

Relationship to the primary Insured : Self ☐ Spouse ☐ Child ☐ Father ☐ Mother ☐ Other ☐ (please specify)

Occupation : Service ☐ Self Employed ☐ Homemaker ☐ Student ☐ Retired ☐ Other ☐ (please specify)

DETAILS OF THE CLAIM

Name of Treating Doctor :

Commencement of Treatment Date : (DD/MM/YYYY) Treatment End Date : (DD/MM/YYYY)

Treatment for :

Claim Form Submitted - Checklist

- ☐ Claim Form Duly Signed
- ☐ Chronic Disease Certificate
- ☐ Prescriptions issued by Govt. Doctors
- ☐ Pharmacy Bills Cash Memo/Receipts
- ☐ Govt. ID of Employee (Main member)
- ☐ ECS Details
- ☐ Cancelled Cheque
- ☐

Total Number of documents submitted :

Select the number as below in lieu of the documents submitted

Members are requested to submit the Illness Certificate by Treating Doctor with detailed duration of the illness for which the treatment would be done

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30+

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30+

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30+

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PN : Expenses related to investigations and doctors consultations are not payable

Sl. No.	Bill No.	Date	Issued By	Towards - Pharmacy Charges	Amount
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

In case more than 10 Bills are to be submitted then attach separate annexure using the same above format

DECLARATION BY THE INSURED

I hereby declare that the information furnished in this claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent & authorize TPA / Insurance company, to seek necessary medical information / documents from any hospital / Medical Practitioner who has attended on the person against whom this claim is made. I hereby declare that I have included all the bills / receipts for the purpose of this claim & that I will not be making any supplementary claim except the pre/post-hospitalization claim, if any.

Date : Place : Signature of the Insured :