# Domiciliary Claim Form

To be filled in by the Insurer

The issue of this form is not to be taken as an admission of liability

(To be filled in Block Letters)

## A) Details of the Primary Insured

| | | |
|---|---|---|
| i) | Policy Number | |
| ii) | Sl.No./Certificate No. (NA) | Not Applicable |
| iii) | Company/TPA ID No. | |
| iv) | Name of the Insured | |
| v) | Address of the Insured | |
| vi) | Phone No. (Mandatory) | |
| vii) | E-Mail ID (Mandatory) | |

## B) Details of Claimant

| | | |
|---|---|---|
| i) | Name | |
| ii) | Gender | |
| iii) | Age-Years :Months :DOB | Years_______ Months_______DOB:________________ |
| iv) | Relation to primary Insured | |
| v) | Occupation | |
| vi) | Address (If different from above) | |

## C. Details of OP Treatment

| | | |
|---|---|---|
| i) | Nature of Illness | |
| ii) | Name of Doctor / Hospital | |
| iii) | Qualification of Medical Practioner | |
| iv) | Address of Doctor / Hospital | |
| | Registration No.of Doctor / Hospital | |
| v) | Period of treatment taken | |
| vi) | Total Amount claimed | |
| vii) | O P Treatment | |

**D. Details of Insurance History** : Not Applicable

**E. Details of Hospitalisation** : Not Applicable

**F. Details of OP Treatment** : Not Applicable

## G. Details of documents submitted (Whichever applicable tick mark)

| | | |
|---|---|---|
| i) | Hospitable Main Bill | |
| ii) | Hospitable Break up Bill | |
| iii) | Hospitable bill Payment Receipt | |
| iv) | Hospitable Discharge Summary | |
| v) | Original Claim form duly signed | |
| vi) | Pharmacy Bill | |
| vii) | Prescription & certificate of illness-Original/Photo copy duly attested. Please tick the relevant field. If Photo copy given reason for the same | |
| viii) | Original Bills of consultation | |
| ix) | Original Bills of medicines purchased | |
| x) | Original bills of laboratory test done | |
| xi) | Reports of the Lab test | |
| xii) | Others | |

## H. Schedule of Expenses incurred and being claimed by the Claimant

| Sl No | Receipt | | Nature of expenditure | Amount Claimed (Rs) | Amount payable (Rs) |
|---|---|---|---|---|---|
| | No. | Date | | | |
| | | | | | |
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| | | | | | |
| Total | | | | | |

## I. Details of Primary Insured Bank account

| | | |
|---|---|---|
| i) | Name of the account holder | |
| ii) | PAN No. | |
| iii) | Branch Name | |
| iv) | Full Bank account No. (14 digits) | |
| v) | IFSC Code (11 digits) | |
| vi) | Cheque/DD No. | |

I hereby declare that the information furnished in the claim form is true and 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 relation to this claim, my right to claim reimbursement shall be forfeited. I also consent & authorise TPA/Insurance Co. 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 hospitalisation claim, if any.

Date : Place Signature of the claimant

DD/MM/YYYY