MedSave Health Care Ltd. (An ISO 9001:2000 Certified Company)
F-701 A, Lado Sarai, Behind Golf Course, New Delhi-110030
Ph No. 91-11-29521061-66 & 39001234, Fax No. 91-11-29521067/71

CLAIM FORM

MEDSAVE REFERENCE NO./FILE NO:_____

NAME OF THE INSURED:_____

CLAIM IN RESPECT OF:_____**RELATION**_____**AGE**_____

ADDRESS _____

TEL. NO.:_____ **Cell NO.**_____**EMAIL**_____

BANK NAME & A/C NO._____ **A/C TYPE**_____**ECS NO.**_____

NAME OF INSURANCE COMPANY:_____

POLICY NO._____**CARD NO**._____

SINCE HOW LONG YOU HAVE BEEN COVERED UNDER MEDICLAIM POLICY_____

NAME OF CORPORATE _____

EMPLOYEE CODE NO. _____

DATE OF COMMENCEMENT OF POLICY:_____ **SUM INSURED + CB**_____

DIAGNOSIS _____

DATE OF ADMISSION_____**DATE OF DISCHARGE**_____

HOSPITAL NAME _____ **REGD NO. OF HOSP./ NO OF BEDS**_____

DATE OF DETECTION OF ILLNESS _____

ANY CLAIM TAKEN IN PAST_____

TOTAL AMOUNT CLAIMED: ROOM RENT / NURSING CHARGES_____

PROFESSIONAL FEES_____ **OTHER CHARGES**_____

TOTAL_____

NO. OF DOCUMENTS ATTACHED:_____

NAME, ADDRESS AND CONTACT NO OF TREATING DOCTOR._____

_____

I hereby warrant the truth of the foregoing particulars in every respect & authorize MedSave Health Care Ltd to process my Hospitalization bills & 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 .

The issuance of this form does not amount to admissibility of any liability under the policy.
I have no objection if my records are verified from the treating Hospitals.

DATE _____ **SIGNATURE OF CLAIMANT**