An ISO 9001-

CLAIM FORM

Please complete all the pages without fail. Do not put 'Dots' (.) Or Dashes (-)

Name of the Insurance Company			
Policy No		Sl. No/ Certificate No	
Name of the Primary Insured in whose name Policy is issued			
Medi Assist ID Number		Employee ID	
Details of the Insured person Hospitalised			

a) Name					
b) Relationship		c) Occupation	Employed	d) Age	
e) Address of Proposer in whose name Policy is issued					
f) Phone No		g) Mobile No			
h) E-mail Address, if any					

i) Your Bank Details– i) Account No (Do Not Use /,- or any Spl Characters	
ii) Name of the Bank	
iii) Branch address	
iii) IFSC Code	
iii) Name of Accountholder as per Bank A/c . Enclose Cancelled Cheque for reference	

Please Note that any incorrect or incomplete or wrong information given with regard to your Bank details may lead to electronic transfer of money of the Claim proceeds, if admissible, to wrong account or no credit to your account for which you will be solely responsible. Neither the Insurer or Medi Assist India TPA Pvt Ltd will be held responsible for such consequences.

I/We agree to indemnify and hold harmless the company Medi Assist India TPA Pvt. Ltd., its Directors, officers and employees against any losses, costs, damages, liabilities, claims and expenses resulting from any wrong information furnished by me/us about our Bank details.

Ailment / Disease/ Injury – contracted/ sustained			
Date of injury sustained/ Disease detected			
If injury, please narrate how it occurred			
Name of the Hospital where treated			
Address of the Hospital with Telephone Number			
PAN No		Registration No of the Hospital	
Name of the Treating Doctor			

Qualification		Registration No		Telephone No	
Admission	Date:	Time:	Discharge	Date:	Time:
Total Amount Claimed			Rs.		

Date of commencement of first insurance for the person (without break)		
Have you been covered with any other Mediclaim/ Health Insurance?	Yes	No
If 'Yes', please attach a photocopy of the Policy/ Policies		
Have you preferred any claim for the same ailment earlier?		

If 'Yes', Claim No		Status: Settled / Denied	
Continued…			
If the claim is for Domiciliary Hospitalisation, please indicate:			
Date of commencement of treatment		Date of completion of treatment	
Name of the treating Doctor		Qualification	
Address of the Doctor			
Reason for not hospitalizing patient			

Date:

Signature of the Claimant

Please send this claim form duly completed with all enclosures to:

MEDI ASSIST INDIA TPA PRIVATE LTD.,
#49, "Shilpa Vidya" Buildings, 1st Main, Sarakki Industrial Layout, 3rd Phase J.P.Nagar, Bangalore - 560078.
Phone: 26584811 **Fax:** 26538793 **Toll Free:** 1800 4259 449

I have incurred the following expenses for the treatment of the disease / ailment / injury detailed overleaf:

To be filled by the Claimant					Medi Assist Use Only	
Bill No	Date	Issued by	Towards	Amount	Disallowed	Reason
Total						

In support of the above claim, I submit the following documents:

Claim form Duly Signed	Yes	No	Pre-hospitalisation Bills __Numbers	Yes	No
Copy of Claim Intimation	Yes	No	Post-hospitalisation Bills __Numbers	Yes	No
Hospital Discharge Summary	Yes	No	Hospital Payment Receipt	Yes	No
Surgeon's Certificate, if any	Yes	No	Investigation Reports	Yes	No
Surgery/ Consultation Bills	Yes	No	Doctor's Reference for Investigation	Yes	No
Hospital Main Bill	Yes	No	MRI	Yes	No
Hospital Break - up Bill	Yes	No	CT Scan	Yes	No
Doctor's Prescriptions	Yes	No	ECG	Yes	No
Pharmacy Bills	Yes	No	USG Scan	Yes	No
Any other (Pl. specify):					

Note:

Please submit Xerox **copies of the Insurance Policy** – current as well as previous

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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/s , suppression or concealment of any fact, 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 availed or claimed under any other medical scheme or Insurance.

I also consent & authorise my insurer as well as Medi Assist India TPA Pvt Ltd., to seek necessary medical information 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 Post - hospitalisation claim, if any.

I also authorise TPA to receive payment from the Insurance Company as reimbursement of hospital bills incurred on my/the Insured person's treatment

Consultants Fee/ Professional Charges shall be admissible as per the hospital Tariff applicable to entitled room category and charges in excess levied by the Visiting Consultants shall be borne by the claimant.

Date: **Signature of the Claimant**

Medi Assist
An ISO 9001-2000 Company

MEDI ASSIST INDIA TPA PRIVATE LTD.,

#49, "Shilpa Vidya" Buildings, 1st Main, Sarakki Industrial Layout, 3rd Phase J.P.Nagar, Bangalore - 560078.
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MEDICAL CERTIFICATE TO BE FILLED IN BY THE DOCOTR TREATING THE PATIENT

Please Do not put 'Dots' (.) Or Dashes (-)

1	Name of the Patient				Age	___ Yrs
2	Hospitalisation Period	Date of Admission		Date of Discharge		
3	Diagnosis					
4	Date of First Consultation (Prior to Hospitalisation)					
5	Presenting Complaints on admission					
6	Since when was the patient suffering from these?					
7	Past history of the patient, if any, with duration of ailments					
8	Whether the present ailment is a complication of any Pre-existing ailment?		Yes		No	
9	If yes, please specify the disease or complication of any previous surgery done and details thereof					
10	Whether the Disease/ Defect/ Disorder is congenital in nature		Yes		No	
11	Nature of treatment given or surgery performed for the present ailment/ injury					
12	If the claim is for maternity, number of living children excluding the new born					
13	Whether the hospital is registered with the Local Authority? If 'Yes', please furnish Registration Number					
14	Number of Inpatient beds in the Hospital.					
15	Whether the hospital has fully equipped Operation Theatre of its own?					
16	Whether qualified Nurses are employed round the clock?					
17	Whether the Hospital is under the supervision of a Registered Medical Practitioner round the clock?					
18	Name of the Treating Doctor		Qualification		Telephone No	

Date:

Signature of the Doctor with Seal

Medi Assist™
An ISO 9001-2000 Company

Date: _____

To `

(Name & Address of the Hospital)

_____
_____

Dear Sirs,

Re: Authorisation to M/s Medi Assist India TPA Private Limited

I wish to inform you that I have undergone treatment for _____ ailment from (Date) _____ to (Date) _____ in your hospital as an inpatient bearing Hospital Inpatient No: _____

I hereby **authorise** **M/s Medi Assist India TPA Private Ltd**, who are my TPA for servicing the Health Insurance Policy I have, to seek any medical information/ records from your Hospital or from the Medical Practitioners who have attended on me in connection with the above ailment.

I have no objection to your furnishing any such information/ records sought by them.

Kindly oblige.

Thanking you,

Yours faithfully,

(SIGNATURE OF THE PATIENT)

Address of the Insured:

_____

_____

_____

Telephone No: _____