Dear Sir/Madam,

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Please provide following details for updating claim intimation in our system |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |
| CLAIM INTIMATION NOTE |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| \*Corporate ID / Policy No: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| \*Vipul ID Card No: | |  |  |  |  |  |  |  |  |  |  |  |  |  |
| \*Patient Name: | | |  |  |  |  |  |  |  |  |  |  |  |  |
| \*Hospital Name: | | | |  |  |  |  |  |  |  |  |  |  |  |
| \*Hospital Type: Network or Non-network | | | | |  |  |  |  |  |  |  |  |  |  |
| \*Hospital State: | | | | | |  |  |  |  |  |  |  |  |  |
| \*Hospital City: | | | | | | |  |  |  |  |  |  |  |  |
| \*Hospital Address: | | | | | | | |  |  |  |  |  |  |  |
| \*Hospital Phone No: | | | | | | | | |  |  |  |  |  |  |
| \*Admission Date: | | | | | | | | | |  |  |  |  |  |
| \*Expected Discharge Date: | | | | | | | | | | |  |  |  |  |
| \*Diagnosis | | | | | | | | | | | |  |  |  |
| \*Intimation Date: | | | | | | | | | | | | |  |  |
| \*Estimated Cost: | | | | | | | | | | | | | |  |
| \*Mobile No: | | | | | | | | | | | | | | |