# STAR HEALTH AND ALLIED INSURANCE CO. LTD.

# MEDICAL INSURANCE CLAIM FORM

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| **Policy No.:** | POL-IN-987654 |
| **Claim No.:** | STAR_HEALTH_session_ |
| **Date of Claim:** | 05/09/2025 |

## PATIENT DETAILS

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|---|---|
| **Name of Insured:** | |
| **Date of Birth:** | N/A |
| **Age:** | N/A |
| **Gender:** | N/A |
| **Address:** | N/A |
| **Contact No:** | N/A |
| **Email ID:** | N/A |

## HOSPITAL DETAILS

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|---|---|
| **Name of Hospital:** | Springfield General Hospital |
| **Hospital Address:** | N/A |
| **Doctor Name:** | |
| **Date of Admission:** | |
| **Date of Discharge:** | |
| **Nature of Illness:** | |
| **Total Bill Amount:** | ■169350.0 |

## BANK DETAILS FOR REIMBURSEMENT

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|---|---|
| **Account Holder Name:** | |
| **Account Number:** | |
| **IFSC Code:** | |

| | |
|---|---|
| **Bank Name:** | |
| **Branch:** | N/A |

## DECLARATION

I hereby declare that the information provided above is true and correct to the best of my knowledge. I understand that any false information may result in rejection of my claim.

**Signature of Insured:** _____ Date: _____

**Name:** Policy No: POL-IN-987654