CLAIM INTIMATION FORM

MEDICARE T.P.A Services (I) Pvt. Ltd.

POLICY INFORMATION

Name of Insurance Company	**New India Assurance Co Ltd. (Union Health Care)**		
Membership No	**0 2 I**	Certificate No	
Policy Start Date	D D / M M / Y Y Y Y	Policy end Date	**0 1 / 0 1 / 2 0** Y Y
Name of Policy Holder			
Phone		Mobile No	

Hospitalization Information

Name of Patient			
Medicare Membership No.			
Age of Patient	_____ years	Sex	Male / Female
Diagnosis			
Date & Time Admission		Probable Date of Discharge	
Line of Treatment			
Name of Hospital			
Address of Hospital			
City		State	
Contact no. of Hospital			
Name of Treating Doctor			
Contact No. of Treating Doctor		**Mob No**	
Name of Family Physician			
Contact No. of Family Physician		**Mob No**	
Estimated Expenses			
Intimation Submitted By	Insured / Patient / Relative / Agent		

1. I hereby authorize **Medicare TPA Services (I) Pvt. Ltd.** / Insurance Company / Representative of Insurance Company to obtain my medical record / information from Hospital / Nursing Home / Treating Medical Professionals / family physician / Diagnostic Centers / Medical Shops necessary to process the claim.
2. Photo Identity (PAN/ VOTER ID of the patient has to be carried to hospital during hospitalization.
3. Photo Identity of the patient has to be attached along with Claim Intimation / Documents.
4. Non submission of the claim Intimation within stipulated time of policy terms will result the claim NO CLAIM

Signature / Thumb Impression of the Patient / Relative / Policy Holder			
Name			
Mob No		Email	
Date			

Please send this to Medicare TPA email id : medicaremumbai@medicaretpa.co.in Fax No 022- 22616650
Mail Address :- MEDICARE TPA SERVICES (I) PVT LTD, 58/64, Hari Chambers, 3rd Floor, Shahid Bhagat Singh Marg, Fort, Mumbai – 400023. Phone No For Cashless : 09819686736 For Reimbursement : 022-66377744