CLAIM NO :- CORP / CL /



STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED

Corporate Office: 1, New Tank Street, Valluvarkottam High Road, Chennai - 600 034.

CLAIM FORM FOR MEDICAL INSURANCE

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DETAILS OF CURRENT CLAIM Financial Details : Bill Amoun	BILLS	COTTON DE SOU				
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inancial Details : Bill Amoun	t			Claim Amount		
have incurred the above expensed	for the treatme	ent of the d	isease/illness/ac	cident and herewith	as per schedule mention	oned below:
Date Bill No.	Descriptio		Bill Amount	Amount Claimed	Claim type (Pre- H	
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If required, additional sheet to be at		TOTAL				
support of the claim, I enclose	the following	g documer	nts			
laim Form Duly Signed	YN	Pre-Ho	spitalization Bills	No(s)	Bill Amount	YN
re-authorization form	YN	Hospita	Payment Rece	ipt		YN
Claim Notification	YN	Investig	ation Report wit	h Dr's request		YN
Discharge Summary	YN		Yes/No. 2) CT S			YN
lospitalization Bills	YN		Yes/No. 4) X-ray Scan Yes/No.	/ Yes/No		
Ooctors Surgery Certificate if any	YN			equest No(s)	of	YN
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Surgery/Consultation Bills if any	YN					
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Hospital Seal:

MEDICAL CERTIFICATE TO BE FILLED IN BY THE TREATING DOCTOR

1. Name of the Patient & Age 2. Admission Date and Time 3. Name of Surgeon / Physician 4. Diagnosis 5. Date of First Consultation (Prior to hospitalisation) 6. (a) With What compliants was the patient admitted for: (b) Since when was the patient suffering from the said complaints 7. Past History of the Patient (if any) with the duration of litness 8. Whether the present aliment is a complication of Pre-existing disease? If yes, please specify the disease (or) complication of any previous surgery done? If yes, please specify details. 9. Whether the disease/disorder is congenital in nature? 10. Nature of Surgery/treatment given for present ailment 11. (a) Whether Hospital/Nursing Home is Registered, if yes, Regn. No. (b) No of in - patient beds in the Hospital (including ICU) (C) Whether the Hospital is having fully equipped Operation Theatre of its own/gualified nurses round the clock/Qualified doctors round the clock reconserved reconserved rec	te and Time Discharge Date And Time con / Physician Consultation tatisation) compliants was the patient in was the patient suffering from laints If the Patient (if any) with the ess present ailment is a complication of isease? specify the disease (or) if any previous surgery done? specify details. isease/disorder is congential in gery/treatment given for present tospital/Nursing Home is yes, Regn. No. patient beds in the Hospital) the Hospital is having fully equipped after of its own/qualified nurses kk/Qualified doctors round the	AND THE PART OF A STATE OF
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