**H**IMALAYAN **E**verest **I**NSURANCE **C**O. **L**TD.
Babarmahal GPO Box - 148, Kathmandu, Nepal
Tel: 4231890, 4231780

# MEDICAL INSURANCE CLAIM FORM

1. Name of the Office/Insured : _____
2. Policy No & Period of Insurance : _____
3. Business Address / Ph. / Fax No. : _____

   _____
4. Claimant i.e. Employee's Name : _____
5. Claimant Occupation / Age / Sex : _____
6. Name / Age / Sex of the patient : _____
7. Claimant relation to the patient : _____
8. Patient's Res. Address & Ph. No. : _____
9. Treatment was due to :
   **a) Illness** **:** (Date of symptoms started) : _____ Date Ist. Treated : _____
   **b) Accident** **:** (Date/time of accident) : _____ Date Ist. Treated : _____
10. Give details of diagnosis/ symptom of illness : _____
11. Give full details of nature of injuries were caused : _____

    _____

    _____

    _____
12. Name of attending doctor : _____
13. Doctor's Qualification & N.M.C. No. : _____
14. Doctor's contact address/ Ph. No. : _____
15. Can the patient be available at above given address for visit by Co's Doctor ? If so, when ? _____

    _____
16. Total Claimed Amount :

We hereby declare that the foregoing statements are true to the best of our knowledge.

Signature of Policy holder _____ _____
with official seal/ stamp Signature of Claimant

Date: _____ Date: _____

**MEDICAL INSURANCE CLAIM STATEMENT**

**INSURED :** **POLICY NO :**

**CLAIMANT :**

| S. No. | BILL NO. | DESCRIPTION | AMOUNT | TOTAL AMOUNT |
|---|---|---|---|---|
| 1. Doctor/ physician/ specialist's fees | | | | |
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| 2. Doctor/ physician/ specialist's fees for visit to the patient at home | | | | |
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| 3. Cost of medicine, medical appliances, dressing/procedure charge etc. | | | | |
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| 4. Cost of X-ray, ECG, EEG, USG, Doppler study, Pathological tests, | | | | |
| CT Scan, MRI, Endoscopy, ECHO, TMT, Physiotherapy etc. | | | | |
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