Medi Assist

REIMBURSEMENT CLAIM FORM

TO BE FILLED BY THE INSURED

The issue of this Form is not to be taken as an admission of liability

(To be Filled in block letters)

SECTION A

DETAILS OF PRIMARY INSURED:

a) Policy No.:

b) Sl. No/ Certificate no.

c) Company / TPA ID (MA ID)No:

d) Name: SRINIVASAN SURESH KUMAR

e) Address: ASV MARDENIA, FLAT-001, BLOCK-A, GROUND FLOOR, CHINNASWAMAPPA LAYOUT, HORAMAVU

City: BENGALURU State: KARNATAKA

Pin Code: 560043 Phone No: 8892393391 Email ID: surey1987@gmail.com

SECTION B

DETAILS OF INSURANCE HISTORY:

a) Currently covered by any other Mediclaim / Health Insurance: ☐ Yes ☐ No b) Date of commencement of first Insurance without break: D D M M Y Y Y Y

c) If yes, company name: Policy No.

Sum insured (Rs.) d) Have you been hospitalized in the last four years since inception of the contract? ☐ Yes ☐ No Date: M M Y Y

Diagnosis: e) Previously covered by any other Mediclaim /Health insurance : ☐ Yes ☐ No

f) If yes, company name:

SECTION C

DETAILS OF INSURED PERSON HOSPITALIZED:

a) Name: SRINIVASAN SURESH KUMAR

b) Gender Male ☑ Female ☐ c) Age years Y Y Months M M d) Date of Birth D D M M Y Y Y Y

e) Relationship to Primary insured. Self ☑ Spouse ☐ Child ☐ Father ☐ Mother ☐ Other ☐ (Please Specify)

f) Occupation Service ☐ Self Employed ☐ Home Maker ☐ Student ☐ Retired ☐ Other ☑ (Please Specify) S/W ENGINEER

g) Address (if diffrent from above) :

City: State: Email ID:

Pin Code Phone No:

SECTION D

DETAILS OF HOSPITALIZATION:

a) Name of Hospital where Admited: TRUST-IN HOSPITAL

b) Room Category occupied: Day care ☐ Single occupancy ☑ Twin sharing ☐ 3 or more beds per room ☐

c) Hospitalization due to: Injury ☐ Illness ☑ Maternity ☐ d) Date of injury / Date Disease first detected /Date of Delivery: D D M M Y Y Y Y

e) Date of Admission: 05 12 25 f) Time 09 : 28 pm g) Date of Discharge: 08 12 25 h) Time: 07 : 17 pm

I) If injury give cause: Self inflicted ☐ Road Traffic Accident ☐ Substance Abuse / Alcohol Consumption ☐ j) If Medico legal ☐ Yes ☐ No

ii) Reported to Police ☐ ☐ iii. MLC Report & Police FIR attached ☐ Yes ☐ No j) System of Medicine:

SECTION E

DETAILS OF CLAIM:

a) Details of the Treatment expenses claimed

1. Pre -hospitalization expenses Rs.
ii. Hospitalization expenses Rs. 52570/-
iii. Post-hospitalization expenses Rs.
iv. Health-Check up cost: Rs.
v. Ambulance Charges: Rs.
vi. Others (code): ☐☐☐ Rs.
Total Rs. 52570/-
vii. Pre -hospitalization period: days
viii. Post -hospitalization period: days

b) Claim for Domiciliary Hospitalization: ☐ Yes ☐ No (If yes, provide details in annexure)

c) Details of Lump sum / cash benefit claimed:
i. Hospital Daily cash: Rs.
ii. Surgical Cash: Rs.
iii. Critical Illness benefit: Rs.
iv. Convalescence: Rs.
v. Pre/Post hospitalization Lump sum benefit: Rs.
vi. Others: ☐☐☐ Rs.
Total Rs.

Claim Documents Submitted - Check List:

- ☐ Claim form duly signed
- ☐ Copy of the claim intimation, if any
- ☐ Hospital Main Bill
- ☐ Hospital Break-up Bill
- ☐ Hospital Bill Payment Receipt
- ☐ Hospital Discharge Summary
- ☐ Pharmacy Bill
- ☐ OperationTheater Notes
- ☐ ECG
- ☐ Docto's request for investigation
- ☐ Investigation Reports (Including CT / MRI / USG / HPE)
- ☐ Doctols Prescriptions
- ☐ Others

SECTION F

DETAILS OF BILLS ENCLOSED:

Sl. No.	Bill No.	Date	Issued by	Towards	Amount (Rs)
1.				Hospital main Bill	45350/-
2.				Pre-hospitalization Bills: Nos	
3.				Post-hospitalization Bills: Nos	
4.				Pharmacy Bills	7220/-
5.					
6.					
7.					
8.					
9.				TOTAL	52570/-
10.					

SECTION G

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT:

a) PAN: CBYPS0197S b) Account Number: 50100575689

c) Bank Name and Branch: HDFC BANK, HORAMAVU BRANCH

d) Cheque / DD Payable details: e) IFSC Code: HDFC0000378

SECTION H

DECLARATION BY THE INSURED:

I hereby declare that the information furnished in the claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealent of any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited, I also consent & authorize TPA / Insurance Company, to seek necessary medical information / documents from any hospital / Medical Practitioner who has attended on the person against whom this claim is made. I hereby declare that I have included all the bills / receipts for the purpose of this claim & that I will not be making any supplementary claim except the pre/post-hospitalization claim, if any.

Date 09 12 2025 Place: BENGALURU Signature of the Insured

(IMPORTANT: PLEASE TURN OVER)