



STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED

Regd. & Corporate Office: 1, New Tank Street, Valluvar Kottam High Road, Nungambakkam, Chennai - 600 034.

Corporate Office - Claims Dept. : No.15, Balaji Complex, Whites Lane, 1st Floor, Royapettah, Chennai - 600 014.

Toll free Phone No: 1800 425 2255 Toll free Fax No: 1800 425 5522

CIN : U66010TN2005PLC056849 Email:support@starhealth.in Website: www.starhealth.in IRDAI Regn. No: 129

REQUEST FOR CASHLESS HOSPITALISATION FOR HEALTH INSURANCE

POLICY PART – C (Revised)

(TO BE FILLED IN BLOCK LETTERS)

DETAILS OF THE THIRD PARTY ADMINISTRATOR/INSURER/HOSPITAL.:

- a. Name of TPA/Insurance company : STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED
- b. Toll free phone number: _____
- c. Toll free fax: _____
- d. Name of Hospital: _____
- i.Address _____
- ii.Rohini ID _____
- iii.e-mail id _____

TO BE FILLED BY INSURED/PATIENT

- A. Name of the Patient : _____
- B. Gender: ☐ Male ☐ Female ☐ Third Gender
- C. Age: _____ (Years) / (Month)
- D. Date of Birth: _____ (DD/MM/YYYY)
- E. Contact number: _____
- F. Contact number of attending Relative: _____
- G. Insured Card ID number: _____
- H. Policy number/Name of Corporate: _____
- I. Employee ID : _____
- J. Currently do you have any other mediclaim / health insurance: Yes ☐ No ☐
- i.Company Name: _____
- ii.Give Details: _____
- K. Do you have a family Physician: Yes ☐ No ☐
- L. Name of the family Physician: _____
- M. Contact number, if any: _____
- N. Current Address of Insured Patient: _____
- O. Occupation of Insured Patient: _____

(PLEASE COMPLETE DECLARATION OF THIS FORM)