INSURANCE CLAIM FORM

Claim Number:	CLM-2025-00823	**Claim Date:**	2025-01-20
Policy Number:	POL-789456-2024	**Policy Type:**	Health Insurance - Family Floater

CLAIMANT INFORMATION	
Full Name:	Priya Sharma
Address:	23 Nehru Nagar, Mumbai, Maharashtra 400001
Phone:	+91-99888-77665
Email:	priya.sharma@email.com
Date of Birth:	1990-03-15

INCIDENT DETAILS	
Date of Incident:	2025-01-18
Time of Incident:	11:30 AM
Location:	Lilavati Hospital, Mumbai, Maharashtra
Type of Incident:	Medical Emergency - Appendicitis
Police Report Filed:	No

Description of Incident:

Experienced severe abdominal pain and was rushed to Lilavati Hospital. Diagnosed with acute appendicitis requiring immediate surgical intervention. Underwent laparoscopic appendectomy. Hospital stay of 3 days with post-operative care and medications.

DAMAGES CLAIMED

Item	Description	Amount
Surgery Charges	Laparoscopic appendectomy	Rs.1,25,000
Hospital Room	3 days private room	Rs.45,000
Medications	Post-operative medicines	Rs.12,500
Doctor Consultation	Surgeon and anesthetist fees	Rs.35,000
	Total Claim Amount:	**Rs.2,17,500**

Claimant Signature: _____ **Date:** **2025-01-20**