HEALTH INSURANCE CLAIM FORM

Claim Number:	CLM-2024-00567
Policy Number:	POL-2024-MH-789456
Claim Date:	15/11/2024
Policy Holder:	Rajesh Kumar Sharma
Patient Name:	Rajesh Kumar Sharma
Hospital Name:	Apollo Hospital, Mumbai
Date of Admission:	10/11/2024
Date of Discharge:	13/11/2024
Diagnosis:	Acute Appendicitis
Treatment:	Appendectomy (Laparoscopic)
Total Claim Amount:	■1,25,000

BILL BREAKDOWN

Description	Amount (■)
Room Charges (3 days @ ■2,500/day)	7,500
Surgery Charges	45,000
Surgeon Fees	25,000
Anesthesia Charges	8,000
Medicines and Consumables	15,500
Diagnostic Tests	12,000

Nursing Charges	6,000
Other Hospital Charges	6,000
TOTAL	**■1,25,000**

DECLARATION

I hereby declare that the information provided above is true and correct to the best of my knowledge. I understand that any false information may result in rejection of this claim.

Signature: _____

Date: 15/11/2024

Place: Mumbai