United India Insurance Co. Ltd
(Government of India Undertaking)
Division Office 010600: 5th Floor
PLA Ratna Towers, 212 Anna Salai, Chennai- 600 006
மண்டல அலுவலகம் 010600: 5 வது தளம், பிளல்ஏ ரத்னா டவர்ஸ்,
212 அண்ணாசாலை, சென்னை- 600 006
044-2829 7804 (ஆயிரம் விளக்குகள் மெட்ரோ நிலையம் அருகில்) E-Mail:010600@uiic.co.in

Common Claim for NHIS Schemes (Employees and Pensioners)

1. Please fill this form in BLOCK CAPITAL letters
2. This form is applicable for one admission only. Use separate forms for each claim.

Name of the Employee/ Pensioner	
Emp/ GPF/ PPO No	
Name of the office/ Treasury	
NHIS ID Card No	
Complete residential address and Pin code	
Mobile No	
Alternate Mobile No	
Name of the Patient	
Relation to the Employee/ Pensioner	
Date of admission	
Date of discharge	
Name of the Hospital	
Date of submission of Claim form	
Office to which Claim form is submitted	

CHECK LIST FOR SUBMISSION OF REIMBURSEMENT CLAIM

While submitting the Reimbursement documents please ensure that a complete set of following documents are attached. Kindly arrange the document in the same order as in the check list and keep checking again the designated box when you do so. This way you can ensure that you have not missed any documents.

Type of Document	Availability (yes/ No) Check the boxes			
Copy of NHIS ID card or Annexure IV form	Yes		No	
Original Discharge Summary issued by hospital	Yes		No	
Original Hospital Final Bill	Yes		No	
Original Detailed /Breakup of hospital final bill	Yes		No	
All original Individual Cash Receipts	Yes		No	
Original Pharmacy Bills with prescription.	Yes		No	
Original Investigation/ Lab Reports/ Films	Yes		No	
Original Implant / Stent Invoice (if applicable)	Yes		No	
Copy of FIR/MLC Report in case of accidents	Yes		No	
First page of bank pass book or cancelled cheque leaf	Yes		No	

Declaration

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 concealment 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.

Date: Signature of the Employee/ Pensioner