

HCL TECHNOLOGIES LTD

HOSPITALIZATION TREATMENT CLAIM SUMMARY FORM

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MEDICAL CYCLE: 2024-25

EMPLOYEE DETAILS			
Claim No. : 1273922	No. of Claim Entries : 1	Total Claim : ₹ 42500.00	Status : Submitted
Name : Manish Kumar Sinha	EmpCode : 52018677	Band : E3	
DOJ : 29- Nov-2021	Email ID : MANISHKUMAR_SINHA@HCLTECH.COM	Landline/Mobile : 8910205855	PayRollAreaCode : LK
Payee Name : Manish Kumar Sinha	Bank Name : ICICI BANK LTD	IFSC Code : ICIC0000165	Account No. : 016505002863

PATIENT'S DETAILS		
Name : Asha Sinha	Relation with the Employee : Mother	Age : 61

CLAIM DETAILS		
Name of Hospital : Divya Drishti Eye Center Private Limited, 3, SBI Colony, Seikpura, Patna - 8000014. Bihar.	Date of Admission : 14-Apr-2025	Date of Discharge : 14-Apr-2025

#	Description	Amount	Claimed(Y/N)	Remarks
1	Room Charges for patient	₹ 0.00		
2	Room Charges for Attendant/Guests	₹ 0.00		
3	Test(s) /X-Charges	₹ 0.00		
4	Medicine Expenses	₹ 0.00		
5	Doctor's Fee	₹ 0.00		
6	Operation Theater Charges	₹ 0.00		
7	Surgery Charges	₹ 0.00		
8	Nursing Charges	₹ 0.00		
9	Any Other Charges(give brief details)	₹ 42500.00		
	Total Claim Amount	₹ 42500.00		

This is to confirm that the below given items as checked are being provided from my end and they are genuine and correct as per my understanding.

Original Discharge summary	<input checked="" type="checkbox"/>
Discharge Summary should include	<input checked="" type="checkbox"/>
It should be on the Hospital Letter Head	<input checked="" type="checkbox"/>
The letter head should bear hospital address, telephone nos., email id, fax nos. etc	<input checked="" type="checkbox"/>
Name of the patient, Age, Gender	<input checked="" type="checkbox"/>

Referred from/By	<input checked="" type="checkbox"/>
IP No	<input checked="" type="checkbox"/>
Date & time of Admission & Date & time of discharge	<input checked="" type="checkbox"/>
Name of the treating doctor / s	<input checked="" type="checkbox"/>
Final Diagnosis	<input checked="" type="checkbox"/>
Provisional Diagnosis	<input checked="" type="checkbox"/>
Chief Complaints/Presenting complaints	<input checked="" type="checkbox"/>
Past History of Presenting illness with duration	<input checked="" type="checkbox"/>
History of any other ailment, treatment, consultation etc. with Personal History	<input checked="" type="checkbox"/>
Menstrual History in case of female patients	<input checked="" type="checkbox"/>
General Physical Examination, Vitals	<input checked="" type="checkbox"/>
Systemic Examination	<input checked="" type="checkbox"/>
Investigations done at the hospital and elsewhere and Findings	<input checked="" type="checkbox"/>
Treatment given in detail	<input checked="" type="checkbox"/>
Surgery Details with Date of Surgery, Procedure, Type of Anaesthesia, Name of the Surgeon, Asst Surgeon, Anaesthetist, Procedure Notes	<input checked="" type="checkbox"/>
Course in the hospital	<input checked="" type="checkbox"/>
Condition at Discharge	<input checked="" type="checkbox"/>
Discharge Advice and Medications	<input checked="" type="checkbox"/>
Follow-up Instructions	<input checked="" type="checkbox"/>
Signed by the Surgeon/Medical Superintendent/ Doctor who treated the patient	<input checked="" type="checkbox"/>
In case of maternity, details of Gravida (GPAL – Gravida / Para / Abortion / Living children) to be given	<input type="checkbox"/>
Original Medicine Bills	<input checked="" type="checkbox"/>
Original Reports/ Tests	<input checked="" type="checkbox"/>
Original Bills of reports/ Tests	<input checked="" type="checkbox"/>
Break up details for hospitalization Final bill	<input checked="" type="checkbox"/>
Pre numbered cash paid receipt for Hospitalization Payment	<input checked="" type="checkbox"/>
Signed Discharge Voucher	<input checked="" type="checkbox"/>
Signed Print out of the Claim Form	<input checked="" type="checkbox"/>
Staple all the supports carefully to ensure there is no loss in transit	<input checked="" type="checkbox"/>

CLAIM HISTORY			
Date	Status	Name	Remarks
02-May-2025	Submitted	Manish Kumar Sinha	Please approve as part of treatment for vision in left eye. All the relevant documents are attached.

Declaration

I hereby agree, affirm and declare that:

1. The statements/information given/stated by me/us in this claim form are true, correct and complete.
2. No material information which is relevant to the processing of the claim or which in any manner has a bearing on the claim has been withheld or not disclosed.

3. If I have given/made any false or fraudulent statement /information /Documents, or suppressed or concealed or in any manner failed to disclose material information, the policy shall be void and that I shall not be entitled to all/any rights to recover there under in respect of any or all claims, past,present or future. Further, I am aware that submission of fraudulent claims can lead to disciplinary action under the Company policies up to and including termination.
4. The receipt of this claim form/other supporting/related documents does not constitute or be deemed to constitute an agreement by the Company of the claim and the Company reserves the right to process or reject or require further/additional information in respect of the claim.
5. I have read and understood the indicative list of Over the Counter Drugs.
6. Non Medical items are not payable under the policy.
7. I have read and understood that treatment for Cosmetic/Acne /Alopecia (Hair fall treatment)/ Malasma /hypo pigmentation / Infertility & Contraception related treatment/ HIV related Problem / Congenital External diseases is not payable.

Please note that before dropping the claim, you have to enter claim information in the medical register which is kept on the medical claim drop box.

Place:

Date: 02-May-2025

Signature of Insured Employee

Important:

Since it is a pre - requisite for admission of claims under the policy that the Hospital / Nursing Home / Clinic where the Insured Person was admitted, is registered with Local Authorities, it is necessary for the claimant to ensure that the Hospital / Nursing Home / Clinic indicates the same on the Bill - cum - Receipt issued by them.

**AUTHORIZATION LETTER TO VIDAL
HEALTH TPA PVT. LTD.**

To

The Medical Superintendent

Sub: Request to verify /obtain copies of the Medical
Records

I have undergone treatment for -----

From----- to----- in
your hospital / Clinic under

I consent & authorize my insurer (New India
Assurance Co. Ltd) and it TPA Vidal Health TPA Pvt
Ltd., to seek necessary medical information from the
hospital / Medical Practitioner with regards to the
settlement of this Medical claims.

Pls. provide the necessary help and inputs required
for the same information/records required by the
insurance. I have no objection whatsoever in this
regard.

Thanking you,

Signature of the Patient:

Name of Patient:

Place:

Signature of the Employee:

Name of Employee:

Date: