Broad Guidelines for Claim Process

1. Please ensure Claim form is completely filled, signed and **submitted in original.**
2. Please provide at least **two contactable mobile numbers and e-mail id** for further communication related to your claim.
3. Indicative list of claim documents has been provided in the Claim Form under Section E. **Please ensure all the documents are submitted in original for smooth processing of claim.**
4. **Claim processing will be delayed in absence of original documents.**
5. **Claim payments are made only through Online Bank Transfers.** Please submit the Bank Account details along with a cancelled cheque. The bank accounts details need to be mentioned in Section G of the Claim Form.

In addition to above, if the claim amount is more than Rs 1 Lakh then following additional documents are required:

6. Pan Card of the Employee.

Claim documents needs to be send on below address: -

Care Health Insurance-Claims Department
Unit No. 604 - 607, 6th Floor, Tower C,
Unitech Cyber Park, Sector-39, Gurugram -122001 (Haryana)

Now, track your claim status with ease

ONLINE : Please visit below link and enter your Client ID and Policy Number
www.careinsurance.com/claim_search.php **Center/Claim Search/Enter Client ID and Policy No.**

SMS : Simply SMS your claim reference number in the message format CLAIM <space> CLAIM NUMBER to 77158-77158
Example: To check claim status of claim reference number 11223344, simply SMS CLAIM 11223344 to 77158-77158

Brief description of the key documents required along with the claim form

1. Indoor Case Papers - This document is prepared by hospital on daily basis which maintains daily doctor notes, nursing notes, patient progress details and having patient condition summary from the date of admission till discharge.
2. Hospital Discharge Summary - Summary of hospitalization period including - Admission date, discharge date, diagnosis, line of treatment given to patient during hospitalization and further advice on discharge.
3. Payment Receipts - Receipts of payment done to hospital authorities towards all bills, investigation reports or any other procedure done.
4. Consultation Papers - Written prescription of the Medical Practitioner with whom patient has consulted.
5. **NEFT (Net Electronic Fund Transfer) – We require original cancelled cheque of the policyholder and relevant details to be mandatorily filled under Sector-G of claim form.**

Terms and Conditions for Payments through RTGS/NEFT

1. The details provided by the policyholder in the mandate form shall be considered as final and Care Health Insurance Limited shall not be responsible for cross verifying of any of the details provided therein.
2. The policy holder agrees that transaction through RTGS/NEFT facility may attract inward RTGS/NEFT charges, which if levied by the policyholder's bank shall be borne by the policy holder only.
3. Submission of documents or bank details or any other information does not in any way, shape or form, imply or express or suggest admission of liability by the company.
4. I/We further undertake to refund any excess amount whether demanded by Care Health Insurance Limited or not, which has been credited in excess to my account at any time due to any reason within 7 days of such receipt of such communication from Care Health Insurance Limited of such excess credit or such information of excess credit coming to the knowledge of the policy holder through any other source.
5. The policyholder agrees that under RTGS/NEFT facility, there may be risk of non-payment in the policyholder accounts number on the day of the credit of payments due to change in the applicable regulations pertaining to RTGS/NEFT facility or due to any other reasons without any fault/inaction/failure on part of Care Health Insurance Limited or any factor beyond the control of Care Health Insurance Limited.

Care Health Insurance Limited (Formerly known as Religare Health Insurance Company Limited)
Registered Office: 5th Floor, 19 Chawla House,Nehru Place,New Delhi-110019 Corresp. Office: Unit No. 604 - 607, 6th Floor, Tower C, Unitech Cyber Park, Sector-39, Gurugram -122001 (Haryana)
Website: www.careinsurance.com E-mail: customerfirst@careinsurance.com Call us: 1800-102-4488 | 1800-102-6655
CIN: U66000DL2007PLC161503 UIN: IRDA/NL-HLT/RHI/P-H/V.I/254/13-14 IRDA Registration No. - 148

HEALTH INSURANCE

Claim Form - 'GROUP CARE'

Part A

1. To be filled in by the Insured.
2. The issue of this Form is not to be taken as an admission of liability.
3. To be filled in block letters.

Section A - Details of Primary Insured

a) Policy No. :

b) SL No./Certificate No.: c) Company/TPA ID No.:

d) Name :

(Surname) (First Name) (Middle Name)

e) Address :

City :

State : Pin Code :

Landline : - Mobile :

E-mail :

Section B - Details of Insurance History

a) Currently covered by any other Mediclaim/Health Insurance : Yes No

b) Date of commencement of first insurance without break : / / (DD/MM/YYYY)

c) If yes, Company Name :

Policy Number : Sum Insured (Rs.):

d) Have you ever been hospitalized in the last 4 years since inception of the contract? Yes No

- Date : / / (DD/MM/YYYY)
- Diagnosis : _____

e) Previously covered by any other Mediclaim/Health Insurance : Yes No

f) If yes, Company Name :

Section C - Details of Insured Person Hospitalised

Title : Mr. Ms.

a) Name :

(Surname) (First Name) (Middle Name)

b) Gender : M F c) Age : / (YY/MM) d) Date of Birth : / /

e) Relationship with Primary Insured : Self Spouse Child Father Mother

Others (Please Specify) _____

f) Occupation : Service Self Employed Homemaker Retired Student Others (Please Specify) _____

g) Address : (if different from above)

City :

State : Pin Code :

h) Landline : - Mobile :

i) E-mail :

Section D - Details of Hospitalisation

a) Name of Hospital where Admitted :

b) Room Category occupied : ☐ Day Care ☐ Single Occupancy ☐ Twin Sharing ☐ 3 or more beds per room

c) Hospitalisation due to : ☐ Injury ☐ Illness ☐ Maternity

d) Date of Injury/Date Disease first detected/Date of Delivery : ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)

e) Date of Admission : ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY) f) Time of Admission : ☐☐ : ☐☐ (HH:MM)

g) Date of Discharge : ☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY) h) Time of Discharge : ☐☐ : ☐☐ (HH:MM)

i) If Injury, give cause : ☐ Self Inflicted ☐ Road Traffic Accident ☐ Substance Abuse/Alcohol Consumption

i) If Medico Legal : ☐ Yes ☐ No ii) Reported to Police : ☐ Yes ☐ No

iii) MLC Report & Police FIR attached : ☐ Yes ☐ No j) System of Medicine : _____

Section E - Details of Claim

Claim made for

Benefit / Optional Extension	Yes / No	Benefit / Optional Extension	Yes / No
Hospitalization Expenses	☐ Yes ☐ No	Alternative Treatments (IPD basis)	☐ Yes ☐ No
Pre - hospitalization Medical Expenses & Post - hospitalization Medical Expenses	☐ Yes ☐ No	Major Diagnostics	☐ Yes ☐ No
Pre - hospitalization Medical Expenses & Post - hospitalization Medical Expenses Benefit	☐ Yes ☐ No	Psychiatric Treatment	☐ Yes ☐ No
Domestic Road Ambulance	☐ Yes ☐ No	Patient Care	☐ Yes ☐ No
Maternity Expenses - Delivery Only	☐ Yes ☐ No	Durable Medical Equipment	☐ Yes ☐ No
Maternity Expenses Comprehensive Cover	☐ Yes ☐ No	Maternity Complications	☐ Yes ☐ No
Maternity Expenses - Delivery	☐ Yes ☐ No	Domiciliary Treatment	☐ Yes ☐ No
Pre Natal and Post Natal	☐ Yes ☐ No	Cover extended outside India	☐ Yes ☐ No
New Born baby	☐ Yes ☐ No	Corporate Floater	☐ Yes ☐ No
Donor Expenses	☐ Yes ☐ No	Health Check-up	☐ Yes ☐ No
OPD Treatment	☐ Yes ☐ No	Alternate Treatments (OPD basis)	☐ Yes ☐ No
Domiciliary Hospitalization	☐ Yes ☐ No	HIV Cover	☐ Yes ☐ No

a) Details of the treatment expenses claimed

(i) Pre-hospitalization Expenses : Rs.
(ii) Hospitalization Expenses : Rs.
(iii) Post-hospitalization Expenses : Rs.
(iv) Health Check-up cost : Rs.
(v) Ambulance Charges : Rs.
(vi) Maternity Benefit : Rs.
(vii) Pre - Natal Expenses : Rs.
(viii) Post - Natal Expenses : Rs.
(ix) New Born Baby Expenses : Rs.
(x) Donor Expenses : Rs.
(xi) OPD Treatment : Rs.
(xii) Domiciliary Hospitalization : Rs.
(xiii) Dental Treatment : Rs.
(xiv) Alternative Treatments (IPD) : Rs.
(xv) Major Diagnostics : Rs.
(xvi) Psychiatric Treatment : Rs.
(xvii) Patient Care : Rs.
(xviii) Durable Medical Equipment : Rs.
(xix) Maternity Complication : Rs.
(xx) Domiciliary Treatment : Rs.
(xxi) Cover extended outside India : Rs.
(xxii) Corporate Floater : Rs.
(xxiii) Alternate Treatments (OPD basis) : Rs.
(xxiv) HIV Cover : Rs.

a) Details of the treatment expenses claimed

(xxv) Comprehensive HIV Cover : Rs. | (xxvii) Pre-hospitalization period : days

(xxvi) Others (code) : Rs. | (xxviii) Post-hospitalization period : days

Total : Rs.

b) Claim for Domiciliary Hospitalization: Yes No

(If yes, provide details in annexure)

c) Details of Lump sum/cash benefit claimed :

(i) Hospital Daily Cash : Rs.

(ii) Surgical Cash : Rs.

(iii) Critical Illness Benefit : Rs.

(iv) Convalescence : Rs.

(v) Pre/Post hospitalization Lump sum benefit : Rs.

(vi) Patient Care : Rs.

(vii) Others : Rs.

Total : Rs.

d) Claim Documents Submitted - Checklist

(I) Claim Form Duly signed :

(ii) Copy of the claim intimation, if any :

(iii) Hospital Main Bill :

(iv) Hospital Break-up Bill :

(v) Hospital Bill Payment Receipt :

(vi) Hospital Discharge Summary :

(vii) Pharmacy Bill :

(viii) Operation Theatre Notes :

(ix) ECG :

(x) Doctor's request for investigation :

(xi) Investigation Reports (Including CT I MRI / USG / HPE) :

(xii) Doctor's Prescriptions :

(xvi) Others _____

Section F - Details of Bills Enclosed

S No.	*Bill No.*	*Date*	*Issued by*	*Towards*	*Amount (INR)*
1		(DD/MM/YYYY)		*Hospital Main Bill*	
2		(DD/MM/YYYY)		*Pre-hospitalization Bills: ____Nos*	
3		(DD/MM/YYYY)		*Post-hospitalization Bills: ___Nos*	
4		(DD/MM/YYYY)		*Pharmacy bills*	
5		(DD/MM/YYYY)			
6		(DD/MM/YYYY)			
7		(DD/MM/YYYY)			
8		(DD/MM/YYYY)			
9		(DD/MM/YYYY)			
10		(DD/MM/YYYY)			

In case of more details, please attach a separate sheet.

Section G - Details of Primary Insured's Bank Account

a) PAN :

b) Account Number :

c) Bank Name & Branch :

d) Cheque/DD payable details :

e) IFSC Code :

Section H - Declaration by the Insured

I hereby declare that the information furnished in this 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/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 & that I will not be making any supplementary claim except the pre/post-hospitalization claim, if any.

Date : | | / | | / | | | | (DD/MM/YYYY) Signature of the Insured : _____

Place : _____

Guidance For Filling Claim Form- Part A (To be filled in by the insured)

Data Element	Description	Format
Section A - Details of Primary Insured		
a) Policy No.	Enter the policy number	As allotted by the insurance company
b) Sl. No/ Certificate No.	Enter the social insurance number or the certificate number of social health insurance scheme	As allotted by the organization
c) Company TPA ID No.	Enter the TPA ID No.	License number as allotted by IRDA and printed in TPA documents
d) Name	Enter the full name of the policyholder	Surname, First name, Middle name
e) Address	Enter the full postal address	Include Street, City and Pin Code
Section B - Details of Insurance History		
a) Currently covered by any other Mediclaim/Health Insurance?	Indicate whether currently covered by another Mediclaim/Health Insurance	Tick Yes or No
b) Date of Commencement of first insurance without break	Enter the date of commencement of first insurance	Use dd-mm-yy format
c) Company Name	Enter the full name of the insurance company	Name of the organization in full
Policy No.	Enter the policy number	As allotted by the insurance company
Sum Insured	Enter the total sum insured as per the policy	In rupees
d) Have you been Hospitalised in the last four years since inception of the contract?	Indicate whether hospitalized in the last four years	Tick Yes or No
Date	Enter the date of hospitalization	Use mm-yy format
Diagnosis	Enter the diagnosis details	Open Text
e) Previously Covered by any other Mediclaim/Health Insurance?	Indicate whether previously covered by another Mediclaim/Health Insurance	Tick Yes or No
f) Company Name	Enter the full name of the insurance company	Name of the organization in full
Section C - Details of Insured Person Hospitalised		
a) Name	Enter the full name of the patient	Surname, First name, Middle name
b) Gender	Indicate Gender of the patient	Tick Male or Female
c) Age	Enter age of the patient	Number of years and months
d) Date of Birth	Enter Date of Birth of patient	Use dd-mm-yy format
e) Relationship with primary Insured	Indicate relationship of patient with policyholder	Tick the right option. If others, please specify
f) Occupation	Indicate occupation of patient	Tick the right option. If others, please specify
g) Address	Enter the full postal address	Include Street, City and Pin Code
h) Landline	Enter the phone number of patient	Include STD code with telephone number
i) E-mail ID	Enter e-mail address of patient	Complete e-mail address
Section D - Details of Hospitalisation		
a) Name of Hospital where admitted	Enter the name of hospital	Name of hospital in full
b) Room category occupied	Indicate the room category occupied	Tick the right option
c) Hospitalization due to	Indicate reason of hospitalization	Tick the right option
d) Date of Injury/Date Disease first detected/ Date of Delivery	Enter the relevant date	Use dd-mm-yy format
e) Date of admission	Enter date of admission	Use dd-mm-yy format
f) Time	Enter time of admission	Use hh:mm format
g) Date of discharge	Enter date of discharge	Use dd-mm-yy format
h) Time	Enter time of discharge	Use hh:mm format
i) If Injury give cause	Indicate cause of injury	Tick the right option
If Medico legal	Indicate whether injury is medico legal	Tick Yes or No
Reported to Police	Indicate whether police report was filed	Tick Yes or No
MLC Report & Police FIR attached	Indicate whether MLC report and Police FIR attached	Tick Yes or No
j) System of Medicine	Enter the system of medicine followed in treating the patient	Open Text
Section E - Details of Claim		
Claim Made for	Select the event for which the claim is made	Tick Yes or No
a) Details of Treatment Expenses	Enter the amount claimed as treatment expenses	In rupees (Do not enter paise values)
b) Claim for Domiciliary Hospitalization	Indicate whether claim is for domiciliary hospitalization	Tick Yes or No
c) Details of Lump sum/cash benefit claimed	Enter the amount claimed as lump sum/cash benefit	In rupees (Do not enter paise values)
d) Claim Documents Submitted-Check List	Indicate which supporting documents are submitted	Tick the right option
Section F - Details of Bills Enclosed		
Indicate which bills are enclosed with the amounts in rupees		

Data Element	Description	Format
Section G - Details of Primary Insuredís Bank Account		
a) PAN	Enter the permanent account number	As allotted by the Income Tax department
b) Account Number	Enter the bank account number	As allotted by the bank
c) Bank Name and Branch	Enter the bank name along with the branch	Name of the Bank in full
d) Cheque/DD payable details	Enter the name of the beneficiary the cheque/ DD should be made out to	Name of the individual/organization in full
e) IFSC Code	Enter the IFSC code of the bank branch	IFSC code of the bank branch in full
Section H - Declaration by the Insured		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign.		

Claim Form - 'GROUP CARE'

Part B

1. To be filled in by the hospital.
2. The issue of this Form is not to be taken as an admission of liability.
3. Please include the original pre-authorization request form in lieu of PART A.
4. To be filled in block letters.

Section A - Details of Hospital

a) Name of the Hospital :

b) Hospital ID :

c) Type of Hospital : ☐ Network ☐ Non-network (if non-network fill section E)

d) Name of the treating doctor :

(Surname) (First Name) (Middle Name)

e) Qualification :

f) Registration No. with State Code :

g) Contact No. :

Section B - Details of the Patient Admitted

a) Name of the Patient:

(Surname) (First Name) (Middle Name)

b) IP Registration No. :

c) Gender : ☐ M ☐ F d) Age : / (YY/MM) e) Date of Birth : / /

f) Date of Admission : / / (DD/MM/YYYY) g) Time of Admission : : (HH:MM)

h) Date of Discharge : / / (DD/MM/YYYY) i) Time of Discharge : : (HH:MM)

j) Type of Admission : ☐ Emergency ☐ Planned ☐ Day Care ☐ Maternity

k) If Maternity,

(i) Date of Delivery : / / (DD/MM/YYYY) (ii) Gravida Status : ____________________

l) Status at the time of discharge : ☐ Discharge to home ☐ Discharge to another hospital ☐ Deceased

m) Total Claimed Amount :

Section C - Details of Ailment Diagnosed (Primary)

a) (i) Primary Diagnosis : ICD 10 Code : Description : ____________________

(ii) Additional Diagnosis : ICD 10 Code : Description : ____________________

(iii) Co-morbidities : ICD 10 Code : Description : ____________________

(iv) Co-morbidities : ICD 10 Code : Description : ____________________

b) (i) Procedure 1 : ICD 10 Code : Description : ____________________

(ii) Procedure 2 : ICD 10 Code : Description : ____________________

(iii) Procedure 3 : ICD 10 Code : Description : ____________________

(iv) Details of Procedure : ____________________

c) Present ailment is a complication of PED : ☐ Yes ☐ No

If yes, specify details : ____________________

d) Pre-authorization obtained : ☐ Yes ☐ No

e) Pre-authorization no. :

f) If authorization by network hospital not obtained, give reason : ____________________

____

g) Hospitalization due to Injury : ☐ Yes ☐ No

(i) If yes, give cause : ☐ Self inflicted ☐ Road Traffic Accident ☐ Substance Abuse/Alcohol Consumption

(ii) If Injury due to Substance abuse/Alcohol consumption, Test conducted to establish this : ☐ Yes ☐ No
(If yes, attach reports)

(iii) If Medico Legal : ☐ Yes ☐ No

(iv) Reported to Police : ☐ Yes ☐ No

(v) FIR No. :

(vi) If not reported to Police, give reason : _____

Section D - Claim Documents Submitted - Checklist

(i)	Duly signed Claim Form	☐	(ix)	Investigation Reports	☐
(ii)	Original Pre-authorization request	☐	(x)	CT/ MRI/ USG / HPE investigation reports	☐
(iii)	Copy of Pre-authorization approval letter	☐	(xi)	Doctor's reference slip for investigation	☐
(iv)	Copy of photo ID card of patient verified by hospital	☐	(xii)	ECG	☐
(v)	Hospital Discharge Summary	☐	(xiii)	Pharmacy Bills	☐
(vi)	Operation Theatre notes	☐	(xiv)	MLC report & Police FIR	☐
(vii)	Hospital Main Bill	☐	(xv)	Original death summary from hospital where applicable	☐
(viii)	Hospital Break-up Bill	☐	(xvi)	Any other, please specify_____	☐

Section E - Additional Details in case of Non-Network Hospital (Only fill in case of non-network hospital)

a) Address of the Hospital :

City :

State : Pin Code :

b) Contact No. : -

c) Registration No. with State Code :

d) Hospital PAN : e) No. of inpatient beds :

f) Facilities available in the hospital : (i) OT : ☐ Yes ☐ No (ii) ICU : ☐ Yes ☐ No

(iii) Others : _____

Section F - Declaration by the Hospital

We hereby declare that the information furnished in this Claim Form is true & correct to the best of our knowledge and belief. If we have made any false or untrue statement, suppression or concealment of any material fact, our right to claim under this claim shall be forfeited.

Date : / / (DD/MM/YYYY) Signature & Seal of the Hospital Authority : _____

Place : _____

Guidance For Filling Claim Form- Part B (To be filled in by the hospital)

Data Element	Description	Format
	Section A - Details of Hospital	
a) Name of Hospital	Enter the name of hospital	Name of hospital in full
b) Hospital ID	Enter ID number of hospital	As allocated by the TPA
c) Type of Hospital	Indicate whether in network or non-network hospital	Tick the right option
d) Name of treating doctor	Name of treating doctor	Name of doctor in full
e) Qualification	Enter the qualifications of the treating doctor	Abbreviations of educational qualifications
f) Registration No. with State Code	Enter the registration number of the doctor along with the state Code	As allocated by the Medical Council of India
g) Contact No.	Enter the phone number of doctor	Include STD code with telephone number
	Section B - Details of Patient Admitted	
a) Name of Patient	Enter the name of hospital	Name of hospital in full
b) IP Registration Number	Enter insurance provider registration number	As allotted by the insurance provider
c) Gender	Indicate Gender of the patient	Tick Male or Female
d) Age	Enter age of the patient	Number of years and months
e) Date of Birth	Enter Date of Birth of patient	Use dd-mm-yy format
f) Date of admission	Enter date of admission	Use dd-mm-yy format
g) Time	Enter time of admission	Use hh:mm format
h) Date of discharge	Enter date of discharge	Use dd-mm-yy format
i) Time	Enter time of discharge	Use hh:mm format
j) Type of Admission	Indicate type of admission of patient	Tick the right option
k) If Maternity		
Date of Delivery	Enter Date of Delivery if maternity	Use dd-mm-yy format
Gravida Status	Enter Gravida status if maternity	Use standard format
l) Status at time of discharge	Indicate status of patient at time of discharge	Tick the right option
m) Total claimed amount	Indicate the total claimed amount	In rupees (Do not enter paise values)
	Section C - Details of Ailment Diagnosed (Primary)	
a) ICD 10 Code		
Primary Diagnosis	Enter the ICD 10 Code and description of the primary Diagnosis	Standard Format and Open text
Additional Diagnosis	Enter the ICD 10 Code and description of the additional Diagnosis	Standard Format and Open text
Co-morbidities	Enter the ICD 10 Code and description of the co-morbidities	Standard Format and Open text
b) ICD 10 PCS		
Procedure 1	Enter the ICD 10 PCS and description of the first procedure	Standard Format and Open text
Procedure 2	Enter the ICD 10 PCS and description of the second procedure	Standard Format and Open text
Procedure 3	Enter the ICD 10 PCS and description of the third procedure	Standard Format and Open text
Details of Procedure	Enter the details of the procedure	Open text
c) PED	Indicate whether present ailment is a combination of PED	Tick Yes or No
If yes, specify details	Enter the details of PED	Open text
d) Pre-authorization obtained	Indicate whether pre-authorization obtained	Tick Yes or No
e) Pre-authorization Number	Enter pre-authorization number	As allotted by TPA
f) If authorization by network hospital not obtained, give reason	Enter reason for not obtaining pre-authorization number	Open text
g) Hospitalization due to injury	Indicate if hospitalization is due to injury	Tick Yes or No
Cause	Indicate cause of injury	Tick the right option
If injury due to substance abuse/alcohol consumption, test conducted to establish this	Indicate whether test conducted	Tick Yes or No
If Medico Legal	Indicate whether injury is medico legal	Tick Yes or No
Reported To Police	Indicate whether police report was filed	Tick Yes or No
FIR No.	Enter first information report number	As issued by police authorities
If not reported to police, give reason	Enter reason for not reporting to police	Open text
	Section D - Claims Document Submitted Checklist	
Indicate which supporting documents are submitted		

Data Element	Description	Format
Section E - Additional Details in case of Non-Network Hospital		
a) Address	Enter the full postal address	Include Street, City and Pin Code
b) Contact No.	Enter the phone number of hospital	Include STD code with telephone number
c) Registration No. with State Code	Enter the registration number of the doctor along with the state Code	As allocated by the Medical Council of India
d) Hospital PAN	Enter the permanent account number	As allotted by the Income Tax department
e) Number of Inpatient beds	Enter the number of inpatient beds	Digits
f) Facilities available in the hospital	Indicate facilities available in the hospital	Tick the right option. If others, please specify
Section F - Declaration by the Hospital		
Read declaration carefully and mention date (in dd:mm:yy format), place (open text) and sign and stamp		

Consent Letter

Date

To,
The Medical Suprintendent
_____
_____
_____

Dear Sir,

Re : Authorization in favour of M/s Care Health Insurance Limited (Formerly known as Religare Health Insurance Company Limited) and its authorized agents.

I have undergone treatment for

_____

_____from _____to _____in your hospital under Inpatient No_____.

I hereby authorise M/s Care Health Insurance Limited (Formerly known as Religare Health Insurance Company Limited) and/or its authorised representative to seek any medical information/records from you or from the Medical Practitioners who has attended on me in connection with the above ailment.

I have no objection in case they seek such information/records in whatsoever regards.

Thanking You,
Yours Faithfully

(Signature of the Claimant)
Address of the Insured -