VIDAL HEALTH
INSURANCE THIRD PARTY ADMINISTRATOR
Vidal Health TPA Pvt Ltd.
Redefining HealthcareServices.

CLAIM FORM FOR HEALTH INSURANCE POLICIES FOR OPD CLAIM

TheissueofthisFormisnottobetakenasanadmissionofliability
(To be filled in block letters)

DETAILS OF PRIMARY INSURED:

Name Of Employee : Prabath M
Department : Public solution
Claim for : OPD
Employee Code : **4202850** TPA ID Card No.: **GUR-US-N0565-001-0001560-A**

Band/ WL/ FLEX PLAN :N5
Location: Bangalore
Claim ID:
Phone No: 9620615444

DETAILS OF INSURED PERSON HOSPITALIZED:

Name of Patient	Age and Relation with Employee	Nature of Disease/ Accident
Adhiyan Prabath	**2 years 4 months and Son**	**Asthma/Chronic Stomach Pain/Fever/Food Poisoning (OPD)**

DETAILS OF HOSPITALIZATION:

Name of Clinic/Hospital	Date of First Billed	Date of Last Billed	Total Claim Amount
Shree Guru Hospital	**22/07/2023**	**23/09/2023**	**5380/-**

DETAILS OF BILLS ENCLOSED:

S.No	Bill No	Date	Issued By	Towards	Amount (Rs)
1.	113	22/07/23	Shree Guru hospital	Consultation + pharmacy	1660/-
2.	001	22/07/23	Apollo pharmacy	Medicine	0315/-
3.	1336051	15/08/23	Sathish Eye care hospital	consultation	0250/-
4.	1336044	15/08/23	Sathish Eye care hospital	Medicine	0278/-
5.	009487	02/09/23	Shree Narayana Medical	Medicine	0131/-
6.	257	02/09/23	Rainbow baby clinic	Consultation	0250/-
7.	C01006132	02/09/23	Ananya shree medicals	Medicine	0326/-
8.	264	06/09/23	Rainbow baby clinic	Consultation	0250/-
9.	C01006779	06/09/23	Ananya shree medicals	Medicine	0101/-
10.	272	07/09/23	Rainbow baby clinic	Consultation	0250/-
11.	C01006837	07/09/23	Ananya shree medicals	Medicine	0151/-
12.	OP2324-18023	07/09/23	Shree Vinayaga Diagnostics & Lab	Diagnosis	1000/-
13.	919	09/09/23	Bawaa medicals	Medicine	0113/-
14.	555	13/09/23	Shree Narayana Children hospital	Consultation	0250/-
15.	011362	23/09/23	Shree Narayana Medical	Medicine	0049/-
				Total	5380/-

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/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 & that I will not be making any supplementary claim except the pre/post-hospitalization claim, if any.

Date: 08/10/2023

Place:

Signature of the Insured