Vipul MedCorp 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 : RAHUL KUMAR SINGH	Band/ WL/ FLEX PLAN : N6
Department : NEC GDC DIGITAL PF	Location: Noida
Claim for : OPD	Claim ID:
Employee Code : 51436623 TPA ID Card No.:	Phone No: +91-9818635867

DETAILS OF INSURED PERSON HOSPITALIZED:

Name of Patient	Age and Relation with Employee	Nature of Disease/ Accident
NAMRATA SINGH	**35, WIFE**	**STOMACH PAIN (LONG), ANXITY, BREATHING ISSUE**

DETAILS OF HOSPITALIZATION:

Name of Clinic/Hospital	Date of First Billed	Date of Last Billed	Total Claim Amount
MANIPAL HOSPITAL	**19-11-2022**	**19-11-2022**	**10846**

DETAILS OF BILLS ENCLOSED:

S.No	Bill No	Date	Issued By	Towards	Amount (Rs)
1.	GHZB-OPP-593515	19 11 2 0 2 2	MANIPAL HOSPITAL	DOCTOR CONSULTATION	1 5 5 0
2.	GHZB-OPP-593611	19 11 2 0 2 2	MANIPAL HOSPITAL	LAB TEST (CARDIO)	2 1 6 8
3.	GHZB-OPP-593694	19 11 2 0 2 2	MANIPAL HOSPITAL	LAB TEST (PATHOLOGY)	3 3 6 8
4.	GHZB-OPP-593692	19 11 2 0 2 2	MANIPAL HOSPITAL	LAB TEST (PATHLOGY)	2 5 2 0
5.	GHZB-OPP-593654	19 11 2 0 2 2	MANIPAL HOSPITAL	LAB TEST(USG)	1 2 4 0
6.					
7.					
8.					
9.					
10.					

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: 1 2 1 2 2 0 2 2

Place:

Signature of the Insured