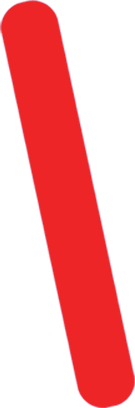
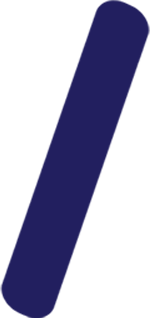
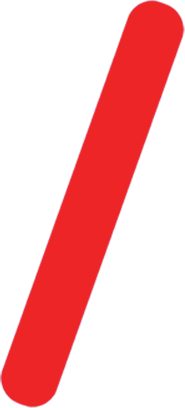
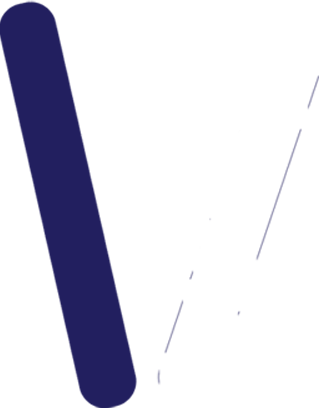
**Vipul MedCorp TPA Pvt Ltd.**



**Redefining Healthcare Services.**

## DETAILS OF PRIMARY INSURED:

**CLAIM FORM FOR HEALTH INSURANCE POLICIES FOR OPD CLAIM**

**The issue of this Form is not to be taken a s an admission of liability**

**(To be filled in block letters)**

|  |
| --- |
| Name Of Employee : |
| Department : |
| Claim for : OPD |
| Employee Code : TPA ID Card No.: |

## DETAILS OF INSURED PERSON HOSPITALIZED:

|  |
| --- |
| Band/ WL/ FLEX PLAN : |
| Location: |
| Claim ID: |
| Phone No: |

|  |  |  |
| --- | --- | --- |
| Name of Patient | Age and Relation with Employee | Nature of Disease/ Accident |
|  |  |  |

## DETAILS OF HOSPITALIZATION:

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Clinic/Hospital | Date of First Billed | Date of Last Billed | Total Claim Amount |
|  |  |  |  |

## DETAILS OF BILLS ENCLOSED:

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| S.No | Bill No | Date | | | | | | Issued By | Towards | Amount (Rs) | | | | | | | |
| 1. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 2. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 3. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 4. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 5. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 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:

Place:

Signature of the Insured