

# HCL Technologies Ltd-IOMC Division.

## HOSPITALIZATION TREATMENT CLAIM SUMMARY FORM

EMPLOYEE DETAILS		MEDICAL CYCLE: 2023-24		
Claim No. : 1127941	No. of Claim Entries : 1	Total Claim : 23724.00	Status : New	
Name : Raj Kishore		EmpCode : 52098226	DOJ : 30 Jun 2022	
Email ID : RAJ.KISHORE@HCLTECH.COM		Landline/Mobile : 09717744691	PayRollAreaCode : 1C	
Payee Name : Raj Kishore		Bank Name : AXIS BANK LTD		
IFSC Code : UTIB0000022		Account No. : 022010100631204		

PATIENT'S DETAILS		
Name : priyanka kumari	Relation with the Employee : Spouse	Age : 33
CLAIM DETAILS		
Name of Hospital : SWASTHAM MEDICARE Plot No 107 Itera Opp Fusion Homes,Tech Zone 4 Greater Noida west		
Date of admission : 9/15/2024	Date of Discharge : 9/15/2024	

#	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	1,200.00		
4	Medicine Expenses	4,524.00		
5	Doctor's Fee	800.00		
6	Operation Theater Charges	6,000.00		
7	Surgery Charges	5,700.00		
8	Nursing Charges	1,500.00		
9	Any Other Charges(give brief details)	4,000.00		
Total Claim Amount		23,724.00		

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 type="checkbox"/>
Discharge Summary should include	<input type="checkbox"/>
It should be on the Hospital Letter Head	<input type="checkbox"/>
The letter head should bear hospital address, telephone nos., email id, fax nos. etc	<input type="checkbox"/>
Name of the patient, Age, Gender	<input type="checkbox"/>
Referred from/By	<input type="checkbox"/>
IP No	<input type="checkbox"/>
Date & time of Admission & Date & time of discharge	<input type="checkbox"/>
Name of the treating doctor / s	<input type="checkbox"/>
Final Diagnosis	<input type="checkbox"/>
Provisional Diagnosis	<input type="checkbox"/>
Chief Complaints/Presenting complaints	<input type="checkbox"/>
Past History of Presenting illness with duration	<input type="checkbox"/>
History of any other ailment, treatment, consultation etc. with Personal History	<input type="checkbox"/>
Menstrual History in case of female patients	<input type="checkbox"/>
General Physical Examination, Vitals	<input type="checkbox"/>
Systemic Examination	<input type="checkbox"/>
Investigations done at the hospital and elsewhere and Findings	<input type="checkbox"/>
Treatment given in detail	<input type="checkbox"/>
Surgery Details with Date of Surgery, Procedure, Type of Anaesthesia, Name of the Surgeon, Asst Surgeon, Anaesthetist, Procedure Notes	<input type="checkbox"/>
Course in the hospital	<input type="checkbox"/>
Condition at Discharge	<input type="checkbox"/>
Discharge Advice and Medications	<input type="checkbox"/>
Follow-up Instructions	<input type="checkbox"/>
Signed by the Surgeon/Medical Superintendent/ Doctor who treated the patient	<input 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 type="checkbox"/>
Original Reports/ Tests	<input type="checkbox"/>
Original Bills of reports/ Tests	<input type="checkbox"/>

Break up details for hospitalization Final bill	<input type="checkbox"/>
Pre numbered cash paid receipt for Hospitalization Payment	<input type="checkbox"/>
Signed Discharge Voucher	<input type="checkbox"/>
Signed Print out of the Claim Form	<input type="checkbox"/>
Staple all the supports carefully to ensure there is no loss in transit	<input type="checkbox"/>

### 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: Sep 23, 2024

**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.

**AUTHORISATION LETTER TO VIDAL HEALTH TPA PVT. LTD.,**

To

The Medical Superintendent

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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 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: