Claimed for National Insurance Co Ltd under Infosys limited Policy S. Sarft 16/12 (2)

Medi Assist

REIMBURSEMENT CLAIM FORM

TO BE FILLED BY THE INSURED

The issue of this Form is not to be taken as an admission of liability

(To be Filled in block letters)

DETAILS OF PRIMARY INSURED:

a) Policy No 6022005241000106 b) Sl. No/ Certificate no

c) Company / TPA ID (MA ID)No

d) Name SARUMATHI S

e)Address 1/151, WEST STREET THOONGAREDDIYAPATTI SATTUR

City VIRUDHUNAGAR State TAMILNADU

Pin Code 626203 Phone No 7708866383 Email ID: saruroyan@gmail.com

DETAILS OF INSURANCE HISTORY

a) Currently covered by any other Mediclaim / Health Insurance: ☐ Yes ☑ No b) Date of commencement of first Insurance without break:

c) If yes, company name: Policy No.

Sum Insured (Rs.) d) Have you been hospitalized in the last four years since inception of the contract? ☐ Yes ☐ No Date:

Diagnosis: e) Previously covered by any other Mediclaim /Health insurance ☐ Yes ☑ No

f) If yes, company name:

DETAILS OF INSURED PERSON HOSPITALIZED:

a) Name: SARUMATHI S

b) Gender Male ☐ Female ☑ c) Age years 24 Months d) Date of Birth 04 06 2000

e) Relationship to Primary insured: Self ☑ Spouse ☐ Child ☐ Father ☐ Mother ☐ Other ☐ (Please Specify)

f) Occupation Service ☐ Self Employed ☐ Home Maker ☐ Student ☐ Retired ☐ Other ☑ (Please Specify) PRIVATE SECTOR

g) Address (if diffrent from above) 1/151, WEST STREET THOONGAREDDIYAPATTI PO SATTUR

City VIRUDHUNAGAR State: TAMILNADU

Pin Code 626203 Phone No: 7708866383 Email ID saruroyan46@gmail.com

DETAILS OF HOSPITALIZATION:

a) Name of Hospital where Admitted: GIRIVAAS DENTAL CLINIC

b) Room Category occupied: Day care ☐ Single occupancy ☐ Twin sharing ☐ 3 or more beds per room ☐

c) Hospitalization due to: Injury ☐ Illness ☐ Maternity ☐ d) Date of injury / Date Disease first detected /Date of Delivery:

e) Date of Admission: f) Time g) Date of Discharge: h) Time:

I) If injury give cause: Self inflicted ☐ Road Traffic Accident ☐ Substance Abuse / Alcohol Consumption ☐ I) If Medico legal ☐ Yes ☐ No

ii) Reported to Police ☐ iii. MLC Report & Police FIR attached ☐ Yes ☐ No j) System of Medicine:

DETAILS OF CLAIM:

a) Details of the Treatment expenses claimed

I. Pre -hospitalization expenses	Rs.	ii. Hospitalization expenses	Rs. 13600
iii. Post-hospitalization expenses	Rs.	iv. Health-Check up cost:	Rs.
v. Ambulance Charges:	Rs.	vi. Others (code):	Rs.
		Total	Rs. 13600
vii. Pre -hospitalization period:	days	viii. Post -hospitalization period:	days

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. Others.	Rs.
		Total	Rs.

Claim Documents Submitted - Check List:

- ☑ Claim form duly signed
- ☐ Copy of the claim intimation, if any
- ☑ Hospital Main Bill
- ☐ Hospital Break-up Bill
- ☐ Hospital Bill Payment Receipt
- ☐ Hospital Discharge Summary
- ☑ Pharmacy Bill
- ☐ Operation/Theater Notes
- ☐ ECG
- ☐ Doctors request for investigation
- ☑ Investigation Reports (Including CT / MRI / USG / HPE)
- ☐ Doctors Prescriptions
- ☐ Others

DETAILS OF BILLS ENCLOSED:

Sl. No.	Bill No.	Date	Issued by	Towards	Amount (Rs)
1.		30/1/24	GIRIVAS DENTAL CLINIC	Hospital main Bill	11500
2.				Pre-hospitalization Bills 2 Nos	850
3.				Post-hospitalization Bills Nos	
4.				Pharmacy Bills	1250
5.					
6.					
7.					
8.					
9.					
10.					

DETAILS OF PRIMARY INSURED'S BANK ACCOUNT:

a) PAN: KSDPS1853Q b) Account Number 377501001003

c) Bank Name and Branch ICICI SATTUR

d) Cheque / DD Payable details: e) IFSC Code: ICIC0003775

DECLARATION BY THE INSURED:

I hereby confirm that the information furnished in the claim form is true & correct to the best of my knowledge and belief. In case if any information is found to be false, I authorize Infosys ltd, to recover any payment made against my claim and pay to the TPA/ Insurance company. I also consent & authorize TPA / Insurance Company, to seek /obtain necessary medical information / documents from any hospital / medical practitioner/pharmacy/ any other person or entity who has attended on to the person against whom this claim is made.

Date 01/12/2024 Place: KOVILPATTI Signature of the Insured S. Sarft

(IMPORTANT: PLEASE TURN OVER)

SECTION A SECTION B SECTION C SECTION D SECTION E SECTION F SECTION G SECTION H