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| **OPTUM - COVID BUFFER BENEFITS PROCESS CLAIM FORM** |

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| --- | --- |
| Name of Patient | HemaLatha S |
| Patient Relation with Employee  (only those dependents who are covered under the corporate base plan will be covered under modular top up plan) | Self Spouse(Yes)  .^Yes  Child Parents |
| Date of Birth of patient(as per official records) | 1-1-1997 |
| Name of Employee | Sathish Sriramoju |
| Name of Spouse/Partner | HEMALATHA |
| Employee Number | 000684705 |
| Insurance Co.  Policy number /Name | **New India Assurance Insurance Ltd** |
| UHC E-card No | 5234352 |
| Employee Address (in Block letters) | H:NO:16-116-9/19, SLN HOMES, MALLA REDDY NAGARCOLONY,BEERAMGUDA,MANDAL:AMEENPUR DIST:SANGA REDDY PIN:502032 |
| Employee Email ID | sathish.sriramoju@optum.com |
| Alternate Email ID | Sathish234573@gmail.com |
| Employee Mobile Number | 9160008349 |
| Alternate Phone No. | 9866443570 |
| Nature of Illness | Covid-19 |
| Period of Illness | 15 days |

**NEFT DETAILS:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Account Holder’s Name | Bank Account No. | Bank Name | IFSC Code | Bank Branch Address |
| **Sathish Sriramoju** | **5119395552** | **Citi Bank** | **CITI0000006** | **Begumpate Branch, Hyderabad** |

**Note:** If this is your first claim then kindly provide a copy of cancelled cheque along with NEFT details.

**Expenses Incurred** (Please fill each line separately for each bill)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Type of Expenses** | **Bill Date** | **Bill Number** | **Name of Clinic/ Doctor/ Lab/ Pharmacy/ Other** | **Amount (Rs.)** | **All original documents attached (Yes/No)** |
| Medicines | 06-05-2021 | PHAR2021-2312 | TIRUMALA MEDICAL &GENERAL STORES | 5947 | Yes |
| 11-05-2021 | PHAR2021-1556 | TIRUMALA MEDICAL &GENERAL STORES | 1709 | Yes |
|  |  |  |  |  |
| Pathological & other tests | 11-05-2021 | DIAG2021-4459 | TIRUMALA DIAGNOSTICS | 2200 | Yes |
| 03-May-2021 | 453 | SRI GANESH DIAGNOSTICS | 1500 | Yes |
| Any Other (Home Isolation Charges) |  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  | **Total Amount** | **11,356** |  |

|  |  |  |
| --- | --- | --- |
| Place | Hyderabad |  |
|  |  | \_\_\_\_\_ Sathish\_\_\_\_\_\_\_\_\_\_\_ |
| Date | \_\_\_\_18/06/2021\_\_\_\_\_\_\_\_\_\_\_\_\_ | (Signature of Insured) |

**Note:**

* *Please enclose the above documents in original along with the claim form. No photocopies will be accepted.*
* *Separate Claim Form for claim of each insured member to be submitted*

**Checklist of documents:**

(Please attach the following documents for claims and mark against the checkbox)

* Duly filled and signed Claim Form
* Original Doctor’s Prescriptions /Consultation on the letter-head
* Original Covid Report (Positive Or Negative)
* Original Doctor’s consultation papers
* All original investigation reports
* All original pharmacy bills along with Doctor’s Prescriptions
* Original Payment receipts
* NEFT details in claim form or attach copy of Cancelled Cheque during every claim

*This is an indicative list, insurer may require additional documents basis the submitted claims*