# OIC Claim Template

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| Claim No | {{claim\_no}} |
| Patient Name | {{patient\_name}} |
| Policy No | {{Policyno}} |
| Date of Admission | {{doa}} |
| Date of Discharge | {{dod}} |
| Insured Name | {{insured\_name}} |
| Hospital Name | {{hospital\_name}} |
| City | {{city}} |
| State | {{state}} |