Claim Form

ApolloMunich HEALTH INSURANCE
www.apollomunichinsurance.com

CLAIM FORM-OPD TO BE FILLED IN BY THE INSURED

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

SECTION A - DETAILS OF PRIMARY INSURED

UHID No.		Employee ID	
Company Name			

SECTION B - DETAILS OF INSURED PERSON

Policy Holders Name			
First Name	Middle Name	Last Name	
Insured Person's Name			
First Name	Middle Name	Last Name	
Gender	Male / Female	Diagnosis	
Relationship of patient with Policy Holder (Self/spouse/Child/Father/Mother/Other)			
Address :			
Landmark :		City/Town :	
District :		State :	
Telephone :		Mobile :	
Pin Code :		E Mail :	

SECTION C - DETAILS OF CLAIM AND DOCUMENTS TO BE SUBMITTED

- Duly filled claim form
- Consultation papers (It should have qualifications of the treating doctor)
- Prescriptions of tests advised
- Prescriptions of medicines advised
- Investigation reports
- Bills and payment receipts
- OPD (Dental X-ray) report in case of dental treatment
- Any other documents submitted
- All financial documents should be in original. Photocopies will not be accepted
- ID proof of the insured

SECTION D - DETAILS OF BILLS ENCLOSED

S.No.	Bill No	Date	Issued By	Towards (consultation/medicines/investigations/others)	Amount (Rs)
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SECTION E - DETAILS OF PRIMARY INSURED'S BANK ACCOUNT

PAN		Account Number	
Bank Name/ Branch		Payable details: Cheque/ DD	
IFSC Code		*please attach a cancelled cheque pertaining to the same	
MICR No		*please attach a cancelled cheque pertaining to the same	

Note:

It is agreed that the Policyholder/Claimant will intimate in writing to Apollo Munich Health Insurance Co. Ltd. about any change in bank account details.

In an event Insured person bears expenses for treatment, please provide account details of Insured Persons in the above format along with proof of incurring such expenses.

SECTION F - 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, if any.

Date : Place : Signature of Insured :