Medi Assist

Group mediclaim - Associate, Family & Parents

Tracking No : H1606210E11555001

Z0008319816

Employee Details

Employee name	CHITHAMBARATHANU T.	Employee number	E11555
Employee's location		Contact number	9841403382

Details of the claimant (Patient Details)

Name	Thiruneelakandan C S	Relationship	Son

Claim Details

Nature of illness	Covid	Duration of illness	16 Day
Name of the Hospital	Siva Hospitals	Location	
Date of Admission	25-May-2021	Total amount	204159
Reason for Non-availing cashless facility	Hospital advised reimbursement		

Medical Expencess breakup

No	Bill No.	Bill Date	Bill Amount	Remarks
1	479	10-Jun-2021	204159	final receipt

Declaration

I hereby declare that the information furnished in this Claim Form is true & correct to the best of my knowledge & belief. If I have made any false or untrue statement, suppressed or concealed any material fact, my right to claim reimbursement shall be forfeited. I also consent & authorize the TPA or the insurance company to seek necessary medical information from any hospital / Medical Practitioner who has attended to the person for whom the 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 except that of Post - hospitalisation claim, if any.

Date	Employee Signature
Date of Submission	

ONLY FOR OFFICE USE

HID Updation :-	☐ Required? ☐ Completed?	**Dummy Claim :-**	☐ Action Required? ☐ Completed?

Document Checklist(Mandatory) To be filled by Help Desk / Front Desk

☐ Claim Form	☐ Cheque	☐ Verified with CF and Name
☐ Bills No of Pages [ ]	☐ Main Bill / Breakup available?	Total No of Docs
☐ Dis. Summary No of Pages	☐ Reports	

Remarks :-

Non Scannable Documents (To be filled by Inward / Receiving personnel)

		Nos	**Description**
CT / MRI Scan	☐		
X-Ray	☐		
CD	☐		
Lens / Implant Sticker	☐		
Test Strips	☐		
Other	☐		

---------- **HELP DESK / CRM**	---------- **RECEIVER / INWARD**	---------- **SCANNING SEAL**