



Group mediclaim - Associate, Family & Parents

Tracking No : H1006210E11555001



Employee Details

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

Details of the claimant (Patient Details)

Name	Thirunelvly Perumal	Relationship	Father
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Claim Details

Nature of illness	Covid	Duration of illness	5 Day
Name of the Hospital	Subam Hospital	Location	
Date of Admission	04-Jun-2021	Total amount	100524
Reason for Non-availing cashless facility	Not aware of cashless process		

Medical Expencess breakup

No	Bill No.	Bill Date	Bill Amount	Remarks
1	CB14062021010	14-Jun-2021	100524	final Consolidated bill

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

<input type="checkbox"/> Claim Form	<input type="checkbox"/> Cheque	<input type="checkbox"/> Verified with CF and Name
<input type="checkbox"/> Bills No of Pages []	<input type="checkbox"/> Main Bill / Breakup available?	Total No of Docs <input type="text"/>
<input type="checkbox"/> Dis. Summary No of Pages	<input type="checkbox"/> Reports	

Remarks :-

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

		Nos	Description
CT / MRI Scan	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
X-Ray	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
CD	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Lens / Implant Sticker	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Test Strips	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Other	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>

----- **HELP DESK /**
CRM

----- **RECEIVER /**
INWARD

----- **SCANNING SEAL**