HDFC ERGO General Insurance Company Limited

OPD CLAIM FORM (Outpatient Treatment Cover Claim Form)

(Please answer all questions in detail)

Policy Details

Policy Number _____ Policy Start Date _____ Policy End date _____

Group Corporate name (In case of corporate/ Group policy) _____

HDFC ERGO ID Number (as mentioned on Health Card) _____

Personal Details of the Employee / Proposer

Employee / Insured name _____

Employee Number (In case of corporate/ Group policy) _____

Email ID _____ Date of Joining D D M M Y Y Y Y

Occupation _____ Contact No. _____

Residence address _____

_____

Patient Details

Name of the Patient _____

Relationship to the Employee / Proposer [Self/ Spouse / Child / Parent / others (please specify)] _____

Date of Birth D D M M Y Y Y Y Age ☐☐ Yrs Gender ☐ Male ☐ Female

Nature of illness/disease contracted or injury suffered _____

Name & address of the attending Doctor _____

Treatment Commencement Date D D M M Y Y Y Y Treatment End Date D D M M Y Y Y Y

Claim Details

Amount Claimed			
Consulting Doctor's Fees	Rs.	Other Doctors Fees	Rs.
Pharmacy/Medicine Charges	Rs.	Other Medicine/ Pharmacy Charges	Rs.
Investigation Charges	Rs.	Other Investigation Charges	Rs.
Others (Kindly Specify)	Rs.	Any other Expenses	Rs.
Total Claimed Amount	Rs.		

Document Check List (Please tick ✓ wherever applicable)

In Support of the above claim, I enclose following Documents	Original	Photocopy
Bills/Receipt/Cash Memos in original for medicines etc.(name of patient along with date)		
Most recent medical prescription in support of the above		
Receipts and Pathological test reports in original from a Pathological Lab supported by the note from the treating doctor/ Surgeon advising such pathological test		
Attending doctors/consultant's/specialist's bill/receipt and certificate regarding diagnosis, whichever is prescribed along with doctors registration number (compulsory).		

Declaration

I hereby agree, affirm and declare that:

a) The statements/information given/stated by me/us in this claim form is true, correct and complete to the best of my information, knowledge and belief.
b) No material information which is relevant to the processing of the claim or which in any manner has a bearing on the claim, has been withheld or not disclosed.
c) If I have given/made any false or fraudulent statement/information or suppressed or concealed or in any manner failed to disclose material information, the policy shall be void and I shall not be entitled to all/any rights to recover there under in respect of any or all claims, past, present or future.
d) The receipt of this claim form/other supporting/related documents, may not constitute an agreement by the Company of the claim and the company reserve the right to process or reject or require further/additional information in respect of the claim.
e) I also consent and authorize the Insurer and its representative to seek medical information from any hospital/medical practitioner who has any time attended on the insured person.
f) I confirm that the expenses for which claim is being lodged have been incurred in respect of the insured.

Date: D D M M Y Y Y Y

Signature of Claimant

The issue or acceptance of this form is not to be construed as admission of liability on the part of the Company