MDINDIA HEALTHCARE SERVICES (TPA) PVT. LTD.
S. No. – 46/1, E-space, A Wing, 3rd Floor, Pune Nagar Road,
VadgaonSheri, Pune - 411014 (Maharashtra)
UAN Voice : 1860-233-4446 UAN Fax: 1860-233-4447
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CLAIM FORM

National Insurance Company ☐ **New India Assurance Company** ☐

Oriental Insurance Company ☐ **United India Insurance Company** ☐

1. Current Policy no. :- ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

2. MDIndia ID No.: MDI5- _____

3. Corporate Name :_____ Employee Code : _____

4. Name & Address of the Policy Holder:_____
_____

5. Name of the Patient: _____

6. Present Contact Address: _____

7. Contact No. (Resi. / Office): _____ Mobile No.: _____

8. Have you preferred any claim for the same **Insured under** the Mediclaim scheme earlier, if so give details viz

Sr. No.	Particulars	Claim 1	Claim 2	Claim 3	Claim 4
(a)	Policy Number				
(b)	Date of Admission				
(c)	Date of Discharge				
(d)	Diagnosis				
(e)	Whether settled / repudiated				
(f)	Claim Amount (if settled) : **Rs**.				

9. Since when the person covered under the policy without break _____ yrs.

Xerox copies of previous year's policies MUST be enclosed:

10. If the claim is of Domiciliary Hospitalization please indicate
    a) Date of Commencement of the treatment_____
    b) Date of Completion of treatment _____
    c) Name & Address of attending Medical Practitioner

d) Contact No._____ Registration No. _____Qualification:_____

11. Details of Expenses incurred by the Claimant

SR. NO.	DATE	BILL No	PARTICULARS	AMOUNT CLAIMED
			GRAND TOTAL:	

NOTE: Please attach the sheets if Necessary

In support of the claim, I enclose the following documents

Sr. No.	Particulars	Yes / No Tick		Sr. No.	Particulars	Yes / No Tick	
1	Policy Schedule / Policy Copy			8	Prescriptions*		
2	Discharge Card / Summary*			9	Pre Hospitalization Medical Bills*		
3	Final Hospital Bill*			10	Post Hospitalization Medical Bills*		
4	Surgeon's Certificate (In all cases of surgery explaining the procedure)			11	Medical Reports*& MLC / FIR (for accident cases)		
5	Attending Doctor's / Consultant's / Specialist's / Anesthetist's bill receipt and certificate regarding diagnosis *			12	Hospital Payment Receipt*		
6	Certificate from attending Medical Practitioner giving reasons for allowing treatment at home.*			13	Indoor Case Papers (preferably for all claims above 1 lakh)		
7	Certificate from attending Medical Practitioner /Surgeon that the patient is fully cured.*			14	Previous Policy Copies, if any		

*** These documents to be submitted as original.**

I have incurred the above expenses for the treatment of the disease / illness / accident and herewith as per schedule mentioned below:

I hereby declare that the above information is true & correct to the best of my knowledge and belief. If I have made any false, fraud or untrue statement, suppression or concealment, my right to claim reimbursement of the expenses shall be forfeited.

I also consent and authorize MDINDIA / Insurance Company to seek medical information from any Hospital Medical Practitioner who has any time attended on the insured person.

I hereby declare that I have included all bills / receipts for purpose of this claim and that I will not be making any supplementary claim in respect thereof, except the post Hospitalization claim if any.

Signature of Policy Holder

MEDICLAIM MEDICAL REPORT (MMR)

CERTIFICATE FROM ATTENDING DOCTOR OF CLAIMANT FROM THE NURSING HOME/HOSPITAL

1. Name of Patient:- _____
2. Age:- _____ DOB:- ____ / ____ / _____ Sex: M ☐ F ☐
3. Are you a family doctor of patient?:- Yes / No Since:- _____ yrs
4. Who referred the case to you? _____
5. When did the patient approach you for the first time in connection with present disease suffered?

   _____

   Date of First Consultation: _____
6. Details of previous history of disease / surgery (if any) of patient? _____

   _____
7. Is the patient suffering from Diabetes, Hypertension (Blood Pressure), Kidney problems, Cancer, T.B., Heart Problem and AIDS or other disease? If yes (Since how long he or she may be suffering from the same.):- _____

   _____

9. Present disease suffered (Diagnosis):- _____

   _____
10. Duration of present disease suffered (i.e. since how long he or she may be suffering from present disease before approaching you) :- _____

    _____
11. Is the present disease suffered connected to previous disease or Diabetes, Hypertension (Blood Pressure), Surgery or other existing disease? :- _____

    _____
12. Is disease suffered Acute or Chronic? :- _____
13. Whether the disease is caused due to any congenital defects (Yes/No)? _____

14. Whether the patient had any complications during or after pregnancy (Yes/No)? _____

15. Whether the disease/injury is caused directly or indirectly due to the use of alcohol or drugs (Yes/No): _____

16. Could the patient have been aware the illness or disease of which treatment is being taken now?

    If yes since when? **(**Approx. period of illness):- _____

    Date when the illness / injury was sustained: - _____

17. Is the disease suffered requires hospitalization? :- Yes / No

    a) Nature of treatment given :-Operative / I.V.Fluid / Injection / Oral Treatment / Other Parenteral Treatment

    b) Indoor case no. of the patient Hospital / Nursing home: _____

18. Date of Admission :_____ Time of admission: _____

19. Date of Discharge: _____ Time of discharge: _____

20. Is your hospital registered with local authority? If yes, please attaché xerox copy of certificate Registration Number of Hospital: _____

21. No. of total beds in your Nursing Home / Hospital:- _____

22. Other comments you would like to make (if any) connected to present disease suffered by the patient:- _____

    _____

23. "Whether the patient is fully cured or not?" Yes / No

Certified that the details furnished above are true to the best of my knowledge and as per the records available at this hospital.

Doctor's Name: _____ Qualification: _____ Registration No: _____

Contact No: _____ _____

Date: ____ / ____ / ____ Signature of Attending Doctor

(With rubber stamp and registration no. of your Nursing Home / Hospital)

Name of Policy Holder: _____

Date: ____ / ____ / ____ _____

Signature of Policy Holder

ELECTRONIC CLEARANCE SYSTEM FORM

Name of Account Holder

Name of Bank

Branch Name

Branch Address

Type of Account:

Account Number

IFSC

Important information to the Policy holder / claimants opting for NEFT:

1. All the information mentioned above mandate form should be filled correctly.
2. The policy holder / claimant should also submit either the Photocopy of cheque leaf or the Photocopy of the page of the passbook / cheque book where details of the Account Holder Name, IFSC, Account Number are mentioned.
3. The account of the policy holder / annuitant should be operational at the time of receipt of policy payment.
4. Before submitting the mandate form, the policyholder/ claimant should confirm from his bank that it is NEFT enabled.
5. Policy holder's/ claimants' name under the policy should match with that of Bank A/c, else it is likely to be rejected.

Declaration

1. I hereby declare that the information furnished in this ECS Form is true & correct to the best of my knowledge & belief. If I have made any false or untrue statement, suppression or concealment of any material fact, my right to claim reimbursement shall be forfeited.
2. I agree that I shall not hold TPA/Insurance Company responsible for delay or non-receipt of the payment for any reason whatsoever after issue of the instructions for payment by Insurer/TPA based on the above.
3. As per the revised RBI guidelines, Canceled cheque should have pre-printed name of account holder.

Date:
Place:

Signature of the Policy Holder

----------SAMPLE CHEQUE FORMAT ----------

Note: Claims Number / Policy number / MDID number to be mentioned on cancel cheque and Please enclose the cancelled cheque of your bank account for our record; your banker should be a participant of NEFT/RTGS Facility.