



CLAIM FORM

Please complete all the pages without fail. Do not put 'Dots' (.) Or Dashes (-)

Name of the Insurance Company							
Policy No				Sl. No/ Certificate No			
Medi Assist ID No							
Name & Address of the Primary Insured							
Details of the Insured Person Hospitalised							
a) Name							
b) Relationship				c) Age			
d) Address							
e) Phone No				f) Mobile No			
g) E-mail Address, if any							
Ailment / Disease/ Injury							
Date of Injury sustained/ disease detected							
If Injury, narration how it occurred							
Name of the Hospital where treated							
Name of the treating Doctor							
Qualification				Registration No			
Admission		Date:		Time:		Discharge	
						Date:	
						Time:	
Total Amount Claimed				Rs.			
Date of commencement of first Insurance for the person (without break)							
Have you been covered with any other Mediclaim / Health Insurance?				Yes		No	
If 'Yes' please attach a photocopy of the Policy							
Have you preferred any claim for the same ailment earlier?				Yes		No	
If 'Yes', Claim No				Status: Settled / Denied			
If the Claim is for Domiciliary hospitalisation, please indicate							
Date of Commencement of treatment							
Date of completion of treatment							
Name of the treating Doctor						Qualification	
Address of the Doctor							
Reason for not hospitalizing patient							

Date:

Signature of the Claimant

Please send this claim form duly completed with all enclosures to:

MEDI ASSIST INDIA PRIVATE LTD.,
 #49, "Shilpa Vidya" Buildings, 1st Main, Sarakki Industrial Layout, 3rd Phase J.P.Nagar, Bangalore - 560078.
 Phone: 26584811 Fax: 26538793 Toll Free: 1800 4259 449



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MEDICAL CERTIFICATE TO BE FILLED IN BY THE DOCTOR TREATING THE PATIENT

1	Name of the Patient				Age	___ Yrs
2	Hospitalisation Period	Date of Admn		Date of Discharge		
3	Diagnosis					
4	Date of first consultation (Prior to Hospitalisation)					
5	Presenting complaints on admission					
6	Since when was the patient suffering from these?					
7	Past history of the Patient, if any, with duration of the ailment/s					
8	Whether the present ailment is a complication of any pre - existing ailment?	Yes		No		
9	If 'Yes', please specify the Disease or complication of any previous surgery done & the details thereof					
10	Whether the Disease / Defect / Disorder is Congenital in nature?					
11	Nature of Treatment given or Surgery performed for the present ailment / injury					
12	If the claim is for Maternity , number of living children excluding the new born					
13	Whether the Hospital is registered with Local Authorities? If 'Yes' please furnish Registration No					
14	Number of In-patient beds in the hospital (including ICU)					
15	Whether the hospital has fully equipped OT of its own?					
16	Whether qualified nurses employed round the clock?					
17	Whether under the supervision of a Registered Medical Practitioner round the clock ?					

Date:

Signature of the Doctor with Seal



To

Dear Sir/s,

Re: AUTHORISATION TO M/s. MEDI ASSIST INDIA PVT. LTD.,

I have undergone treatment for _____
from _____ to _____ in your hospital under Inpatient
No:_____.

I hereby authorise M/s. Medi Assist India Pvt. Ltd., who are my TPA for the Mediclaim policy I have, to seek any medical information / records from you or from the Medical Practitioners who has attended on me in connection with the above ailment.

In case they seek any such information / records kindly oblige. I have no objection whatsoever in this regard.

Thanking you,

Yours faithfully,

(Signature of the Claimant)

Date:

Address of the Insured:
