



Dedicated Healthcare Services (India) Private Limited

Corporate Office :

Office No 18 , 2nd Floor

Khetan Bhavan,

J. Tata Road, Churchgate,

Mumbai 400 020.

IRDA License No 28

Tel No. :022-22795900

Fax :022-22874235

Email id contactus@dhs-india.com

Claim Form

Policy No: _____ ID card no: _____

Name of the insurance company: _____ Insured: _____

Name of Patient: _____ Age: _____

Address: _____

Contact No: _____ Email id: _____

Corporate Name: _____ Employee No: _____

Bank details of insured in case of electronic transfer of funds in insured's account.

Name of the bank: _____

Branch: _____ Account no: _____

Nature of Disease/Illness: _____

Date of Admission: _____ Date of Discharge: _____ Hosp.Inpatient no. _____

Name of the hospital: _____

Please mark as (✓) Nature of claim

a) Pre- Hospitalization () b) Hospitalization () c) Post- Hospitalization ()

Total Amount Claimed: _____ Payable to Hospital : _____

Payable to Insured : _____

Name of the treating doctor: _____

Address & Telephone no: _____

Declaration: I Hereby declare that all the information provided is true to the best of my knowledge. I agree that if I have made or shall make any false, untrue statement or if there is suppression or concealment of any material information reimbursement of said expenses shall be forfeited.

Date & Place: _____

Signature: _____