

4. Registration No. of the doctor/ Ayurvedic Practitioner

Date of Admission

Date of Discharge

5. Details of other health insurance policies if any:

Policy No.	
Name of the Insurer	
Sum Insured	
Servicing TPA	
Date of Claim Intimation to Primary Insurer	
Amt. Settled / Pre-Auth. Given by TPA	

6. Please mark as (√) Specifying nature of claim as follows:

- A) Hospitalization Normal Pre-Hospitalization Post-Hospitalization
- B) Type of Admission Emergency Planned Day Care
- C) Others Hospital Cash Domiciliary External - Aids OPD Dental

In case of emergency hospitalization at non network hospital, please enclose doctor's letter stating the same with reasons

- D) Did you obtain pre-authorization for hospitalization Yes No
 If yes please attach copy of reference / approval of the same

- E) Policy categorization for Class of admission [Tick as (√) a class in which you were Admitted]

- ICU / ICCU/NICU/PICU/SICU (Specify number of days)**
- Air-Conditioned Single room (Specify number of days)**
- Non-Air Conditioned Single room (Specify number of days)**
- Air-Conditioned Twin sharing room (Specify number of days)**
- Non- Air Conditioned Twin sharing room (Specify number of days)**
- Other types**

Important:

Please enclose separate undertaking from provider hospital stating your class of admission and explicitly specifying whether AC or Non AC and accommodation type namely suite/apartment/single room/twin sharing room/ more than three-bed wards Etc.

7. Expense Details: Please specify the amount for the following heads

Pre-Hospitalization Expenses	Rs :
Hospitalization Expenses	Rs:
Post-Hospitalizations Expenses	Rs:
Ambulance Charges	Rs:
Daily cash for shared accommodation	Rs:
Minor accompaniment daily cash	Rs:
OPD Dental	Rs:
External Aids	Rs:
Domiciliary treatment	Rs:
General Health Check up costs	Rs:
Eye check up cost	Rs:
OPD expenses (Tax gain policy)	Rs:
Total Amount Claimed:	Rs:

8. For Health check up, please specify type of check up: (This facility is subject to pre-authorization at network Providers only)

General Health check up Eye Check up

Name/Address/Contact No. Of network provider :	
Description of tests carried out e.g. CBC. Sugar etc.	
Date of check up:	

In support of the above claim please submit the following documents; please mark it (√) for the documents submitted by you. :-

- Filled claim form duly signed by the claimant /Insured.
- Detailed discharge summary.
- Final hospital bill with detailed break up & payment receipt for the same.
- Investigation / lab reports supporting the diagnosis.
- Pharmacy/medicine bills with supporting doctor prescription
- Invoice / sticker for the implants used in the treatment
- External Aids vendors supported by the proper Prescription from Doctor
- Home Hospitalization treatment - Certificate from treating Doctor specifying reasons for Home hospitalization
- Obstetric history for maternity claims (GPAL Status)
- Copy of MLC / FIR in case of road traffic accidents (RTA)

Declaration

I/WE hereby to the best of my/our knowledge and belief, warrant the truth of the above details in every respect. I hereby give my consent and authority for you to seek medical information from any Hospital or Doctor who has at any time attended me whether in relation to the subject matter of this claim or otherwise. I also hereby confirm that the amount payable to me under the coverage terms and conditions would, when received constitute full and final discharge towards claim.

Date

Place _____ Signature of the Claimant / Insured
 Issue of this form is not to be taken as an Admission of Liability. Please provide Information correctly and completely.
 Please attach separate sheet, if the space provided is not sufficient.

NEFT Details:

I/ WE here by authorize Cholamandalam MS General Insurance Co Ltd to transfer the claim amount payable under Claim NO _____, to my Bank account number _____ with _____ bank in _____ branch,	
Located at _____ City, The MICR Code is _____ and IFSC Code is _____	
Date: _____	Signature of the claimant/ Insured
Place: _____	