



IN-PATIENT MEDICAL EXPENSES CLAIM FORM

NOTE:

This form is to be supported with paid receipts, prescriptions and discharge summary* of the hospital in original.

POLICY PARTICULARS:

Policy No.: _____
 Name of Company: _____
 Name of Employee: _____ Emp ID# _____
 Name of Patient: _____
 Age of Person hospitalized: _____ Relationship with Employee: _____
 Wellness Card Number: _____

DETAILS OF ILLNESS:

Date of illness first noticed: _____
 Date of recovery: _____
 Diagnosis: _____
 Has the claimant suffered from this illness before? YES/NO
 If yes, please give date(s) and details: _____

DETAILS OF HOSPITAL:

Name of Hospital attended: _____
 Name of medical practitioner consulted: _____
 Period of confinement: From: _____ To: _____
 Were any drugs prescribed: Yes/No _____
 If yes, please list the drugs prescribed and administered: _____

OTHER INSURANCE:

Is the patient entitled to payment under any other insurance in respect of this ailment? Yes/No
 If yes, please give details: _____

AMOUNT OF CLAIM:

Please list in the column below all expenses claimed and attach original (not photocopies) of all relevant paid receipt supported by relevant prescriptions and discharge summary*

Name of expenses	Amount
Total	

*Discharge summary means a concise description of the patient’s hospitalization entered into the medical record, including the reasons for admission, findings of laboratory testing and other diagnostic procedures, the discharge diagnostic provided by the attending physician upon the patient’s discharge from the hospital and instructions for the patient.

DECLARATION BY THE INSURED PERSON & ASSURED:

(a) To be signed by the Insured Person

I declare that to the best of my knowledge and belief the statements contained herein are true and that all relevant information has been disclosed.

Date: _____ Signature: _____

(b) To be signed by an official of the Assured

I confirm that at the date of claims the member of whose behalf this claim is made was an eligible employee in terms of the policy.

Date: _____ Signature: _____

(c) Declaration by the attending Doctor

I confirm having treated Mr/Mrs/Miss: _____

between the dates _____ and _____

and that the details shown on this form are consistent with my own knowledge of the patient.

Date: _____ Signature: _____

NOTE:

For speedy settlement of the claim, we request you to please fill in each and every column with as much details as possible. Please do not leave any column blank.

CHECK LIST FOR CLIENT PURPOSE: Requirement for Reimbursement

- Inpatient Claim Form (filled and stamped by the employer and treating Physician)
- Copy of Wellness card
- Proper itemized hospital original bill with following details
 - Room Board charges
 - Lab charges with reports
 - Pharmacy details with cost.(Receipts should have date, printed name & address of pharmacy or stamp of issuer)
 - Surgeon, anesthesia and O.T charges (applicable in surgical Procedures)
 - Labor room charges (in maternity cases)
- Original Discharge card/Summary
- Detailed breakup of Ancillaries & supplies with cost.
- Birth certificate in case of Delivery