Grand Healthcare TPA Services Pvt. Ltd.

45A, Hindustan Park, Kolkata – 700 029.

HOSPITALISATION CLAIM FORM

Issuance of this form does not amount to admission of any liability under the claim on the part of the insurers

Policy Holder Information	**Patient Information**
Name :	Name :
Grand ID No.	Relation :
Address :	UHID of Provider Tel: # Policy Holder:
City : State : Pin :	E-mail:
Provider Information	
Name :	Provider Information Number (UPIN/MCI NO.):
Address :	
City : State : Pin :	
Claim Information	
Admission Date : Time :	Name & Contact No. of Attending Medical Practitioner :
Patient Status:	
First Occurrence Date:	
Discharge Date : Time :	
Patient Paid Amount:	Registration No.:
Principal Diagnosis :	
Other Diagnosis :	
Procedure Code:	Disease Code:

Serviceline Information

Sl. No.	Service Description	Amount	Discount	Net Amount	Patient Paid Amount	Balance Due	Remarks
1	Room Charges						
2	ICU/CCU/Nursing Charges						
3	Doctor's Fee						
4	Lab Investigation						
5	Radiology						
6	Other Investigation						
7	Special Procedure						
8	Pharmacy Service						
9	OT/ Labour Room Service						
10	Package Charge						
11	Misc.						
	Total Amount Claimed:						

List of Enclosures (Please Tick)	**Comments / Remarks / Objections**
☐ Grand Pre authorization / First Admission Report ☐ Discharge Summary in original ☐ Hospitalization Bills with breakups in original ☐ Investigation Reports in original ☐ Consultation bills with Receipt in original ☐ If Surgery, Surgery bills with Receipt in original ☐ Medicine bills with prescriptions in original ☐ OT Pharmacy Bills in original ☐ Others	

I hereby warrant the truth of the foregoing particulars in every respect& I agree that if I have made or shall make any false or untrue statement, suppression or concealment my right to claim reimbursement of the expenses shall be absolutely forfeited. I further declare that in respect of the above treatment no benefits are admissible under any other Medical Scheme or Insurance.

Provider Representative	**Policy Holder/Patient**
Name : Date :	Name :
	Date:
Signature:	Signature: