Grand Healthcare TPA Services Pvt. Ltd.
45A, Hindustan Park, Kolkata – 700 029.
Toll free no.1800 345 3315

CLAIM FORM

Policy No: _____ ID Card No:_____

Name of the Insurance Company: _____

Name of the Proposer : _____ Name of the Claimant:_____

Address: _____

Contact No.:_____ E-mail: _____

Name of the patient: _____Relation with Claimant:_____ Age: _____Sex: M / F

Date of injury sustained or Disease first detected: _____Date:_____

Hospital Name and address: _____Regd. No.: _____

Name of attending Doctor:_____ Regd. No.: _____

Admitted on: Date _____ Time _____ Discharged on: Date _____ Time _____

IPD No./ File No.:_____ Room No.: _____Type of Room: _____

Total Amount Claimed: Rs._____

Whether Cashless Facility / claim availed earlier, if yes please provide details:_____

Previous coverage details, if any:_____

Nature of claims: a. Hospitalization ( ) b. Pre / Post Hospitalisation ( ) c. Domiciliary ( )

Declaration: I hereby declare that above particulars are true to the best of my knowledge. I agree that the reimbursement of the above expenses may be forfeited incase of any FALSE / UNTRUE statement or if there is suppression / concealment of any material information to this effect.

Signature (Insured / Claimant)

In support of the above claim, Please enclose the following documents, **in original: -**

- Photocopy of Cashless ID Card.
- Completely filled and signed claim form.
- Advice for hospitalisation.
- Original detailed Discharge Summary.
- Final bill of the hospital and the payment receipts in original.
- Package Break-up details, (if applicable)
- All investigation reports in original.
- All medicines bills with supporting prescriptions in original.
- Record of treatment taken in Pre & post hospitalisation periods, if any.
- Hospital Registration Certificate with local Government authorities.

CERTIFICATE

(TO BE FILLED BY THE HOSPITAL / NURSING HOME / CLINIC AUTHORITY)

This is to certify that _____

was admitted under my treatment from _____ at _____

to _____ at _____ and detail information is as under :

Name of Hospital / Nursing Home _____

Whether the same is registered with the local authority or not _____

If so, Registration No. _____

If not answer the following queries :-

No. of inpatient beds in the Hospital / Nursing Home:_____

Whether you have fully equipped theater of your own: Yes / No

Whether you have fully qualified Nursing Staff in your employment round the clock Yes / No

Whether you have qualified Doctor in Charge round the clock Yes / No

Date / Time of Admission _____

Date / Time of Discharge _____

History of present illness with duration of the presenting complaints :

What is the exact nature of complaint with which the patient first presented (seen) _____

_____

Since how long he / she has been suffering for the same. _____

_____

Past History of the disease _____

_____

Signature of Doctor
OR
Hospital Authorities
(Seal of Hospital)