MDINDIA HEALTHCARE SERVICES (TPA) PVT. LTD.
805, Sukhasagar Complex, 8thFloor, Usmanpur, Near Fortune Landmark Hotel,
Ashram Road, Ahmedabad-380 013 (Gujarat).
UAN Voice No. 1860-233-4446. UAN Fax No. 1860-233-4447
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CLAIM FORM

National Insurance Company ☐ **The New India Assurance Company** ☐

Oriental Insurance Company ☐ **The United India Insurance Company** ☐

1. Current Policy no. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

2. MDIndia ID No.: MDI5- ____________________________________

3. Corporate Name :_____________________________________Employee Code : __________________

4. Name & Address of the Policy Holder:____

   ____

5. Name of the Patient: ____

6. Present Contact Address: ____

7. Contact No. (Resi. / Office): _______________________ Mobile No.: _________________________

8. Have you preferred any claim for the same **Insured under** the Mediclaim scheme earlier, if so give details viz

Sr. No.	Particulars	Claim 1	Claim 2	Claim 3	Claim 4
(a)	Policy Number				
(b)	Date of Admission				
(c)	Date of Discharge				
(d)	Diagnosis				
(e)	Whether settled / repudiated				
(f)	Claim Amount (if settled) : **Rs.**				

9. Since when the person covered under the policy without break __________yrs.

   Photocopies of previous year's policies MUST be enclosed:

10. If the claim is of Domiciliary Hospitalization please indicate

    a) Date of Commencement of the treatment_______________________________________

    b) Date of Completion of treatment ______________________________________

    c) Name & Address of attending Medical Practitioner

    d) Contact No.______________Registration No. _______________________Qualification:________

11. Details of Expenses incurred by the Claimant

SR. NO.	DATE	BILL No	PARTICULARS	AMOUNT CLAIMED
			GRAND TOTAL:	

NOTE: Please attach the sheets if Necessary
In support of the claim, I enclose the following documents

Sr. No.	Particulars	Yes / No Tick		Sr. No.	Particulars	Yes / No Tick	
1	Policy Schedule / Policy Copy			8	Prescriptions*		
2	Discharge Card / Summary*			9	Pre Hospitalization Medical Bills*		
3	Final Hospital Bill*			10	Post Hospitalization Medical Bills*		
4	Surgeon's Certificate (In all cases of surgery explaining the procedure)			11	Medical Reports*& MLC / FIR (for accident cases)		
5	Attending Doctor's / Consultant's / Specialist's / Anesthetist's bill receipt and certificate regarding diagnosis *			12	Hospital Payment Receipt*		
6	Certificate from attending Medical Practitioner giving reasons for allowing treatment at home.*			13	Indoor Case Papers (preferably for all claims above 1 lakh)		
7	Certificate from attending Medical Practitioner /Surgeon that the patient is fully cured.*			14	Previous Policy Copies, if any		

*** These documents to be submitted as original.**

I have incurred the above expenses for the treatment of the disease / illness / accident and herewith as per schedule mentioned below:

I hereby declare that the above information is true & correct to the best of my knowledge and belief. If I have made any false,

Fraud or untrue statement, suppression or concealment, my right to claim reimbursement of the expenses shall be forfeited.

I also consent and authorize MDINDIA / Insurance Company to seek medical information from any Hospital Medical Practitioner who has any time attended on the insured person.

I hereby declare that I have included all bills / receipts for purpose of this claim and that I will not be making any supplementary claim in respect thereof, except the post Hospitalization claim if any.

Signature of Policy Holder

MEDICLAIM MEDICAL REPORT (MMR)

CERTIFICATE FROM ATTENDING DOCTOR OF CLAIMANT FROM THE NURSING HOME/HOSPITAL

1. Name of Patient:- ____

2. Age:- ___________ DOB:- _____/ _____/ _____ Sex: M ☐ F ☐

3. Are you a family doctor of patient?:- Yes / No Since:- _______________yrs

4. Who referred the case to you? ____

5. When did the patient approach you for the first time in connection with present disease suffered?

   ____

   Date of First Consultation: ____________________

6. Details of previous history of disease / surgery (if any) of patient? ______________________________

   ____

7. Is the patient suffering from Diabetes, Hypertension (Blood Pressure), Kidney problems, Cancer, T.B., Heart Problem and AIDS or other disease? If yes (Since how long he or she may be suffering from the same.):- ____

   ____

9. Present disease suffered (Diagnosis):- ____

   ____

10. Duration of present disease suffered (i.e. since how long he or she may be suffering from present disease before approaching you) :- ____

    ____

11. Is the present disease suffered connected to previous disease or Diabetes, Hypertension (Blood Pressure), Surgery or other existing disease? :- ____

    ____

12. Is disease suffered Acute or Chronic? :- ____

13. Whether the disease is caused due to any congenital defects (Yes/No)? __________________________

14. Whether the patient had any complications during or after pregnancy (Yes/No)? _________________

15. Whether the disease/injury is caused directly or indirectly due to the use of alcohol or drugs (Yes/No): ___________

16. Could the patient have been aware the illness or disease of which treatment is being taken now?

    If yes since when? (Approx. period of illness):- ____

    Date when the illness / injury was sustained: - ___________________________

17. Is the disease suffered requires hospitalization? :- Yes / No

    a) Nature of treatment given :-Operative / I.V.Fluid / Injection / Oral Treatment / Other Parenteral Treatment

    b) Indoor case no. of the patient Hospital / Nursing home: ______________________

18. Date of Admission :____________________Time of admission: ____________________

19. Date of Discharge: _____________________Time of discharge: ____________________

20. Is your hospital registered with local authority? If yes, please attach photocopy of certificate
    Registration Number of Hospital: ___________________________________

21. No. of total beds in your Nursing Home / Hospital:- _______________________

22. Other comments you would like to make (if any) connected to present disease suffered by the patient:- ____

    ____

23. "Whether the patient is fully cured or not?" Yes / No

Certified that the details furnished above are true to the best of my knowledge and as per the records available at this hospital.

Doctor's Name: _______________________________Qualification: ________Registration No: __________

Contact No: ____________________ ___________________________________

Date: _____/ _____/ ____

Signature of Attending Doctor

(With rubber stamp and registration no. of your Nursing Home / Hospital)

Name of Policy Holder: ____

Date: _____/ _____/ ____ ___________________________________

Signature of Policy Holder

Mandate Form for Electronic Clearance System

Policy Number

MDID / EMP Number

Claim Number

Policy Holder Name

Telephone Number   Email ID

Name of Account Holder

Name of Bank

Branch Name

Branch Address

Type of Account:

Account Number   Cancelled Cheque Y N

MICR Code   IFSC Code

Declaration:-

1. I hereby declare that the information furnished in this ECS Form is true & correct to the best of my knowledge & belief. If I have made any false or untrue statement, suppression or concealment of any material fact, my right to claim reimbursement shall be forfeited.
2. I agree that I shall not hold TPA/Insurance Company responsible for delay or non-receipt of the payment for any reason whatsoever after issue of the instructions for payment by Insurer/TPA based on the above.
3. As per the revised RBI guidelines, Canceled cheque should have pre-printed name of account holder.

Date:

Place:

Signature of the Policy Holder

---SAMPLE CHEQUE FORMAT ---

Note: Claims Number / Policy number / MDID number to be mentioned on cancel cheque and Please enclose the cancelled cheque of your bank account for our record; your banker should be a participant of NEFT/RTGS Facility.