

(c) Whether Settled Y N

Repudiated Y N

(d) Amount of settlement

Grid for amount of settlement

(e) Admitted on

Date and Time input fields

(f) Discharged on

Date and Time input fields

DETAILS OF CURRENT CLAIM BILLS

Financial Details : Bill Amount Claim Amount

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

Table with columns: Date, Bill No., Description, Bill Amount, Amount Claimed, Claim type (Pre- Hospitalization/ Post-Hospitalization/Hospitalization). Includes a GRAND TOTAL row.

*If required, additional sheet to be attached

In support of the claim, I enclose the following documents

- List of documents to be enclosed: Claim Form Duly Signed, Pre-authorization form, Claim Notification, Discharge Summary, Hospitalization Bills, Doctors' Surgery Certificate if any, Surgery/Consultation Bills if any, Operation Theatre Pharmacy Bills, Medicines Bills with Dr's Prescription. Includes checkboxes and fields for bill amounts.

I hereby warrant the truth of the foregoing particulars in every respect and 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 said expenses shall be absolutely forfeited.

I also consent and authorize Star Health And Allied 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.

Date : [Grid]

Signature of Claimant

MEDICAL CERTIFICATE TO BE FILLED IN BY THE TREATING DOCTOR

1.	Name of the Patient & Age	
2.	Admission Date and Time	Discharge Date And Time
3.	Name of Surgeon / Physician	
4.	Diagnosis	
5.	Date of First Consultation (Prior to hospitalisation)	
6.	(a) With What complaints was the patient admitted for:	
	(b) Since when was the patient suffering from the said complaints	
7.	Past History of the Patient (if any) with the duration of illness	
8.	Whether the present ailment is a complication of Pre-existing disease? If yes, please specify the disease (or) complication of any previous surgery done? If yes, please specify details.	
9.	Whether the disease/disorder is congenial in nature?	
10.	Nature of Surgery/treatment given for present ailment	
11.	(a) Whether Hospital/Nursing Home is Registered, if yes, Regn. No.	
	(b) No. of in - patient beds in the Hospital (including ICU)	
	(C) Whether the Hospital is having fully equipped Operation Theatre of its own/qualified nurses round the clock/Qualified doctors round the clock?	

Signature of the Doctor with Seal

Date

Hospital Seal :