THE ORIENTAL INSURANCE COMPANY LIMITED

Regd. Office: Oriental House, P.B. No. 7037, A-25/27, Asaf Ali Road, New Delhi 110002

Claim No.

Issuing Office

MEDICLAIM POLICY -CLAIM FORM

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

Please give the following information correctly and completely to enable the company to process your claim promptly.

				For office use only
1.	Name of the Insured (In whose name policy is issued)	(Surname)	(Initial)	
2.	Details of the Insured Person (In respect of whom claim is made			
a	Name & relationship with the insured			
b	Present completed age	DOB	Age	
c	Occupation			
d	Residential Address Telephone No.			
3.	Policy No.			
4.	Nature of Disease/illness contracted or injury suffered			
5.	Date of injury sustained or disease/illness first detected			
a	Name and address of the attending Medical Practitioner			
b	Qualification Telephone No.			
c	Registration No.			
6a	Name & Address of the Hospital / Nursing Home /Day care Clinic			
b	Date of admission			
B	Date of Discharge			

I have incurred on the treatment of Disease / illness / injury referred to above, the expenses as per the details given by me in the Schedule of Expenses given overleaf.

In support of the above claim I enclose the following documents (please indicate by /)

1. Discharge certificate/card from the Hospital.
2. Bill, Receipt and Cash Memos from the Hospital/Chemist(s), supported by the proper prescription and duly attested by me.
3. Receipt and Pathological test reports from a Pathologist supported by the note from the attending Medical Practioner/Surgeon demanding such Pathological test (s).
4. Surgeon's certificate stating nature of operation performed and Surgeon/s bill and receipt.
5. Attending Doctor's Consultant's / Specialist's/ Anaesthestist's bill and receipt and certificate regarding diagnosis.
6. Certificate from the attending Medical Practitioner / Surgeon that the patient is fully cured.

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 further declare that in respect of the above treatment no benefits are admissible under any other Medical Scheme or Insurance.

Dated at ______________________this_____________________day of _____________200

NAME OF THE CLAIMANT ____SIGNATGURE OF THE CLAIMANT

POLICY NUMBER __________SUM INSURED OPTED_____________ CLAIM NO. _____________

SCHEDULE OF EXPENSES INCURRED BY THE CLAIMANT			**FOR OFFICE USE ONLY**	
Details of Expenses claimed under Hospitalisation / Domiciliary Hospitalisation (To be supported by Bills/Receipts, Cash memos etc.)		Amount Claimed (1)	Amount not payable (2)	Net Payable (1) – (2) = (3)
1	**Hospitalisation Benefits:**			
I	Room, Board Nursing expenses provided by Hospital for ____days @ Rs ________ per day			
ii	IC Unit for _____ days @ Rs ________ per day			
iii	Emergency Ambulance charges			
	Total Amount under i, ii & iii			
2	Hospitalisation Benefits (Other than Room, Board & Nursing Expenses & ICCU (including pre & post Hospitalization)			
i	Surgeon's, Anaesthetist's, Medical Practitioner's, Consultant's, Specialist's fees.			
ii	) Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines & Drugs, Dialysis, Chemotherapy, Radiotherapy, Artificial Limbs, Cost of **Prosthetic devices implanted during surgical procedure like pacemaker**, **Relevant Laboratory** / Diagnostic **test,** X-Ray **etc.**.			
	Total			
3	Maternity Expenses Benefit Extension			
i	Room, Board Nursing expenses for ___________days @ Rs _________per day.			
ii	Gynaecologist/ Obstetrician/ Surgeon/ Physician / Anaesthetist Fees __________and Normal delivery, Miscarriage and Abortion, Caesarean Section / Abdominal Opening for extra uterine pregnancy.			
iii	Diagnostic materials, X-Ray, Medicines and drugs, injections etc.			
	Total			

Name of the claimant **Signature of the Claimant :**

DATE
PLACE

FOR OFFICE USE

Prepared by: __________________	Total amount claimed Rs	in case entire claim is not admissible reasons thereof
Checked by: __________________		
Approved by: _________________	Net amount Payable Rs	

Passed for payment of Rs ____________.

COMPETENT AUTHORITY