The Oriental Insurance Company Limited
(Incorporated in India, subsidiary of General Insurance Corporation of India)
Regd. Office: Oriental House, P.B. No.7037, A-25/27, Asaf Ali Road, New Delhi- 110 002

Issuing Office

HOSPITALISATION & DOMICILIARY HOSPITALISATION BENEFIT CLAIM FORM

Claim No._____

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

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 wohole 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 (c) Occupation (d) Residential address		
3. Policy No.		
4. Nature of Disease/illness contracted or injury suffered		
5. Date of injury sustained or Disease/illness first detected	Date Month Year	

a) Name & Address of the attedning Medical Practitioner : _____
_____Pin Code_____
State/U. Territory

(b) Qualification & Telephone No. _____

(c) Registration No.

6. (a) Name and Addres of the Hospital/Nursing Home/Clinic : _____ _____Pin Code_____ State/U.Territory

(b) Date of Admission : Date Month Year

(c) Date of Discharge : Date Month Year

7. If the claim is for Domicilliary Hospitaliation Please indicate

(a) Date of Commencement of treatment : Date Month Year

(b) Date of completion of treatment : Date Month Year

(c) Name & Address of attending Medical Practitioner :

(d) Telephone No.

(e) Registration No.

I have incurred on the treatment of Disease/illness/Accident 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. Bill, Receipt and Discharge certificate/card from the Hospital.
2. Cash Memos from the Hospital/Chemist(s), supported by the proper prescription.
3. Receipt and Pathological test reports from a pathologist supported by the note from the attending medical Practitioner/surgeon demanding such pathological test.
4. Surgeon's certificate stating nature of operation performed and Surgeon's bill and receipts.
5. Attending Doctor's/Consultant's /Specialist's/ Aneasthetist's bill and receipt and certificate regarding diagnosis.
6. In case of Domicialary Hospitalisation, receipt from a qualified nurse who attended the patient at his/her residence duly supported by a certificate from attending Medical practitioner.
7. Certificate from the attending Medical practitioner giving reasons for allowing treatment home.
8. 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_____tjos_____of _____200

Signature of the Claimant

FOR OFFICE USE ONLY:

DATE OF CLAIM | | | | | |

Policy No._____Scheme A/B_____Category of Benefits_____Claim No. ☐☐☐☐

SCHEDULE OF EXPENSES INCURRED BY THE CLAIMANT		FOR OFFICE USE ONLY	
Details of Expenses claimed under Hospitalisation/Domiciliary Hospitalistion (To be supported by Bills/Receipts Cash memos etc.)	Amount Claimed (1)	Amount not Payable (2)	Net Payable (1)-(2)-(3)
1. (A) HOSPITLISATION BENEFIT: (i) Room Board, Nursing expenses (including Boarding to be provided by the Hospital) for_____days_____ ☐☐ (ii) I.C. Unit For _____days_____ ☐☐		☐☐☐ ☐☐☐	
(B) Hospitalisation Benefits other than Room, Board & Nursing Expenses & ICCU(including Pre & Post Hospitalisation) ☐☐ 1. Surgeon, Anaestheitist, Medical Practitioner, Consultants, Specialists fees. ☐☐ 2. Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines & Drugs, Diagnostic materials & X-ray dialysis, Chemotherapy, cost of Pacemaker, artificial limbs & cost of Organs and similar other expeses. ☐☐		☐☐☐ ☐☐☐ ☐☐☐ ☐☐☐ ☐☐☐	

SCHEDULE OF EXPENSES INCURRED BY THE CLAIMANT		FOR OFFICE USE ONLY
II. Domiciliary Hospitalisation Benefit (Non-surgical treatment only) 1. Medical Practitioners, Consultatns & Specialists fee for vists etc. Blood, Oxygen, Diagnostic material, X-ray, Employment of qualified Nurses, Mediciens and Drugs and Similar expenses	(1)	(2) (3)
Total		

Signature of Claimant:

Date:
Place:

FOR OFFICE USE ONLY

Prepared by:
Checked by:
Aproved by:

Total amount payable under the Claim Rs._____
Less: Advance/on account payment if any Rs._____
Net amount Payable Rs._____

In case entire claim is not admissible, Reason thereof

Passed for payment of Rs._____

Competent Authority