Hospitalization Claim Form for Chronic Illness

1. Patient Details

Full Name:

Date of Birth:

Gender:

Select

Contact Number:

Policy Number:

Address:

2. Hospital & Admission Details

Name of Hospital:

Hospital Address:

Admission Date:

Discharge Date:

Treating Doctor's Name:

3. Details of Illness

Name of Chronic Illness:

Date of First Diagnosis:

Description of Treatment:

4. Claim Details

Expense Type	Amount Claimed (INR)	Receipt No./Date
Room Charges		
Doctor Fees		
Medicines		
Diagnostics		
Other Expenses		
Total		

5. Declaration

I/we hereby certify that the above details are true and correct to the best of my/our knowledge. I/we authorize the insurer to verify the information provided.

Patient's/Guardian's Signature:

Date:

Note: Please attach copies of all medical reports, prescriptions, bills, and discharge summary along with this form.