Surgical Claim Form for Day Care Procedures

Instructions: Please complete all sections of the form. Attach supporting documents such as medical reports, bills, and discharge summary for timely processing.

1. Patient Information

Patient's Full Name:

Policy Number:

Date of Birth:

Contact Number:

Address:

2. Hospital & Provider Details

Hospital Name:

Treating Doctor/Surgeon's Name:

Doctor's Registration Number:

Date of Admission (Day Care):

Date of Discharge:

3. Procedure Details

Procedure Name	Procedure Code (ICD/CPT)	Date Performed	Amount Claimed (INR)

4. Bank Details for Reimbursement

Account Holder Name:

Bank Name:

Bank Account Number:

IFSC Code:

5. Declaration & Signature

I hereby declare that the details provided above are true and complete to the best of my knowledge. I authorize the insurance company to seek medical information from the hospital, if required.

Claimant's Signature:

Date:

Note: Attach all relevant documents including hospital bills, medical reports, and discharge summary to expedite claim processing.