The New India Assurance Company Limited
D.No. 49-01-09, II nd Floor, Daliraju Super Market,
Sangam Office Bus Stop, Akkayyapalem Main Road,
VISHAKAPATNAM – 530 016
Ph: 0891-2517737: 2591977: 2504849(D) Telfax: 0891-2517781

ANNEXURE – II to Mediclaim Policy
HOSPITALISATION AND DOMICILIARY HOSPITALIZATION
BENEFIT POLICY CLAIM FORM

Please fill in all columns without exception put "NA ", wherever the column is not relevant

1. Name of the insured : _____
2. Details of the person
   Undergoing treatment
   a) Name : ----------
   b) Date of birth : _____
   c) Occupation : _____
   d) Residence Address:_____
   _____
   e) Phone / Cell No : _____
3. MIN NO / Mediclaim Policy Number :
4. Nature of disease / illness / Injury suffered : _____
5. a) Name & Address of Hospital / Nursing Home : _____
   _____
   b) Date of admission _____
   c) Date of Discharge: _____
6. If the claim is for Domiciliary Hospitalization, Please indicate:
   a) Date of commencement of treatment:_____
   b) Date of completion of treatment: _____
   c) Name & Address of the attending medical Practitioner: _____
7. Total Claimed Amount: _____

All claim bills should be sent to following address

VIDAL HEALTH INSURANCE TPA Pvt. Ltd.
D.No.50-94-19/1, N R Bhavan, Ground Floor, Shanthipuram, Vishakhapatnam – 530 016
Phone: 0891-2754316 / 2723959, Mobile : 9704764949

The New India Assurance Company Limited
D.No. 49-01-09, II nd Floor, Daliraju Super Market,
Sangam Office Bus Stop, Akkayyapalem Main Road,
VISHAKAPATNAM – 530 016
Ph: 0891-2517737: 2591977: 2504849(D) Telfax: 0891-2517781

I have incurred on the treatment of disease / illness / accident referred to above, the expenses as per the details given by me in schedule of expenses given overleaf.

In support of the above claim, I enclose the following documents (Please indicate by tick):

1. Original Bill , Receipt and Discharge Certificate / Card from the Hospital
2. Original Cash memos from the hospital / chemist (s), supported by the proper prescription
3. Pathological test reports :
4. Surgeon's certificate stating nature of operation performed
5. Attending doctor's / consultant's Specialist's / Anesthetist's report.
6. Cancelled Cheque / Bank Passbook front page copy of Insured – Mandatory

I hereby warrant the truth of the foregoing particulars in every respect. I further declare that, In respect of the above treatment, no benefits under any other scheme of insurance or from my present employer's if any, have been claimed by me.

Insured (claimant's) Bank account details for ensuring e-payments:

Name Of the Claimant	
Account Number	
Name of the Bank	
Name of the Branch	
Address of the Branch	
Type of Account	
IFSC CODE	

****Note:** All original documents should be enclosed. Photocopy will not be accepted. However photocopy of the document submitted may be retained by the claimant.

Date: **Signature of the employee/ Spouse**

All claim bills should be sent to following address

VIDAL HEALTH INSURANCE TPA Pvt. Ltd.
D.No.50-94-19/1, N R Bhavan, Ground Floor, Shanthipuram, Vishakhapatnam – 530 016
Phone: 0891-2754316 / 2723959, Mobile : 9704764949

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ANNEXURE – III to Mediclaim Policy

O.P.D. TREATMENT CLAIM FORM

1. Name of the Employee :

2. Name of the Patient :

3. Employee Number :

4. Mediclaim Policy No :

5. Address (In Block letters) :

6. Phone No. with STD Code / CELL Number :

7. Nature of illness :

8. Period of illness :

9	Expenses Incurred	Amount	Bill No	Bill Date
a)	For Consultation			
b)	For Medicines			
c)	For Pathological and other diagnostic test			

I declare that the facts given are correct and that I have not claimed reimbursement for the above expenses incurred by me from any other source

Place: **(SIGNATURE OF THE EMPLOYEE / SPOUSE)**
Date:

Name of Account Holder :
(Only Name of Employee / Spouse):
Bank Name: Account Number:
Branch Name: IFSC Code :

Please enclose the following documents along with the claim form:

a) OPD Claim Form dully filled in;
b) All Original Doctor's Prescriptions;
c) All Original Cash Receipts/Bills for Durgs/Diagnostic Tests etc, all Diagnostic Reports;
d) Bank Account proof / Cancelled cheque copy

**** All the above documents should be in original. Photocopies will not be accepted**

All claim bills should be sent to following address

VIDAL HEALTH INSURANCE TPA Pvt. Ltd.
D.No.50-94-19/1, N R Bhavan, Ground Floor, Shanthipuram, Vishakhapatnam – 530 016
Phone: 0891-2754316 / 2723959, Mobile : 9704764949