

ADDRESS OF
ISSUING OFFICE



ITGI / MS / 06

IFFCO-TOKIO GENERAL INSURANCE CO. LTD.

Regd. Office: 34, Nehru Place, New Delhi - 110 019

CLAIM NO. _____

MEDISHIELD CLAIM FORM

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

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

Policy No.	
Name of the Insured (in whose name policy is issued)	
Details of Insured Person (in respect of whom claim is made) Name/relationship to the Insured Present completed Age Occupation Residential address	
Nature of Disease/illness contracted or injury suffered	
Date of injury sustained or Disease/illness first detected	
Name & Address of the attending Medical Practitioner Qualification & Tel. No. Registration No.	
Name & Address of the Hospital/Nursing Home/Clinic Date of Admission	Date Month Year



Date of Discharge	Date	Month	Year
If the Claim is for Domiciliary Hospitalisation, please indicate			
Date of Commencement of Treatment	Date	Month	Year
Date of Completion of treatment	Date	Month	Year
Name & Address of attending Medical Practitioner			
Telephone No.			
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, Receipts and Discharge Certificate/Card for 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 tests.
4. Surgeon's certificate stating nature of operation performed and Surgeon's bill and receipt.
5. Attending Doctor's / Consultant's / Anaesthetist's bill and receipt and certificate regarding diagnosis.
6. In case of domiciliary 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 at 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: This _____ Day of _____ 20__

Signature of the Claimant

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DATE OF CLAIM	
POLICY NUMBER	
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/ Amount Domiciliary Hosp. (to be supported by Bills Receipts, Claimed Cash Memos etc.)	Amount Payable	Net Payable (1)-(2)=(3)
(a) HOSPITALISATION BENEFITS 1. Room, Board, Nursing Expenses (including Boarding to be provided by the Hospital) For Days 2. I.C. Unit For Days		

<p>(b) Hospitalisation Benefits other than Room, Board & Nursing Expenses & ICCU (including Pre & Post Hospitalisation)</p> <p>(i) Surgeon, Anaesthetist, Medical practitioner, Consultants, Specialists fees</p> <p>(ii) Anaesthesia, Blood, Oxygen, Operation theatre charge, Surgical & Appliances, medicines & Drugs, Diagnostic Materials & X-ray, dialysis, Chemotherapy, Radiotherapy, cost of Pacemaker, artificial limbs & cost of Organs and similar other expenses.</p> <p>II DOMICILLARY HOSPITALISATION BENEFITS (NON-SURGICAL TREATMENT ONLY)</p> <p>I. Medical Practitioners, Consultants & Specialists for visits etc.</p> <p>II. Blood, Oxygen, Diagnostic materials, X-ray, Employment of qualified Nurses, Medicines and Drugs – and similar expenses</p>			
Total			
<p>Signature of the Claimant</p> <p>Date</p> <p>Place</p>			

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Prepared by

Checked By

Passed for payment of Rs.

Total amount payable under the claim Rs.....in case entire claim is
 Less: Advance/on account payment if any Rs.....not admissible reasons
 Net amount payable Rs.....thereof