CHOLAMANDALAM MS GENERAL INSURANCE COMPANY LIMITED
Registered and Head Office: "Dare House", II floor, Old No.234, New No.2, NSC Bose Road, Chennai - 600 001. India

Cholamandalam MS GENERAL INSURANCE

Health Claim Form

Policy No. **Policy Validity** D D M M Y Y To D D M M Y Y

TPA ID. **Plan Type** **Sum Insured**

1. Name of the Insured :

Name Mr. Mrs. Ms. Dr. Prof. M/s.

2. Details of the Insured person in respect of whom the Claim is made

Name Mr. Mrs. Ms. Dr. Prof. M/s.

Relation :

Date of Birth: D D M M Y Y Age: Sex: M F Marital Status: Single Married

Occupation:

Residential Address:

City

Pin Code State Tel. No

Fax No Mobile No Email

Have you previously consulted the present doctor or any doctor or hospital for the medical condition for which you are now claiming :If Yes, Please give full details: _____

_____

3. In case of Corporate Group Policies

Name of the Employee Mr. Mrs. Ms. Dr. Prof. M/s.

Relation with the Employee

4. Details of the Disease / Ailment

Nature of disease / illness contracted or injury suffered/Diagnosis _____

_____

_____

Date of injury sustained or disease/ illness first detected D D M M Y Y

Please give a brief history of this or any related condition ,with dates on which any previous consultations or treatment _____

_____

_____

Name/Address/Registration No/Tel. No. of the provider:

Tel.

Registration No. of the doctor :

Date of Admission D D M M Y Y Date of Discharge D D M M Y Y

5) Please mark as (✓) specifying nature of claim as follows:

A) Pre-hospitalisation Hospitalization Post-Hospitalisation Hospital daily allowance

B) Type of Provider Hospital Network Non-Network

C) Type of Admission # Emergency Planned Day care

 # In case of emergency hospitalization to non network hospital, please enclose doctor's letter stating the same with reasons

D) Did you obtain pre-authorisation for Hospitalization Yes ☐ No ☐

Policy categorization for Class of admission [Tick As (✓)a class in which your were Admitted]

Class A - Air-conditioned Single room upwards (i.e. Suite, apartment) ☐

Class B - Air-conditioned or Non air - conditioned Single room ☐

Class C - Air-conditioned or Non air-conditioned Two Bed room ☐

Class D - More than three bed room

Important :
Please enclose separate undertaking from provider stating your class of admission and explicitly specifying whether AC / Non AC and accommodation type namely suite/apartment/single room/two bed room/more than three -bed room etc.

6) Expense Details : Please specify the amount for the following heads

Pre-Hospitalisation Expenses :	Rs:
Hospitalization Expenses :	Rs:
Post-Hospitalisation Expenses :	Rs:
Ambulance charges :	Rs:
Total Amount Claimed :	Rs:

7) For Health Check Up, please specify type of check up : (This facility is subject to pre-authorization at PHS network providers only)

General Health Check up ☐ **Eye Check up** ☐

Name / Address / Contact No. of Network provider :
Description of tests carried out for e.g. CBC/Sugar etc.
Date of check up : D D M M Y Y

In support of the above claim following documents to be submitted otherwise it will delay the claim settlement. Please mark it (✓) which ever documents you are submitting :-

- ☐ Bills, Receipt and Discharge card/Summary of procedure in case of Day care treatment from the Hospital/Nursing Home.
- ☐ Cash memos from the Hospital / Chemist(s), supported by the proper prescription.
- ☐ Receipt and Diagnostic test reports from a Diagnostic center supported by the note from the attending Medical Practitioner / Surgeon demanding such diagnostic tests.
- ☐ Surgeons certificate stating nature of operation performed and surgeon's bill and receipt.
- ☐ Attending Doctor's / Consultant's / Specialist's / Anesthetist's bill and receipt and certificate regarding diagnosis, whichever is prescribed & thereby expenses incurred
- ☐ Undertaking from provider for class of admission.

Declaration

I/we hereby to the best of my/our knowledge and belief, warrant the truth of the above details in every respect.
I/we agree that if we have made already of if I/We make in any of my/our further statements in respect of the said incident or any false or fraudulent declaration or suppose or conceal any material fact, the policy shall be void and all rights of compensation in respect the present or future claim shall be forfeited. I hereby give my consent and authority for you to seek medical information from any Hospital or Doctor who has at any time attended me whether in relation to the subject matter of this claim or otherwise.
I also hereby confirm that the amount payable to me under the coverage terms and conditions would, when received constitute full and final discharge towards claim.

Date D D M M Y Y

Place **Signature of the Claimant / insured**

Issue of this form is not to be taken as an Admission of Liability. Please provide information correctly and completely. Please attach separate sheet, if the space provided is not sufficient.