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| For speedy Claim Processing of Health Insurance Claims, Bill should be submitted in this Format only |
| Name of the Policyholder |  | Policy No: |  |
| Name of the Patient |  | Relationship |  |
| Claim No: |  | Claim Amount: |  |
| Diagnosis |  | Treatment |  |
| Hospital Name |  | Tel: | E- mail: |
| Address |  |  |  |
| Bill No: |  | Dt.: | D.O.A**:** |  | D.O.D: |  |
| Patient Name: | Age: | Yrs. | Sex: | M / F |
| Address: |
| E- mail: | Tel: | Fax: |
| **Submit along with this Format, all the Original Bills (Hospital, doctors, pharmacy, lab etc.) signed on the back by the Patient and the Doctor. List the Bills under separate heads. Payments will be against the bills only.** |
| **Particulars** | **No. Days** | **Days x Rate** | **Amount** | **Advance** |
| Bed Charges |  |  |  |  |
| Nursing Charges |  |  |  |  |
| Medicine Charges |  |  |  |  |
| Anesthetist Charges |  |  |  |  |
| Physician’s name & Charges |  |  |  |  |
| Surgeon` s name & Charges |  |  |  |  |
| Lab / ECG / Scan etc. Charges |  |  |  |  |
| OT Charge |  |  |  |  |
| Surgical Sundries |  |  |  |  |
| Disposables |  |  |  |  |
| Pharmacy |  |  |  |  |
|  |
| **TOTAL** |  |
| Amount collected from the Patient |  | **Balance** |  |
| **Total Amount in words:** |
|  |
| Doctor’s Signature / Hospital/seal | Patient `signature | Policyholders Signature |