CLAIM FORM FOR NIRAMAYA HEALTH INSURANCE SCHEME

Notes: This form is issued without admission of liability and must be completed and returned to the insurance company for processing the claim.

Claim No (to be allotted by the insurer): _____Policy No: _____

1. Details of the Claimant:
Name in Full:_____
Present Age: _____ Years, Relationship with the patient _____

Telephone No.:_____
Residential Address:_____
_____
_____

2. Details of the Patient:
Name in Full: _____Age: _____Years, Disability: _____
Son / daughter of: _____BPL Card No._____
Residential Address:
_____
_____
_____

3. Permanent Business or Occupation: (If more than one state all)_____

4. (a) Name & address of the hospital where the treatment was conducted:
_____
_____
(b) Name, address & qualification of the doctor who conducted the treatment
_____
_____
_____

(5) Nature of claim: OPD/ IPD
a) Date/s: _____
b) Details of disease _____
c) Date of Admission: _____ Time: _____
d) Date of Discharge: _____ Time: _____

(6) Total Claimed Amount:

(7) 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 attending Medical Practitioner_____

d) Qualification_____

e) Telephone No._____

8. Are you insured elsewhere? If so, give details:
(a) Name of the Company and Sum Insured: _____
(b) The amount you are entitled to Claim under above policy: _____

In support of the above claim, I enclose following documents {Please indicate by (✓)}

1. Bills, Receipt and Discharge Certificate / card from the Hospital/Nursing Home. (In original)
2. Cash memos from the Hospital / Chemist(s), supported by the proper prescription.(In original)
3. Receipt and Pathological test reports from a Pathologist supported by the note from the attending Medical Practitioner / Surgeon demanding such Pathological tests. (In Original)
4. Surgeons certificate stating nature of operation performed and surgeon's bill and receipt. (In Orginal)
5. Attending Doctor's / Consultant's / Specialist's / Anesthetist's bill and receipt and certificate regarding diagnosis, whichever is prescribed & thereby expenses incurred (In Original)
6. If any transportation bill then pls. submit the bill. (In original)

Declaration:
I HEREBY DECLARE that the particulars are true to best of my knowledge and warrant the truth of the foregoing particulars in every
respect, and I agree that if I have made, or if shall make any false or untrue statement, suppression or concealment, my right to compensation shall be absolutely forfeited.

Place:
Date: **Signature of Insured**

Important:
Since it is a pre-requisite for admission of claims under the policy that the Hospital / Nursing Home / Clinic where the Insured Person was admitted, is registered with Local Authorities, it is necessary for the claimant to ensure that the Hospital / Nursing Home / Clinic indicates the same on the Bill-cum-Receipt issued by them.

Mailing Address : ICICI Lombard General Insurance Company Limited, Narain Manzil, 3rd Floor, 23 Barakhamba Road, New Delhi-110003. Tel:+91 11 55310657
Registered Office : ICICI Lombard General Insurance Company Limited, ICICI Bank Towers, Bandra Kurla Complex, Mumbai - 400 051.

Mandate Form for Electronic Clearance System for NIRAMAYA CLAIMS

Policy Number	
Application ID	
Claim Number	
Policy Holder Name	
Telephone Number	
Name of Account Holder	
Name of Bank	
Branch Name	
Branch Address	
Type of Account:	
Account Number	
IFSC Code	

Declaration:-

1. I hereby declare that the information furnished in this ECS Form is true & correct to the best of my knowledge & belief. If I have made any false or untrue statement, suppression or concealment of any material fact, my right to claim reimbursement shall be forfeited.
2. I agree that I shall not hold TPA/Insurance Company responsible for delay or non-receipt of the payment for any reason whatsoever after issue of the instructions for payment by Insurer/TPA based on the above.

Date:

Place: Signature of the Policy Holder