Claim Form:

Max Bupa Health Insurance

Claim Form- Employee First Health Insurance Plan
(For reimbursement of expenses incurred in non-network hospitals)

Claim No Date

(For official use only)

Please provide the following information fully to enable us to process your claim appropriately.

1. **Policy number (In full)**
2. **Commencement Date ----------** **Expiry Date---------**
3. **Name of the Employee** --------
4. Employee Code
5. Designation
6. **Details of the insured person**
   a) Name of the patient
   b) Relationship with the Employee-----Self ------Spouse ----- Son ----- Daughter ------ -Father ------Mother ------ Father-in-law -------Mother-in-law
   c) Date of birth-------
   d) Current Address----------
   City ---------
   State-------
7. **Details of the Employer**
   a) Group Name/Name of Employer
   b) Current Address
   City---------
   State-------
8. **Nature of illness contracted or injury suffered----------**
9. **Date on which injury was sustained /disease or illness first detected ----------**
10. **Details of the attending doctor**
    a) Name
    b) Address of the doctor City Pin code
    c) Qualification d) Phone no
    e) Registration number

11. Details of the Hospital

a) Name

b) Address of the hospital

City Pin code

State

Country

Contact no

c) Registration no

12. Inpatient bill no. ----------

13. Date of admission ----------

14. Type of Hospitalization Planned Emergency

15. Details of expenses

Expense Head		Amount		Amount
In Patient Treatment			Out-patient expenses	
Room Rent			Domiciliary Treatment	
General Hospitalization			Emergency Ambulance	
Pre-Hospitalization			Day Care	
Post Hospitalization			Medicine bill*	
Organ Donation/transplantation			Diagnostic bill*	
New Born Baby			Out patient expenses	
Maternity			Other expenses not included above	
Sub Total (A)			Sub Total (B)	
Total Claimed Amount (A +B)				

16. Number of document(s) submitted including this claim form -------

17. Please enclose the following documents

i) Original bills, receipts and discharge certificate/card from the Hospital/Doctor

ii) Original bills by chemist supported by proper prescription

iii) Original Investigation test reports and payments receipts

iv) Original Medical Fractioned /Doctor's referral letter advising hospitalization

v) Details of any other policy that may respond to claim

vi) Duly filled claims form(s)

18. Are you at present covered under any type of insurance (Individual or Group Health Insurance) Yes No

If yes, please give the details as follows:

Name of insurance company				Policy Number	Sum Insured	

The submission/receipt of this form does not amount to admission of any liability under the claim on the part of the insurers.

I/we here by authorize Max Bupa Health Insurance Company Limited to transfer the claim amount payable under this claim to my bank account.

Account holder's name

Bank

Account no

Branch

City

IFSC code MICR code

Other payment option is cheque. Please tick if you want the payment to made via cheque. The cheque will be sent to the policy holder's address

Please refer to the Max Bupa policy guide for detailed information of the benefits that you are eligible under your policy.

MICR Code: The MICR code can be found on the bottom of the cheque/cheque book. It appears after the cheque number.

IFSC Code: The IFSC code is listed on your cheque/cheque book. In case it is not listed, please request your bank for the same.

Declaration:

I hereby declare that the above information given is true and correct.

I further authorize any hospital, physician Insurance Company or Organization that has any records or knowledge of me or my health to furnish such information to Max Bupa Health Insurance Company Limited (“Max Bupa”) and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment and copies of all hospital or medical records. A Photostat copy of this authorization shall be considered as effective and valid as the original.

I understand that if I and / or the member (s) fail to provide any information requested in this pre-authorization form, it may result in the inability of Max Bupa to accept or process this pre-authorization.

I understand that all Customer personal Information personal information collected or held by Max Bupa will be used for processing the claims and analysis related to Insurance / Reinsurance business.

Date Signature of Claimant

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