## IN-PATIENT CLAIM FORM

(TO BE FILLED BY CLAIMANT EMPLOYEE)

| | | |
|---|---|---|
| 1 | NAME OF THE COMPANY / CLIENT: | |
| 2 | NAME OF EMPLOYEE: | |
| 3 | IGI HEALTH CARD #: | |
| 4 | PATIENT'S NAME: | |
| 5 | AGE/ RELATION TO EMPLOYEE: | |
| 6 | DATE WHEN ILLNESS WAS FIRST NOTICED: | |
| 7 | DATE OF ADMISSION / INVESTIGATION: | |
| 8 | DATE OF DISCHARGE: | |
| 9 | STATE WHERE AND WHEN THE MEDICAL DEPARTMENT PERSONNEL OF THE COMPANY CAN VISIT THE PATIENT, IF NECESSARY: | |
| 10 | HAS THE INSURED CLAIMED ELSEWHERE? IF YES, GIVE DETAILS WITH DATE OF CLAIM: | |
| **11** | **TOTAL AMOUNT CLAIMED IN Rs.** | |

**DATE OF SUBMISSION OF CLAIM :** _____

**DECLARATION:** We, the undersigned, do hereby declare that, to the best of our knowledge and belief, the foregoing particulars are true and correct. We authorize IGI to obtain information from Doctor/Hospital concerning the treatment for which claim is made.

_____ _____

**Employee's Signature** **Employer's Signature & Stamp**

## **MEDICAL CERTIFICATE** (TO BE FILLED BY DOCTOR)

| | | |
|---|---|---|
| 1 | PATIENT'S NAME | |
| 2 | AGE & SEX | |
| 3 | DATE OF ADMISSION | |
| 4 | DATE OF DISCHARGE | |
| 5 | DETAILS OF THE ILLNESS / REASON FOR NECESSITY OF HOSPITALIZATION: | |
| 6 | ANY COMORBIDS / OTHER DISEASE(S), EXCLUDING THE CURRENT ILLNESS, OR ANY OTHER CIRCUMSTANCES WHICH MAY AFFECT/ DELAY RECOVERY? IF YES, KINDLY SHARE DETAILS: | |
| 7 | NAME, ADDRESS & CONTACT DETAILS OF THE HOSPITAL IN WHICH HE/SHE HAS BEEN TREATED: | |
| 8 | NAME & CONTACT DETAILS OF TREATING / ATTENDING CONSULTANT: | |

**DATE: _____** **_____**

**SIGNATURE & STAMP OF ATTENDING DOCTOR with PMDC Registration No_____**

| **Mandatory Documentation Checklist (in support of your in-patient claim) please mark:** | |
|---|---|
| Original Hospital Bill / Payment Receipts | |
| Hospital Discharge Summary with complete details | |
| Inpatient Claim Form with complete details | |
| Birth Certificate (for maternity case only) | |
| **Others, please specify:** | |