CLAIM FORM

Form No. 9

(Issuance of this Claim Form is not tantamount to acceptance of Liability by the Insurer)

Name of Insurance Company :

Policy No. Serial No. of the Schd. / Certificate No. :
(Mandatory field)
TTK ID No.

Name & Address of the Insured :
(in whose name policy is issued)

Detail of Insured person :
(in respect of whom claim is made)

a) Name & relationship of the Insured
b) Present completed Age
c) Contact Address

d) Phone No.
f) Mobile No. (Mandatory Field)
g) E-mail Address

AILMENT / DISEASE / INJURY

Date of injury sustained or disease / illness first detected :-
Name of the Hospital :

a) Have you been insured under any Mediclaim Scheme earlier (held with us or any other Insurance Co.) if yes Photo copies of Previous years' policies **MUST** be enclosed :

b) Date of Commencement of very first insurence for this Insured person with continuous Insurance coverage :

Have you preferred any claim for the same under the Mediclaim scheme earlier, if so give details viz. :
(a) Previous Claim File Ref. No. / Office :
(b) Diagnosis :
(c) Whether settled / Repudiated :
(d) Amount (if settled) : Rs.

Date of Admission Date of Dischaged :

Total Amount Claimed : Rs.

If the claim is of Domicilary Hospitalization please Indicate
a) Date of Commencement of the treatment
b) Date of Completion of Treatment.
c) Name & Address of attending Medical Practitioner with Telephone No. & Registration No.

Signature of the Claimant

Please send this form along with enclosures to :
TTK Healthcare Services Private Limited
AFL House, 3rd Floor, Lok Bharati Complex,
Marol, Maroshi Road,
Andheri (East), Mumbai - 400 059.
Tel. : 2924 0700, Fax : 1600 221919

I have incurred the following expenses for the treatment of the disease / illness / accident and herewith as per schedule mentioned below :-

Schedule of Expenses Incurred by the Claimant

				FOR TTK USE ONLY	
DATE	BILL No.	DESCRIPTION	AMOUNT CLAIMED		

In support of the claim, I enclosed the following documents

	Yes	/No		Yes	/No
Claim from Duly Signed	☐	☐	Pre Hospitalization Bills & No(s)..... of Bills	☐	☐
TTK Pre-authorisation from	☐	☐	Post Hospitalization Bill & No(s)..... of Bills	☐	☐
Claim Notification	☐	☐	Hospital Payment Receipt	☐	☐
Discharge Summary	☐	☐	Investigation Report with Dr's request	☐	☐
Hospitalization Bills	☐	☐	1. MRI Yes/No 2. CT Scan Yes/No	☐	☐
Doctors Surgery Certificate if any	☐	☐	3. ECG Yes/No 4. X-ray Yes/No 5. US Scan Yes/No	☐	☐
Surgery / Consultation Bills if any	☐	☐	Lab Report with Dr's request No(s)..... of Rep.....	☐	☐
Operation Theatre / Pharmacy Bills	☐	☐	Others if any	☐	☐
Medicines Bills with Dr's prescription	☐	☐		☐	☐

Previous Policy Numbers if any : (Enclose copies)

I hereby declare that the above information is true & correct to the best of my knowledge and belief. If I have made any false, or untrue statement, suppression or concealment, my right to claim reimbursement of the expenses shall be forfeited.

I also consent and authorise TTK / Insurance company to seek medical information forom any Hospital / Medical Practitioner who has any time attended on the insured person.

I hereby declare that I have included all bills / receipts for purpose of this claim and that I will not be making any supplementary claim in respect thereof, expect the post the hospitalization claim if any.

Date

Signature of the Claimant