Medical Claims Loss Adjustment Report

Claimant Details

Name: _____

Policy Number: _____

Date of Birth: _____ / _____ / _____

Contact Number: _____

Claim Details

Claim Number: _____

Date of Claim: _____ / _____ / _____

Reported By: _____

Date Received: _____ / _____ / _____

Diagnosis & Treatment

Diagnosis: _____

Treatment Provided: _____

Hospital/Clinic: _____

Attending Physician: _____ **Reg. Number:** _____

Loss Adjustment Summary

Description	Billed Amount	Non-admissible	Admissible	Remarks
Room Rent	_____	_____	_____	_____
Medicines	_____	_____	_____	_____
Investigation Charges	_____	_____	_____	_____
Professional Fees	_____	_____	_____	_____
Others	_____	_____	_____	_____
Total	**_____**	**_____**	**_____**	

Adjustment Remarks

_____

_____

Loss Adjuster Name: _____

Signature: _____

Date of Adjustment: _____ / _____ / _____

Important Notes:

- This form should be duly completed and signed by the authorized loss adjuster.
- All supporting hospital/medical documents must be attached with this report.
- Ensure correctness of the calculations and classification of admissible versus non-admissible items.

- Discrepancies or suspected fraud should be clearly mentioned in the remarks section.
- Incomplete forms may delay claim processing.