Health Insurance Reimbursement Form

Please fill out all the required fields and attach the necessary documents.

1. Policyholder Information

Full Name

Policy Number

Date of Birth

Contact Number

Email Address

Address

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2. Patient Information (if different from Policyholder)

Patient Name

Relationship

Select

Date of Birth

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3. Hospitalization / Treatment Details

Hospital Name

Admission Date

Discharge Date

Diagnosis / Reason for Admission	
Total Amount Claimed	

4. Bank Details (for reimbursement)

Account Holder's Name	
Bank Name	
Account Number	
IFSC / SWIFT Code	
Branch	

5. Declaration

I hereby declare that the information provided above is true and complete to the best of my knowledge. I authorize the insurance company to obtain any further information, if required.

Policyholder's Signature

Date

Important Notes:

- Ensure all required fields are completed and supporting documents are attached (original bills, discharge summary, prescriptions, etc.).
- Claims should be submitted within the stipulated period as specified in your policy.
- Incomplete forms or missing documents may result in delays or rejection of your claim.
- The insurance company reserves the right to request further information if necessary.
- Keep copies of all documents submitted for your reference.