

# Surgery Expense Claim Form

## 1. Patient Details

Full Name

Date of Birth

Policy Number

Contact Number

Address

## 2. Surgery Details

Hospital/Clinic Name

Date of Admission

Date of Surgery

Date of Discharge

Name of Surgeon

Description of Surgery

## 3. Expense Details

Hospital Charges

Surgeon Fees

Anaesthesia Charges

Medication Charges

Other (Specify)

Amount

#### 4. Bank Details for Reimbursement

Account Holder Name

Account Number

Bank Name

IFSC Code

#### 5. Declaration

I hereby declare that all information furnished above is true and correct to the best of my knowledge, and that the expenses claimed have not been previously reimbursed.

Signature

Date

#### Important Notes:

- Attach all supporting documents such as hospitalization bills, prescriptions, discharge summary, and relevant medical reports.
- Incomplete or incorrect information may delay claim processing.
- Claim submission should be within the prescribed timeline as per your policy terms.
- Keep copies of all submitted documents for future reference.
- Original bills may be required at the time of verification.

