



The Oriental Insurance Company Limited  
(Incorporated in India, subsidiary of General Insurance Corporation of India)  
Regd. Office: Oriental House, P.B. No.7037, A-25/27, Asaf Ali Road, New Delhi- 110 002

Issuing Office

HOSPITALISATION & DOMICILIARY HOSPITALISATION BENEFIT CLAIM FORM

Claim No. \_\_\_\_\_

Issuance of this form does not amount to admission of any liability under the claim on the part of the Insurance.

Please give the following information correctly and completely to enable the Company to process your claim promptly.

For Office use only

1. Name of the Insured																				
(In whole name policy is issued)	SURNAME										INITIAL									
2. Details of the Insured Person (In respect of whom claim is made)																				
(a) Name & relationship with the Insured																				
(b) Present completed age																				
(c) Occupation																				
(d) Residential address																				
3. Policy No.																				
4. Nature of Disease/illness contracted or injury suffered																				
5. Date of injury sustained or Disease/illness first detected																				
	Date			Month			Year													

a) Name & Address of the attending Medical Practitioner : \_\_\_\_\_  
Pin Code \_\_\_\_\_  
State/U. Territory \_\_\_\_\_

(b) Qualification & Telephone No. \_\_\_\_\_

(c) Registration No.

6. (a) Name and Address of the Hospital/Nursing Home/Clinic : \_\_\_\_\_  
Pin Code \_\_\_\_\_  
State/U.Territory \_\_\_\_\_

(b) Date of Admission : Date Month Year

(c) Date of Discharge : Date Month Year

7. If the claim is for Domicilliary Hospitaliation

Please indicate

(a) Date of Commencement of treatment : Date Month Year

(b) Date of completion of treatment : Date Month Year

(c) Name & Address of attending Medical Practitioner :

(d) Telephone No.

(e) Registration No.

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I have incurred on the treatment of Disease/illness/Accident referred to above, the expenses as per the details given by me in the Schedule of Expenses given overleaf.

In support of the above claim, I enclose the following documents (Please indicate by ► )

1. Bill, Receipt and Discharge certificate/card from the Hospital.
2. Cash Memos from the Hospital/Chemist(s), supported by the proper prescription.
3. Receipt and Pathological test reports from a pathologist supported by the note from the attending medical Practitioner/surgeon demanding such pathological test.
4. Surgeon's certificate stating nature of operation performed and Surgeon's bill and receipts.
5. Attending Doctor's/Consultant's /Specialist's/ Aneasthetist's bill and receipt and certificate regarding diagnosis.
6. In case of Domiciliary Hospitalisation, receipt from a qualified nurse who attended the patient at his/her residence duly supported by a certificate from attending Medical practitioner.
7. Certificate from the attending Medical practitioner giving reasons for allowing treatment home.
8. Certificate from the attending Medical Practitioner/Surgeon that the Patient is fully cured.

I hereby warrant the truth of the foregoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppression or concealment, my right to claim reimbursement of the said expenses shall be absolutely forfeited, I further declare that, in respect of the above treatment, no benefits are admissible under any other Medical Scheme or Insurance.

Dated at \_\_\_\_\_ tjos \_\_\_\_\_ of \_\_\_\_\_ 200

Signature of the Claimant

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FOR OFFICE USE ONLY:

DATE OF CLAIM

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Policy No. \_\_\_\_\_ Scheme A/B \_\_\_\_\_ Category of Benefits \_\_\_\_\_ Claim No.

SCHEDULE OF EXPENSES INCURRED BY THE CLAIMANT		FOR OFFICE USE ONLY	
Details of Expenses claimed under Hospitalisation/Domiciliary Hospitalisation (To be supported by Bills/Receipts Cash memos etc.)	Amount Claimed (1)	Amount not Payable (2)	Net Payable (1)-(2)-(3)
<b>1. (A) HOSPITALISATION BENEFIT:</b> (i) Room Board, Nursing expenses (including Boarding to be provided by the Hospital) for _____ days _____ <input type="text"/> <input type="text"/>		<input type="text"/> <input type="text"/> <input type="text"/>	
(ii) I.C. Unit For _____ days _____ <input type="text"/> <input type="text"/>		<input type="text"/> <input type="text"/> <input type="text"/>	
<b>(B) Hospitalisation Benefits other than Room, Board &amp; Nursing Expenses &amp; ICCU(including Pre &amp; Post Hospitalisation)</b> <input type="text"/> <input type="text"/>		<input type="text"/> <input type="text"/> <input type="text"/>	
1. Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists fees. <input type="text"/> <input type="text"/>		<input type="text"/> <input type="text"/> <input type="text"/>	
2. Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines & Drugs, Diagnostic materials & X-ray dialysis, Chemotherapy, cost of Pacemaker, artificial limbs & cost of Organs and similar other expenses. <input type="text"/> <input type="text"/>		<input type="text"/> <input type="text"/> <input type="text"/>	
		<input type="text"/> <input type="text"/> <input type="text"/>	
		<input type="text"/> <input type="text"/> <input type="text"/>	

SCHEDULE OF EXPENSES INCURRED BY THE CLAIMANT		FOR OFFICE USE ONLY
II. Domiciliary Hospitalisation Benefit (Non-surgical treatment only)	(1)	(2) (3)
1. Medical Practitioners, Consultants & Specialists fee for visits etc. <input type="text"/>		<input type="text"/>
Blood, Oxygen, Diagnostic material, X-ray, Employment of qualified Nurses, Medicines and Drugs and Similar expenses <input type="text"/>		<input type="text"/>
		<input type="text"/>
		<input type="text"/>
Total		

Signature of Claimant:

Date:

Place:

FOR OFFICE USE ONLY

Prepared by: Total amount payable under the Claim Rs. \_\_\_\_\_  
 Checked by: Less: Advance/on account payment if any Rs. \_\_\_\_\_  
 Approved by: Net amount Payable Rs. \_\_\_\_\_

In case entire claim is not admissible, Reason thereof

Passed for payment of Rs. \_\_\_\_\_

Competent Authority