**Please Intimate the Claim on following form:**

|  |  |
| --- | --- |
| **Insured/Corporate Name** |  |
| **Policy No.** |  |
| **Employee Code** |  |
| **Employee Name** |  |
| **Pt insurance card no** |  |
| **Patient Name** |  |
| **Relation** |  |
| **Date of Birth** |  |
| **Gender** |  |
| **Location** |  |
| **Name of Hospital** |  |
| **Address of Hospital** |  |
| **Date of Admission** |  |
| **Time of Admission** |  |
| **Ailment/ Diagnosis** |  |