WBPDCL CASHLESS GROUP TAILOR MADE MEDICLAIM SCHEME/ WBPDCL TAILOR MADE GROUP MEDICLAIM LOSS RECOVERY SCHEME

The Oriental Insurance Company Limited

FAMILY HEALTH PLAN LIMITED
16/2, Lakeview Road, Kolkata – 700 029
Toll Free No.: 1800 425 40 33, Ph No.: 9231001005 / 9230101116
FAX No.: 033-24659377, Website: www.fhpl.net

MEDICAL BENEFITS CLAIM FORM (REGULAR EMPLOYEES/ RETIRED PERSONS)

To be filled by the Insured

A. **Emp No./ UHID No.: .....**

B. **Name of the Proposer : .....**

C. **Name of the Patient : ..... Relationship.....**

D. **Full Address: .....**

.....

E. **Telephone No./ Mobile No.: .....**

F. **Date of Admission: ..... Date of Discharge: .....**

G. **Name of Disease: .....**

H. **Name of the Hospital/ N.Home : .....**

I. **Bank Details :**

- **Name of the Bank/ Branch : .....**
- **A/c No. : .....** **IFSC Code : .....**

J. **Sum Assured Amount : .....**

CHECKLIST FOR THE MRC CLAIM					
REQUIRED DOCUMENTS					
PLEASE TICK	*SL. NO*	*IN CASE OF HOSPITALISATION CLAIM*	PLEASE TICK	*SL. NO*	*IN CASE OF PRE & POST HOSPITALISATION CLAIM*
	1	COMPLETELY FILLED CLAIM FORM		1	COMPLETELY FILLED CLAIM FORM
	2	PHOTO COPY OF THE TPA CARD AND PHOTO ID		2	PHOTO COPY OF THE TPA CARD AND PHOTO ID
	3	ADVICE FOR ADMISSION **(IN CASE OF PLANNED)**/EMERGENCY MEDICAL OFFICER'S NOTE**(IN CASE OF EMERGENCY)**		3	ATTESTED PHOTO COPY OF THE DISCHARGE SUMMARY
	4	ORIGINAL DISCHARGE SUMMARY/**ATTESTED COPY OF CASE SUMMARY AND DEATH CERTIFICATE OF THE HOSPITAL AND MUNICIPALITY (IN CASE OF DEATH)**		4	ALL THE BILLS SHOULD BE SUPPORTED BY THE RELEVANT ORIGINAL/ ATTESTED PRESCRIPTION & INVESTGATION REPORTS OF PRE/POST HOSPITALISATION PERIOD.
	5	ORIGINAL CONSOLIDATED BILL WITH BILL No. DETAIL BREAKUP BILL OF ALL ITEMS/PACKAGE		5	IF THE MEDICINES ARE NOT PRESCRIBED IN THE DISCHARGE SUMMARY, PRESCRIPTION IS MUST TO SUBSTANTIATE ANY MEDICINE BILL
	6	**STICKER AND INVOICES OF IMPLANTS/IOL AND IOL CARD**			
	7	CASH/MONEY RECEIPT for BILLS PAID (Advance and Final) WITH RECEIPT No.			
	8	If DOCTORS / SURGEONS CHARGE IS NOT INCLUDED IN THE FINAL BILL THEN SEPARATE RECEIPT IN ORIGINAL (mentioning the Regn. No.) FROM THEM IS A MUST.			
	9	ALL THE BILLS SHOULD BE SUPPORTED BY THE RELEVANT ORIGINAL PRESCRIPTION/ INDENTS OF MEDICINES & INVESTGATION REPORTS AT THE TIME OF HOSPITALISATION			
	10	**IN CASE OF ROAD TRAFFIC ACCIDENT/BURNS/POISIONING/OTHER ACCIDENTS-MLC/FIR COPY AND TREATING DOCTORS CERTIFICATE STATING CAUSE OF INJURY**			
	11	**IN CASE OF MATERNITY CLAIM PRE NATAL USG REPORT AND OBSTRETIC HISTORY IS MANDATORY**			

SCHEDULE OF EXPENSES INCURRED BY THE CLAIMANT:

Name of the Proposer: ..... Emp No.: / UHID No.: .....

Details of Expenses Claimed	Claimed Amount	Sanctioned Amount (By WBPDCL)	Settled Amount (For Office Use)	Not Allowed Amount (For Office Use)
1. A) **Room Rent @** X Days				
B) Nursing Charges X Days				
2. Consultation Charges				
A) Surgeon Fees				
B) Anaesthetist Fees				
C) Cons. Doctor Fees				
D) Asst. Doctor Fees				
3. Medicines				
A) Supplied by Hospital				
B) Medicines From Shop				
4. Investigations				
5. Operation Theatre Charges, Blood, Oxygen, OT Consumables				
6. Others (Ambulance etc.)				
TOTAL:				
7. Pre/ Post-Hospitalization Period				
a. Doctor's Fees				
b. Investigations Fees				
c. Medicine Cost				
8. Others				
TOTAL				

I hereby confirm the truth of the above 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 of insurance. I consent and authorize the insurers/TPA to seek medical information from any Hospital/Medical Practitioner who has at any time attended concerning the claim.

For Office use only:

Prepared By:

Amount Payable Rs.:

Approved by
Competent Authority:

Passed for Payment Rs.:

In support of the above claim, I enclose the following:

1. Original Bill and all original receipts.
2. Original Discharge Summary/ Card from the Hospital/ Hursing Home
3. All original prescriptions
4. Original Pathological Test reports and receipts supported by Doctor's prescription.

   (No of Bills ..... Amount .....)
5. Original Chemist's Bills supported by prescription

   (No of Bills ..... Amount .....)
6. Confirmation letter from Insurer: Inception date of policy with continuous continuity & if any Exclusion imposed
7. Any other relevant paper:

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SIGNATURE OF THE INSURED:

Date:

Place: