



**HOSPITALIZATION CLAIM FORM**

(To be filled by the insured)

Claim Number (If available) otherwise for HDFC ERGO use only \_\_\_\_\_

**Policy Details**

Policy Number \_\_\_\_\_ Policy Start Date \_\_\_\_\_ Policy End date \_\_\_\_\_  
 Group Corporate name (In case of corporate/ Group policy) \_\_\_\_\_

HDFC ERGO ID Number (as mentioned on Health Card) \_\_\_\_\_

**Personal Details of the Employee / Proposer**

Employee / Insured name \_\_\_\_\_  
 Employee Number (In case of corporate/ Group policy) \_\_\_\_\_ Date of Joining   
 Email ID \_\_\_\_\_ Contact No. \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Residence address \_\_\_\_\_  
 Diagnosis \_\_\_\_\_

**Patient Details**

Name of the Patient \_\_\_\_\_  
 Relationship to the Employee / Proposer [Self/ Spouse / Child / Parent / others (please specify)] \_\_\_\_\_  
 Date of Birth  Age  Yrs Gender  Male  Female

**Claim Details**

Ailment / Diagnosis \_\_\_\_\_  
 Claimed from Other Insurer  Yes  No If Yes please provide details \_\_\_\_\_  
 Type of Claim  Hospitalization  Pre- Hospitalization  Post Hospitalization

**Expenses Incurred Details/Treatment Cost Details**

Hospitalization Expenses	Rs.	Pre Hospitalization Expenses	Rs.
Post Hospitalization Expenses	Rs.	Other Doctors Fees	Rs.
Other Medicine/ Pharmacy Charges	Rs.	Other Investigation Charges	Rs.
Any other Expenses	Rs.	Total Claimed Amount	Rs.

**Document Check List (Please  wherever applicable)**

In Support of the above claim, I enclose following documents	Original	Photocopy
Final Hospital bill with receipt		
Discharge Summary/ Card/ Certificate		
Cash Memos from, the Hospital/ Chemist, supported by Proper Prescription		
Surgeons certificate stating nature of Operation performed and Surgeons bills and receipts		
Attending Doctors/ Consultants/ Specialist's/ Anesthetist bill and receipt and certificate regarding same		
Certificate from the attending Medical Doctor/ Surgeon that the person is fully cured		

In case of any other document (please specify) \_\_\_\_\_

NOTE: Please submit medical certificate form (attached herewith) duly signed & stamp by the attending doctor/ hospital along with this claim form.

I hereby warrant the truth of the foregoing particulars in every aspect 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 (If not specified above). I consent and authorize the insurers to seek medical information from any hospital/ medical practitioner/ chemist who has at any time attended concerning the claim

- Acceptance of this form does not imply acceptance of the Liability
- Every field should be answered in detail

\_\_\_\_\_  
 Signature of Claimant