HDFC ERGO General Insurance Company Limited

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 D D M M Y Y Y Y

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 D D M M Y Y Y Y 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/ Anesthesist 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

D D M M Y Y Y Y

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

Signature of Claimant

CF/Ver - 1FEB2021

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