



Dedicated Healthcare Services TPA (India) Pvt. Ltd.

Corporate Office :
Cambata Building (Eros Theatre Building)
East Wing, 3rd Floor,
42, Maharshi Karve Road,
Churchgate, Mumbai – 400 020

IRDA License No 28
Email id: contactus@dhs-india.com
Tel No. 022-66275900 / 022-66275901
Fax No. 022-22874235

CLAIM FORM

Name of the Insured DHS Card No.

Corporate Name

Employee Number

Policy Number

Insurance Co. Name

Name of Patient Sex

Date of Birth Age

Address

Contact Number

Email-id

Bank Details of Insured in case of electronic transfer of funds in insured's account

Name of the Bank

Branch Name

Account Number IFSC Code

Hospitalisation Details:

Name of Hospital

Hospital In-patient No.

Nature of Disease / Illness

Date of Admission Date of Discharge

Please select the Nature of the Claim: Pre-Post Hospitalisation Hospitalisation OPD

Total Amount Claimed ₹

Name of the Treating Doctor

Address & Telephone No.

Declaration: I hereby declare that all information provided is true to the best of my knowledge. I agree that if I have made or shall make any false, untrue statement or if there is suppression or concealment of any material information reimbursement of said expenses shall be forfeited.

I also consent and authorize the THIRD PARTY ADMINISTRATOR to seek medical information from any hospital / medical practitioner who has at any time attended on me.

Date and Time: 16-08-2011 2:22:47 PM

Place

Signature

DOCUMENTS CHECK LIST	Click	No of Pages
Duly Signed Original Claim Form	<input type="checkbox"/>	
Photocopy of Policy	<input type="checkbox"/>	
Photocopy of DHS ID card	<input type="checkbox"/>	
Original Discharge Card / Day care card	<input type="checkbox"/>	
Photocopy of Death Summary	<input type="checkbox"/>	
Original Final Hospital Bill	<input type="checkbox"/>	
Original Payment Receipt	<input type="checkbox"/>	
Original Investigation reports		
a) Blood Report	<input type="checkbox"/>	
b) Urine Report	<input type="checkbox"/>	
c) X-Ray report	<input type="checkbox"/>	
d) X-Ray Film	<input type="checkbox"/>	
e) ECG	<input type="checkbox"/>	
f) USG	<input type="checkbox"/>	
g) Histopathology	<input type="checkbox"/>	
h) MRI with Film	<input type="checkbox"/>	
I) CT Scan with Film	<input type="checkbox"/>	
Others		
j) <input type="text"/>	<input type="checkbox"/>	
k) <input type="text"/>	<input type="checkbox"/>	
l) <input type="text"/>	<input type="checkbox"/>	
Original Medicine Bills with prescription	<input type="checkbox"/>	
Original Consultation Papers	<input type="checkbox"/>	
Original invoice of the implants, if any	<input type="checkbox"/>	
Original Sticker of the implants, if any	<input type="checkbox"/>	
In case of OPD claim, Original consultation papers	<input type="checkbox"/>	
Any other document, please specify		
a) <input type="text"/>	<input type="checkbox"/>	
b) <input type="text"/>	<input type="checkbox"/>	
c) <input type="text"/>	<input type="checkbox"/>	
d) <input type="text"/>	<input type="checkbox"/>	
e) <input type="text"/>	<input type="checkbox"/>	
Total No of Pages		0
Server Date and Time: 16-08-2011 2:22:47 PM		

***Important Note:** Before printing, please check all entered values are true and correct or not.
 For better print results, please set page margins to 0.2 inches to all four sides from "File Menu >> Page Setup..." command in your browser.

[Print Claim Form...](#)