



General

IN-PATIENT CLAIM FORM

(TO BE FILLED BY CLAIMANT EMPLOYEE)

1	NAME OF THE COMPANY / CLIENT:	
2	NAME OF EMPLOYEE:	
3	IGI HEALTH CARD #:	
4	PATIENT'S NAME:	
5	AGE/ RELATION TO EMPLOYEE:	
6	DATE WHEN ILLNESS WAS FIRST NOTICED:	
7	DATE OF ADMISSION / INVESTIGATION:	
8	DATE OF DISCHARGE:	
9	STATE WHERE AND WHEN THE MEDICAL DEPARTMENT PERSONNEL OF THE COMPANY CAN VISIT THE PATIENT, IF NECESSARY:	
10	HAS THE INSURED CLAIMED ELSEWHERE? IF YES, GIVE DETAILS WITH DATE OF CLAIM:	
11	TOTAL AMOUNT CLAIMED IN Rs.	

DATE OF SUBMISSION OF CLAIM : _____

DECLARATION: We, the undersigned, do hereby declare that, to the best of our knowledge and belief, the foregoing particulars are true and correct. We authorize IGI to obtain information from Doctor/Hospital concerning the treatment for which claim is made.

Employee's Signature

Employer's Signature & Stamp

MEDICAL CERTIFICATE (TO BE FILLED BY DOCTOR)

1	PATIENT'S NAME	
2	AGE & SEX	
3	DATE OF ADMISSION	
4	DATE OF DISCHARGE	
5	DETAILS OF THE ILLNESS / REASON FOR NECESSITY OF HOSPITALIZATION:	
6	ANY COMORBIDS / OTHER DISEASE(S), EXCLUDING THE CURRENT ILLNESS, OR ANY OTHER CIRCUMSTANCES WHICH MAY AFFECT/ DELAY RECOVERY? IF YES, KINDLY SHARE DETAILS:	
7	NAME, ADDRESS & CONTACT DETAILS OF THE HOSPITAL IN WHICH HE/SHE HAS BEEN TREATED:	
8	NAME & CONTACT DETAILS OF TREATING / ATTENDING CONSULTANT:	

DATE: _____

SIGNATURE & STAMP OF ATTENDING DOCTOR with
PMDC Registration No _____

Mandatory Documentation Checklist (in support of your in-patient claim) please mark:	
Original Hospital Bill / Payment Receipts	
Hospital Discharge Summary with complete details	
Inpatient Claim Form with complete details	
Birth Certificate (for maternity case only)	
Others, please specify:	