# IN-PATIENT CLAIM FORM

(TO BE FILLED BY EMPLOYEE)

| | | |
|---|---|---|
| 1 | NAME OF THE COMPANY / CLIENT | |
| 2 | NAME OF EMPLOYEE | |
| 3 | IGI HEALTH CARD # | |
| 4 | PATIENT'S NAME | |
| 5 | AGE | |
| 6 | DATE OF ILLNESS/ACCIDENT / INVESTIGATION/TREATMENT | |
| 7 | DATE OF ADMISSION | |
| 8 | DATE OF DISCHARGE | |
| 9 | STATE WHERE AND WHEN A MEDICAL OR OTHER OFFICER OF THE COMPANY CAN VISIT THE PATIENT, IF NECESSARY | |
| 10 | HAS THE PATIENT CLAIMED ELSEWHERE?' IF YES, GIVE DETAILS | |
| | **TOTAL AMOUNT CLAIMED IN Rs**. (Please attach all the related supporting invoices) | |

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 | |
| 3 | DATE OF ADMISSION | |
| 4 | DATE OF DISCHARGE | |
| 5 | FULL PARTICULARS OF THE ILLNESS /REASON OF HOSPITALIZATION | |
| 6 | IS HE/ SHE SUFFERING FROM ANY DISEASE, IRRESPECTIVE OF THE PRESENT ILLNESS, OR ARE THERE ANY OTHER CIRCUMSTANCES WHICH MAY TEND TO DELAY RECOVERY? IF | |
| 7 | NAME AND ADDRESS OF THE HOSPITAL IN WHICH HE/SHE HAS BEEN TREATED | |

DATE: _____ _____

SIGNATURE & STAMP OF ATTENDING DOCTOR with
PMDC Registration No_____

**CHECK LIST (in support of your in-patient claim) :**

**FOR NORMAL HOSPITALISATION**

- ‰ Proper Original hospital bill with breakup of all charges.
- ‰ Hospital Discharge Summary indicating diagnosis.
- ‰ Original cash memos for all medicines purchased.
- ‰ Doctor's prescription for all medicines purchased.
- ‰ Lab and Ultrasound reports and receipts (if applicable).
- ‰ X-ray reports and original film indicating lesion (if applicable).

**~~FOR MATERNITY CASES~~**

- ‰ Proper Original hospital bill with breakup of all charges.
- ‰ Hospital Discharge Summary indicating mode of delivery.
- ‰ Original cash memos for all medicines purchased.
- ‰ Doctor's prescription for all medicines purchased.
- ‰ A Copy of Union Council Birth Certificate of newborn baby.
- ‰ Lab and Ultrasound reports and receipts (if applicable).
- ‰ Blood Group reports of mother and baby (if applicable).