Hospitalization Claim Statement

Policyholder/Insured Details

Name: _____

Policy Number: _____

Contact Number: _____

Email Address: _____

Address: _____

Patient Information

Patient Name: _____

Relationship to Policyholder: _____

Date of Birth: _____

Gender: _____

Hospitalization Details

Hospital Name: _____

Hospital Address: _____

Date of Admission: _____

Date of Discharge: _____

Reason for Hospitalization: _____

Claimed Expenses

Sl. No.	Expense Head	Amount Claimed	Remarks
1			
2			
3			

Total Amount Claimed: _____

Bank Details (for reimbursement)

Account Holder Name: _____

Bank Name: _____

Branch: _____

Account Number: _____

IFSC Code: _____

Declaration

I hereby declare that the information provided above is true and complete to the best of my knowledge. I authorize the insurance company to seek necessary medical information from the hospital, if required.

Date:

_____

Signature of Policyholder/Claimant