Surgery Expense Claim Submission Format

Policyholder Name

Policy Number

Patient Name

Relationship to Policyholder

Date of Surgery

Hospital Name

Surgery Type / Procedure Description

Treating Doctor / Surgeon

Expense Details

Expense Description	Date	Amount	Receipt/Invoice No.

Total Amount Claimed

Bank Account Number (for reimbursement)

IFSC Code

Bank Name

Account Holder Name

Declaration

I hereby declare that all the information provided above is true to the best of my knowledge and all enclosed documents are genuine.

Date

Signature (Name)