Hospitalization Claim Form

1. Patient Information

Full Name

Date of Birth

Gender

Address

Contact Number

Insured ID / Policy No.

2. Hospitalization Details

Hospital Name

Hospitalization Dates From - To

Diagnosis / Reason for Admission

Treatment / Surgery Details

3. Claimant Information

Claimant Name

Relationship to Patient

Bank Name

Account Number

IFSC Code

4. Declaration

I hereby declare that the information provided above is true and correct to the best of my knowledge.

Claimant Signature

Date