A Max India Joint Venture

Max Bupa
Health Insurance

Employee First Claim Form

(For reimbursement of expenses incurred in non-network hospitals)

Claim No. ______ Date DD MM YYYY

(For official use only)

Please provide the following information fully to enable us to process your claim appropriately.

1. **Policy number (In full)** ______
2. **Commencement Date** DD MM YYYY **Expiry Date** DD MM YYYY
3. **Name of the Employee** ______
4. **Employee Code** ______
5. **Designation** ______
6. **Details of the Insured Person**
   a. Name of patient ______
   b. Relationship with Employee ☐ Self ☐ Spouse ☐ Son ☐ Daughter ☐ Father ☐ Mother ☐ Father-in-law ☐ Mother-in-law
   c. Date of birth DD MM YYYY
   d. Current address ______
   City ______ District ______
   State ______ Pin code ______
   Phone No.STD code ______ Landline No. ______ Mobile No. ______
7. **Details of the Employer**
   a. Group Name/Name of Employer ______
   d. Current address ______
   City ______ District ______
   State ______ Pin code ______
8. **Nature of illness contracted or injury suffered** ______
9. **Date on which injury was sustained/disease or illness first detected** DD MM YYYY

10. **Details of the attending Doctor**

a. Name

b. Address of the doctor

City District

State Pin code

c. Qualification d. Phone No.

e. Registration number

11. **Details of the Hospital**

a. Name

b. Address of hospital

City District

State Pin code

Contact No c. Registration No.

12. **Inpatient bill no.**

13. **Date of admission** DD MM YYYY Date of discharge DD MM YYYY

14. **Type of Hospitalisation** ☐ Planned ☐ Emergency

15. **Details of expenses**

Expense Head	**Amount (Rs.)**		**Amount (Rs.)**
In Patient Treatment		Out-patient expenses	
Room Rent		Domiciliary Treatment	
General Hospitalization		Emergency Ambulance	
Pre-Hospitalization		Day Care	
Post Hospitalization		Medicine bill*	
Organ Donation/transplantation		Diagnostic bill*	
New Born Baby		Out patient expenses	
Maternity		Other expenses not included above	
Sub Total (A)		Sub Total (B)	
Total Claimed Amount (A +B)			

*Bought from outside.

16. **Number of document(s) submitted including this claim form**

17. **Please enclose the following documents**

(i) Original bills, receipts and discharge certificate/card from the Hospital/Doctor.

(ii) Original bills by chemist supported by proper prescription.

(iii) Original Investigation test reports and payments receipts.

(iv) Original Medical Fractioned /Doctor's referral letter advising hospitalization.

(v) Details of any other policy that may respond to claim.

(vi) Duly filled claims form(s).

18. **Are you presently covered under any other type of insurance (individual or group health insurance)?** ☐ **Yes** ☐ **No**

If yes, please give the details as follows:

Name of Insurance Company	Policy Number	Start Date	End Date	Sum Insured

The submission/receipt of this form does not amount to admission of any liability under the claim on the part of the insurers.

I/we hereby authorise Max Bupa Health Insurance Company Limited to transfer the claim amount payable under this claim to my bank account.

Account holder's name

Bank

Account No.

Branch

City

IFSC code

MICR code

All payments will be do made in accordance with the instructions of the policy holder.

19. Have you notified Max Bupa about this claim via telephone, email, fax or any other means of communication?

If yes please provide the date, time and **Claim notification number:** ______________________

Claim Intimation Number: ______________________ Date DD MM YYYY Time___________

20. If you have not notified Max Bupa about this claim within 2 days (48 hrs) of hospitalisation or before discharge of the patient, whichever is earlier, __________________ please provide the reason for the delay or lack of such intimation,

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Please refer to the Max Bupa policy guide for detailed information of the benefits that you are eligible under your policy.

MICR Code: The MICR code can be found on the bottom of a cheque/cheque book. It appears after the cheque number.
IFSC Code: The IFSC code is listed on your cheque/cheque book. In case it is not listed, please request your bank for the same.

Declaration:

I declare and warrant that the information given above and the information that will be given in respect of this claim is correct and complete.
I further agree and understand that if any false statement, or declaration is made or used in support of such claim, or if any fraudulent means or devices are used by the Insured Person to obtain any benefit under this Policy, then this Policy shall be void and all claims being processed shall be forfeited for all Insured Persons and all sums paid under this Policy shall be repaid to Us by all Insured Persons who shall be jointly liable for such repayment.
I further agree that all customers' personal information collected or held by Max Bupa will be used for processing the claims and analysis related to insurance/reinsurance business.

Date DD MM YYYY

Signature of the Claimant

Please send your claim documents to the claims department at the Max Bupa registered office.

Reimbursement Claims Checklist

	Checklist for claim submission	Mandatory documents	Available
1	Self attested copy of valid age proof (Passport / Driving License / PAN card* / class X certificate / Birth certificate)	Yes	
2	Self attested copy of identity proof (Passport / Driving License / PAN card / Voters identity card)	Yes	
3	Original Discharge summary	Yes	
4	Original first consultation paper (in case disease is first time diagnosed)	Yes	
5	Original Laboratory Investigation reports	Yes	
6	Original X-Ray/ MRI / Ultrasound films and other Radiological investigations.	Yes	
7	Indoor case paper/OT notes (if required)	Yes	
8	Medicolegal (MLC/FIR copy attested by the concerned hospital / police station (if applicable)	Yes	
9	Original self-narration of incident in absence of MLC / FIR		
10	Original Final Bill from Hospital with detailed break-up and paid receipt	Yes	
11	Original bills of medicines purchased, or of any other investigation done outside hospital with reports and requisite prescriptions	Yes	
12	Invoice of major accessories in case billed and utilized during treatment (if not included in the final hospital bill)		
13	Other documents : ____		
14	Cancelled Cheque Copy Proposer/Insured name should reflect on cheque copy or Bank Passbook reflecting name and account no. if cancelled cheque does not have name.	Yes	

Max Bupa Health Insurance Company Limited
Registered Office: Max House, 1 Dr. Jha Marg, Okhla, New Delhi -110 020.
Corporate Office: D-1, 2nd Floor, Salcon Ras Vilas, District Centre, Saket, New Delhi-110 017.
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