A Max India Joint Venture

Max Bupa
Health Insurance

Claim Form

(For reimbursement of expenses)

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. **Name of the Policyholder** (In whose name policy is issued) ______

3. **Details of the Insured Person**

   a. Name of patient ______

   b. Relationship with Policyholder ☐ Self ☐ Spouse ☐ Son ☐ Daughter c. Date of birth DD MM YYYY

   d. Current address ______

   City ______ District ______

   State ______ Pin code ______

   Phone No.STD code ______ Landline No. ______ Mobile No. ______

4. **Nature of illness contracted or injury suffered** ______

5. **Date on which injury was sustained/disease or illness first detected** DD MM YYYY

6. **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 ______

7. **Details of the Hospital**

a. Name

b. Address of hospital

City District

State Pin code

Contact No c. Registration No.

c. Inpatient bill no.

d. Date of admission D D M M Y Y Y Y e. Date of discharge D D M M Y Y Y Y

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

9. **Details of expenses**

Expense Head	Amount (Rs.)
In Patient Treatment	
Pre-Hospitalisation	
Post-Hospitalisation	
Domiciliary Treatment	
Emergency Ambulance	
Medicine bills from outside hospital	
Diagnostic tests from outside hospital	
Out-patient expenses	
Other expenses not included above	
Total Claimed Amount	

10. **Have these expenses been paid by you?** **Yes** ☐ **No** ☐

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

12. **Please enclose the following documents**

(i) Original bills, receipts and discharge certificate/card from the hospital/doctor.

(ii) Original bills from chemists supported by proper prescription.

(iii) Original investigation test reports and payment receipts.

(iv) Original medical practitioner/doctor's referral letter advising hospitalisation.

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

13. **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

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 D D M M Y Y Y Y

Signature of the Claimant

Complete your documents as per checklist provided on the last page and send them to claims department.

Claims Department
Max Bupa Health Insurance Company Limited
2nd Floor, Salcon Rasvilas
D-1, District Centre, Saket
New Delhi - 110017

Reimbursement Claims Checklist

	Checklist for claim submission	Mandatory documents	Available
1	Self attested copy of valid age proof of Insured (Passport / Driving License / PAN card* / class X certificate / Birth certificate)	Yes	
2	Self attested copy of identity proof of Proposer (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 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

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.
Insurance is the subject matter of solicitation.