TTK Healthcare TPA Private Limited

#2, H.B Complex,100 Feet BTM Ring Road,BTM First Stage, BTM Lay Out,Bangalore – 560 068, PH: 080-40125678

CLAIM FORM Form no : 9

(Issuance of this Claim Form is not tantamount to acceptance of Liability by the Insurer)

TTK ID No :

Name & Address of the Insured :
(in whose name policy is issued)

Details of Insured Person :
(in respect of whom claim is made)
a) Name & relationship of the Insured
b) Present completed Age
c) Occupation
d) Contact Address

e) Phone No
f) Mobile No
g) E-Mail Address
Name of the Insurance Company

Policy No. Serial No. Of the Schd/ Certificate No::

AILMENT / DISEASE / INJURY:

Date of Injury sustained or disease / illness first detected: -
Name of the Hospital :

a) Have you been insured under any mediclaim scheme earlier (held with us or any other insurance co.) If yes, xerox copies of previous years' policies **MUST** be enclosed.

b) Date of commencement of very first insurance for this person with with continous insurance coverage.

Have you preferred any claim for the same insured under the mediclaim scheme earlier, if so, give the following details:
a) Previous claim file ref.no/office :
b) Diagnosis :
c) Whether settled/repudiated :
d) Amunt (if settled) :Rs.

Date of Admission Date of Discharge :
Time of Admission Time of Discharge:

TOTAL AMOUNT CLAIMED : Rs.
If the claim is of Domiciliary Hospitalization please indicate
a) Date of Commencement of the treatment
b) Date of Completion of treatment
c) Name & Address of attending Medical Practioner with Telephone No. & Registration No.

Signature of the claimant

I have incurred the below expenses for the treatment of the disease / illness / accident and herewith as per schedule mentioned below: -

Schedule of Expenses incurred by the Claimant

				FOR TTK USE ONLY	
Date	**Bill No.**	**Description**	**Amount Claimed.**		

In support of the claim, I enclose the following documents

	Yes / No		Yes / No
Claim form Duly Signed	☐ ☐	Pre Hospitalization Bills & N0(s)…of Bills	☐ ☐
TTK Pre-authorization form	☐ ☐	Post Hospitalization Bills & N0(s)…of Bills	☐ ☐
Claim Notification	☐ ☐	Hospital Payment Receipt	☐ ☐
Discharge Summary	☐ ☐	Investigation Reports with Dr's request	☐ ☐
Hospitalization Bills	☐ ☐	1. MRI Yes / No 2. CT Scan Yes/ No	☐ ☐
Doctors Surgery Certificate if any	☐ ☐	3. ECG Yes/No 4. X-ray Yes/No 5.US Scan	☐ ☐
Surgery / Consultation Bills if any	☐ ☐	Lab Reports with Dr's request N0(s).. of Reports	☐ ☐
Operation Theatre Pharmacy bills	☐ ☐	Others if any	☐ ☐
Medicines bills with Dr's prescription	☐ ☐		☐ ☐

Previous Policy Numbers if any:

I hereby declare that the above information is true & correct to the best of my knowledge and belief. If I have made any false, fraud or untrue statement, suppression or concealment, my right to claim reimbursement of the expenses shall be forfeited.

I also consent and authorise TTK / Insurance company to seek medical information from any Hospital/ Medical Practitioner who has at any time attended on the insured person.

I hereby declare that I have included all bills/ receipts for the purpose of this claim and that I will not be making any supplementary claim in respect thereof, except the post Hospitalisation claim if any.

Date

Signature of the Claimant

MEDICAL CERTIFICATE TO BE FILLED IN BY THE DOCTOR TREATING THE PATIENT

1. Name of the patient and Age

2. Date of Admission
   Time of Admission

3. Date of Discharge
   Time of Discharge

3. Name of surgeon/Physician

4. Diagnosis

5. Date of First consulatation
(PRIOR TO HOSPITALISATION)

6.(A) With what complaints was the patient admitted for:

(B) Since When was the patient suffering from the said complaints

7. Past History of the patient (if any) with the duration of illness

8. Whether the present ailment is a complication of pre-existing disease?

If yes, please specify the disease (or) complication of any previous surgery done?
If yes, please specify the details

9. Whether the disease/disorder is congenital in nature?

10. Nature of Surgery/Treatment given for the present ailment

11. (a) whether Hospital/Nursing home is Registered, if yes, Regn.No.

(b) No of in patient beds in the Hospital (including ICU)

© Whether the Hospital is having fully equipped Operation Theatre of its Own/ Qualified Nurses Round the clock/ Qualified doctors round the Clock?

Signature of the Doctor with Seal **Date:**

TTK Healthcare Services Private Limited

#2, H.B Complex,100 Feet BTM Ring Road,BTM First Stage, BTM Lay Out,Bangalore – 560 068, PH: 080-40125678

Date:

To: THE HOSPITAL NAME AND ADDRESS

_____

_____

_____

Dear Sirs,
Re: AUTHORISATION TO TTK HEALTHCARE SERVICES PVT. LTD.
I have undergone treatment for _____ from _____
to _____ in your hospital.

I hereby authorise M/s.TTK Healthcare Services P Ltd., who are my TPS for the Mediclaim plicy I have, to seek any medical information / records from you or from the Medical Practitioners who have attended on me in connection with the above ailment.

In case they seek any such information / records kindly oblige.

Thanking you,

Yours faithfully,

(Signature of the Claimant)

Address of the Insured:

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