Claim Form

Mizoram State Health Care Scheme

(For treatment within Mizoram)

(Issuance of this Form does not amount to admission of any liability under the Claim on the part of the Society).

Health Care Enrollment No:				
1	Head of Family (HOF):			
2	Name of the Patient:		Sex:	Age:
	Relationship to HOF:	Telephone No:		
3	Permanent Address:			
4	Diagnosis:			
5	Name & Address of the Hospital:			
6	For OPD (Day Care) Treatment	Date:		
7	For IPD Treatment	Date of Admission:	Date of Discharge:	
8	Name and Address of the attending Medical Practitioner:			
	Qualification:	Signature/Seal:		
	Registration No:			
9	Total (Hospital Bill): ₹	Transportation Charges: ₹		
10	Grand Total (Hospital Bill + Transportation): ₹ …….. *(Rupees……..only).*			
11	**Details of Bank Account for crediting the approved amount of the Claim:**			
	Name of Bank Account Holder (Capital letters):			
	Account No:	Name of Bank:		
	Name of Branch:	IFSC Code:		
	*(Bank Account hi chhungkaw member ni lo hman a nih chuan, damlo chhungkaw remtihna **Form A** thil thil tel tur a ni).*			

In support of the above Claim, I enclose the following documents (tick):

Bank Passbook front page *(photocopy)*	Claim Form Duly Signed
Voter ID of Head of Family *(photocopy)*	Family Ration Card *(photocopy)*
Original Discharge/Death Summary	Birth Certificate from Hospital *(If applicable)*
Enrollment Form & Receipt *(photocopy)*	Hospitalization Bill with Payment Receipt
Original Medicines Bills with Dr's Prescription	Original Investigation Receipts & Reports with Dr's Prescription
Transportation Tickets, if any	Other's *(if any)*

I hereby warrant the truth of the foregoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppression or concealment, my right to claim reimbursement of the said expenses shall be absolutely forfeited. I further declare that, in respect of the above treatment, no benefits are admissible under any other Medical Scheme or Insurance.

Date: **Signature of the Patient/Claimant**

(Damdawiin chhuah ni atanga ni 45 ral hma ngeiin Hospital-ten bill theh luh tur a ni. Damloten inentir lehna tura lehkha mamawh tur zawng zawngte chu bill theh luh hmain photocopy siam vek tur a ni).

FORM: A

TO WHOM IT MAY CONCERN

Kei _____ [Chhungkaw Hotu (HOF)] hian kan Health Care Bill hi kei leh ka chhungte Bank Account ni lo, *Health Care Claim Form* a tarlan Account-ah dah luh ka remti e.

A chhan: _____

_____

_____

Date: **Signature of HOF**

** Rokhawlhna avanga Chhungkaw Hotu (HOF) a remchanglo a nih chuan, chhungkaw member dang kumtlingin a sign thei ang, signature petu Voter ID/Aadhaar Card (photocopy) thil tel tur a ni.*