Claim Form

Mizoram State Health Care Scheme

(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:		
2	Name of the patient:	Sex:	Age:
	Telephone No:	Relationship to Sl. No. 1:	
3	Permanent Address:		
4	Brief History of Disease/Injury:		
5	Diagnosis (Prov./Final):		
6	Name & Address of the Hospital:		
7	Date of Admission:	Date of Discharge:	
8	Name and Address of the attending Medical Practitioner:		
	Qualification:	Phone No:	
	Registration No:	Signature:	
9	Total (Hospital Bill): ₹	Transportation Charges: ₹	
10	Grand Total (Hospital Bill + Transportation): ₹ (Rupees……..…only).		
11	Package Code:		
12	**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:	
	MICR:	Other's (if any):	

In support of the above Claim, I enclose the following documents (tick):	
Xerox copy Bank Passbook front page	Claim Form Duly Signed
Voter ID of Head of Family (xerox)	Family Ration card xerox
Original Discharge Summary	Death/Birth Certificate from Hospital
Xerox copy of Enrolment Form/Smart Card	Hospitalization Bill with Payment Receipt
Original Medicines Bills with Dr's Prescription/	Medical Board Referral letter for referred patients
Original Investigation Receipts & Reports with Dr's Prescription	Transportation Tickets, if any **(Boarding Pass for Air travel)**
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**