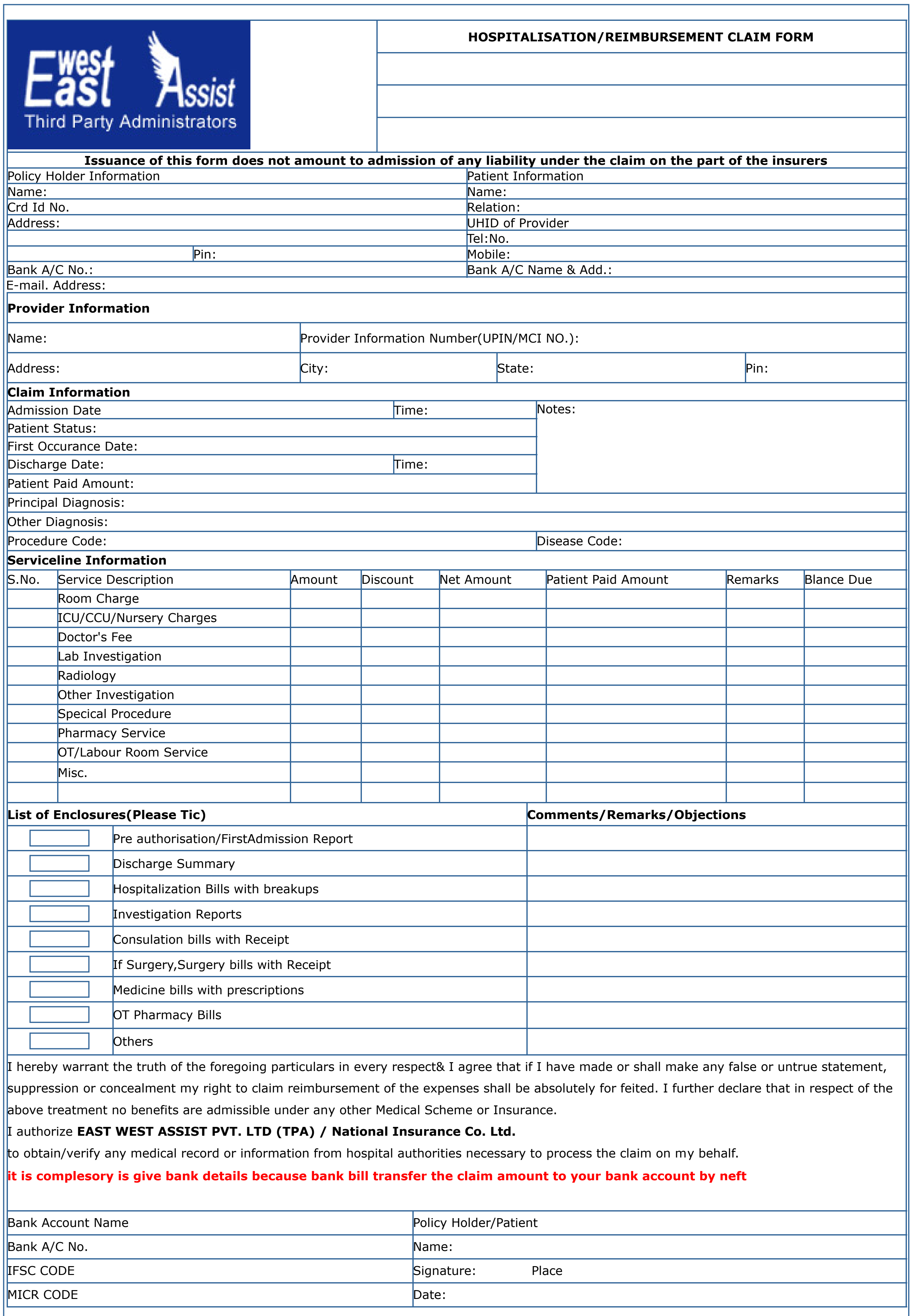

East West Assist
Third Party Administrators

HOSPITALISATION/REIMBURSEMENT CLAIM FORM

Issuance of this form does not amount to admission of any liability under the claim on the part of the insurers

Policy Holder Information		Patient Information
Name:		Name:
Crd Id No.		Relation:
Address:		UHID of Provider
		Tel:No.
	Pin:	Mobile:
Bank A/C No.:		Bank A/C Name & Add.:
E-mail. Address:		

Provider Information

Name:	Provider Information Number(UPIN/MCI NO.):		
Address:	City:	State:	Pin:

Claim Information

Admission Date	Time:	Notes:
Patient Status:		
First Occurance Date:		
Discharge Date:	Time:	
Patient Paid Amount:		
Principal Diagnosis:		
Other Diagnosis:		
Procedure Code:		Disease Code:

Serviceline Information

S.No.	Service Description	Amount	Discount	Net Amount	Patient Paid Amount	Remarks	Blance Due
	Room Charge						
	ICU/CCU/Nursery Charges						
	Doctor's Fee						
	Lab Investigation						
	Radiology						
	Other Investigation						
	Specical Procedure						
	Pharmacy Service						
	OT/Labour Room Service						
	Misc.						

List of Enclosures(Please Tic)		**Comments/Remarks/Objections**
☐	Pre authorisation/FirstAdmission Report	
☐	Discharge Summary	
☐	Hospitalization Bills with breakups	
☐	Investigation Reports	
☐	Consulation bills with Receipt	
☐	If Surgery,Surgery bills with Receipt	
☐	Medicine bills with prescriptions	
☐	OT Pharmacy Bills	
☐	Others	

I hereby warrant the truth of the foregoing particulars in every respect& 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 expenses shall be absolutely for feited. I further declare that in respect of the above treatment no benefits are admissible under any other Medical Scheme or Insurance.

I authorize **EAST WEST ASSIST PVT. LTD (TPA) / National Insurance Co. Ltd.**
to obtain/verify any medical record or information from hospital authorities necessary to process the claim on my behalf.

it is complesory is give bank details because bank bill transfer the claim amount to your bank account by neft

Bank Account Name	Policy Holder/Patient
Bank A/C No.	Name:
IFSC CODE	Signature: Place
MICR CODE	Date: