TTK Healthcare Services
Private Limited

AFL House, 3rd Floor, Lok Bharati Complex, Marol-400059
Phone No: 91-022-23012590/ 23099900
Toll Free No: 18004258854. Toll Free Fax No: 18002334535

Outpatient Treatment Cover Claim Form

(The issue of this is not to be taken as an Admission of Liability)

Please give the following information correctly and completely.

1. Insured Details :	
a) Policy Certificate No.	
b) TTK ID No.	
c) Name of Insured Person(s)	
d) Health Card No.	
e) Age	
f) Correspondence Address	
g) Mobile No.	
h) Residence No.	
2. Nature of disease / illness contracted/ailment of injury suffered:	
3. Kindly indicate :	
a) Date of commencement of treatment	
b) Name and contact details of treating doctor	
4. Amount Claimed :	
a) Consulting Doctor's Fees	
b) Pharmacy/Medicine Charges	
c) Pathological Test Charges	
d) Others (Kindly Specify)	
Total Claimed Amount :	

In support to above claim, I enclose following documents {Please indicate by ( )}

1. Bills/Receipt/Cash Memos in original for medicines etc. (name of patient along with date should be mentioned on it.)
2. Most Recent Medical prescription in support of the above.
3. Receipts and Pathological test reports in original from a Pathological Lab supported by the note from the treating doctor/ Surgeon advising such pathological tests.
4. Attending doctors/Consultant's/ Specialist's bill and receipt and certificate regarding diagnosis, whichever is prescribed and thereby expenses incurred along with doctors registration number (compulsory).

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Declaration:

I hereby agree, affirm and declare that:

a) The statements/information given/stated by me/us in this claim form is true, correct and complete.
b) No material information which is relevant to the processing of the claim or which any manner has a bearing on the claim has been withheld or not disclosed.
c) If I have given/made any false or fraudulent statement/information or suppressed or concealed or in any manner failed to disclose material information, the policy shall be void and that I shall not be entitled to all/any rights to recover there under in respect of any or all claims, past, present or future.
d) The receipt of this claim form/other supporting/related documents, does not constitute an agreement by the Company of the claim and the company reserve the right to process or reject or require further/additional information in respect of the claim.
e) I also consent and authorize Third Party Administrator /Insurance Company to seek medical information from any hospital/medical practitioner who has any time attended on the insured person.
f) I confirm that the expenses for which claim is being lodged have been incurred in respect of the insured.

Place : _____

Date : _____ _____

Signature of Claimant.