DOMICILIARY TREATMENT - CLAIM FORM

TO BE FILLED IN BY THE INSURED (The issue of this form is not to be taken as admission of liability)

(To be filled in block letters)

DETAILS OF PRIMARY INSURED : INDIAN OVERSEAS BANK HO/ZO/RO/DO/BO:

a) Policy no:

b) IOB Employee ID No

c) MDIndia ID No:

f) IOB Emp Branch Location

Emp Name:

e) Address:

City:

State:

Pin Code:

Phone No:

Email ID:

DETAILS OF INSURED PERSON HOSPITALIZED

a) Name :

b) Gender : Male Female

c) Age: years months

d) Date of Birth:

e) Relatuionship to Primary Insured: Self Spouse Child Father Mother Other (Please specify)

f) Occupation: Service Self Employed Homemaker Student Retired Other (Please specify)

DETAILS OF CLAIMS

a) Name of Treating Doctor:

b) Commencement of Treatment: Date (DD/MM/YYYY)

c) Treatment End Date: (DD/MM/YYYY)

c) Domiciliary Treatment For:

Claim Documents Submitted- Check List:

- ☐ Claim FormDuly signed
- ☐ Illness Certificate by Treating Doctor with Duration
- ☐ Pharmacy Prescriptions by Treating Doctor
- ☐ Pharmacy Bills Cash Memo
- ☐ Investigation Prescriptions by Treating Doctor
- ☐ Investigation Bills Cash Memo
- ☐ Investigation Reports
- ☐ Treating Doctor Consultancy Charges Cash Receipts

Total Number of Claim Documents Submitted:

Select the Number as below in lieu of the documents submitted

Members are requested to submit the Illness Certificate by Treating Doctor with detailed duration of the illness for which the treatment would be done.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30+

DETAILS OF BILLS ENCLOSED:

Sl. No.	Bill No.	Date	Issued By	Towards - Pharmacy, Investigations or Consultancy Charges	Amount (`)
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

In case more than 10 Bills are to be submitted then attach separate annexure using the same above format

DECLARATION BY THE INSURED

I hereby declare that the information furnished in this claim form is true & correct to the best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact with respect to questions asked in relation to this claim, my right to claim reimbursement shall be forfeited. I also consent & authorize TPA / insurance company, to seek necessary medical information / documents from any hospital / Medical Practitioner who has attended on the person against whom this claim is made. I hereby declare that I have included all the bills / receipts for the purpose of this claim & that I will not be making any supplementary claim except the pre/post-hospitalization claim, if any.

Date:

Place:

Signature of the insured: