DEDICATED ADMINISTRATION SERVICES PVT. LTD.

No. 46/1/3, Narahenpita Road,3rd Floor, Nawala 11222,Srilanka

HOSPITLIZATION EXPENSE REIMBURSEMENT CLAIM FORM

Details of the Insured

Name of the insured hospitalised____

Name of the proposer_______________________________ Age- Gender- Male / Female

Relation with proposer-Self/Spouse/Daughter/Son/Mother/Father/other___________ Hospitalisation due to-Injury/Illness/Maternity

Address____

Contact No_______________________ E-mail Id_______________________

DAS ID No____________ National ID____________ Employee ID in case of Corporate policy____________

Policy No_______________________________ Policy Type-Retail/Corporate

Date of commencement of first health insurance without break __ __/__ __/__ __ __ __

Currently covered by any other health insurance-Yes/No **(If yes please mention the name of Insurance company & Policy details)**

Name of the Insurance company ________________Policy No. ______________Sum insured__________

Hospitalization Details

Name of the hospital____

Hospital Address____

Admission date __ __/__ __/__ __ __ __ Time__ __:__ __ AM/PM Discharge date __ __/__ __/__ __ __ __ Time__ __ :__ __ AM/PM

To be filled up in case of injury only

Date of injury:	__ __/__ __/__ __ __ __		Time of injury:	__ __ :__ __ AM/PM
Place of injury:			Mode of injury:	RTA/Assault/Other
Informed to Police:	Yes/No		MLC copy attached-	Yes/No

Expense Incurred Details

Total amount claimed	Detailed Break-up of Charges	
	Pharmacy	
	Investigation	
	Consultation fees	
Pre hospitalisation	**Total**	
	Room charge	
	ICU charge	
	Consultation fees	
	OT charge	
	Implant charge, if any	
	Pharmacy charge	
	Others/ Package Charges	
	Ambulance Charge	
Hospitalisation	**Total**	
	Pharmacy	
	Investigation	
	Consultation fees	
Post hospitalisation	**Total**	

Declaration By the Claimant

I hereby declare that the information furnished in the claim form is true and correct to best of my knowledge and belief. If I have made any false or untrue statement, suppression or concealment of any material fact, my right to reimbursement shall be forfeited. I also authorize insurance company or its representative to seek necessary information from the treating physician and / or hospital. I also declare that I am not claiming for any thing which has been reimbursed by another insurance company and I shall not claim the same from any other insurance company in future.

Date:__ __/__ __/__ __ __ __ ______________________________(Signature)