CLAIM FORM FOR GROUP MEDICLAIM POLICY - *OPD*

Assam Gas Company Limited

1) Name of Patient: _____

2) UHID (Card) No. of Patient: _____

3) Name of the Employee : _____

4) Phone Number & Email ID: _____

5) Nature of Illness: _____

6) Period of Illness: _____

7) Expenses Incurred

Type of Expenses	Bill Date	Bill No.	Name of the Hospital/Lab/Medical Shop	Amount
a) For Consultation				
b) For Medicines				
c) For Pathological & other diagnostic tests				
d) Any other				
Total Expenses Incurred:				

I declare that the given information is correct and that I have not claimed reimbursement for the above expenses incurred by from any other source.

Place: _____

Date: _____

(Signature of Insured)

Note : Please enclose the following documents in original along with the claim form :

a) Copy of Mediclaim card
b) Chemist/Nursing Home Bills/Receipts and Original prescriptions.
c) All Pathological & other test report and bills, if any.
d) Any ID proof of the patient

All the above should be in original. No Photocopies will be accepted.

Signature of Competent Authority (AGCL):