THE VISAKHAPATNAM CO-OPERATIVE BANK LTD.

(Regd. No. MSCS/CR/1101/2014) (A MULTI STATE CO-OPERATIVE BANK)

THE VISAKHA CO-OP. BANK AROGYA SANKSHEMA PATHAKAM

CLAIM BILL FOR HOSPITALIZATION

1. Name of the Covered Member : .....
2. General Number : ..... Branch : .....
3. Phone / Cell No. : .....
4. Residence Address : .....
   .....
5. Name of the Patient : ..... Age in completed years :.....
6. Relationship with the Member : .....
7. Nature of the disease/injury : .....
8. Date of Claim intimation : .....
9. Address of the Hospital / Nursing Home : .....
   .....
10. Date of Admission (DOA) : ..... 11. Date of Discharge (DOD) : .....
12. Amount Claimed : Rs. .....
13. Have you obtained reimbersement for any claim previously? : Yes / No
14. If yes give details of nature of illness, period of treatment, Amount received : .....
15. SB A/c. No. of the Member : .....
16. Are you covered under in any other Medical Insurance Policy / Scheme : .....
17. If Yes, furnish details of that policy / scheme : .....

I have incurred the above expenses towards treatment of disease / illness / accidental injuries at the above hospital / Nursing Home, in support of which I enlcose the following documents in original for my claim of Rs. ..... as detailed below :

a. Case sheet / Discharge summary from Hospital / Nursing Home.
b. Hospital Bill for all payments made to the Hospital (including Surgeon's, Anesthetist's / Asst. Doctor's fees, if any)
c. Bills for consultation of attending Doctor and his recommendations for Hospitalization.
d. Cash Memos/Chemists' bills duly supported by prescriptions.
e. Diagnostic reports and Bills, X-ray reports & films, and attending doctors prescription for the tests.
f. Any other document relating to the claim (please specify)

I hereby warrant truth of the above particulars in every respect and I agree that, if I made any false or untrue statement, suppression or concealment, my right to reimbursement shall be absolutely forfeited. I further declare that in respect of the above treatment, I have not claimed benefits under any other Medical Insurance Policy / Scheme.

I am aware that the Board has final authority to entertain, reduce or reject my claim and I shall abide by the decision of the Board without raising any dispute.

Dated at ..... this ..... day of ..... 20.....

Signature of the Claimant / Covered Member

CERTIFICATE FROM THE AUTHORISED HOSPITAL

We hereby certify that Sri / Smt. ..... aged ..... a member/spouse of the member Sri / Smt. ..... of The Visakhapatnam Co-operative Bank Ltd., bearing General No. ..... has undergone treatment for illness / injury in accident in our Hospital from ..... to ..... and our Hospital charged Rs. ..... towards treatment which was paid by the member on ..... vide our Receipt No. .....

Date : .....

Authorised Person I/C of the Hospital

Place : .....

FOR OFFICE USE

1. Claim No. ..... Branch .....
2. Intimation dated ..... Received on .....
3. Present illness ..... Claimed Amount Rs. .....
4. Details :

Nature of Expenditure	Claimed	Allowed
Room, Boarding and Nursing expenses, visits fee, RMO Charges, I.V. Fluids / Blood transfusion charges / injection administration charges, Dressing charges and similar expenses.		
Incentive Care Unit (ICU) expenses		
Surgeon, Anesthetist fees, Assistant Doctor's Fees to be included in the Hospital Bill.		
Medical Practitioner, Consultants, Specialists Fees IOL Master, Physiotherapist		
Cost of Anesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical appliances, Medicines & Drugs, Relevant Laboratory / Diagnostic tests, X-Ray and other medical expenses related to the treatment.		

6. Sanctioned Amount. Rs. ..... approved by the committee of the Branch held on ..... and hence forwarded for payment subject to limit.

Branch Manager

Date :

FORM-B

THE VISAKHAPATNAM CO-OPERATIVE BANK LTD.,

(Regd. No. MSCS/CR/1101/2014) (A MULTI STATE CO-OPERATIVE BANK)

THE VISAKHA CO-OP. BANK AROGYA SANKSHEMA PATHAKAM

MEDICAL BILL FORWARDING MEMO

From :	To
The Branch Manager **THE VISAKHAPATNAM** **CO-OPERATIVE BANK LTD.** Branch Office	The Insurance Department **The Visakhapatnam Co-operative Bank Ltd.** Head Office, 5th Lane Dwarakanagar Visakhapatnam-530 016

Dear Sir,

Sub : Claim Bill under Members Medi-claim Policy for the year 02-12-2014 to 01-12-2015 -

Claim of Sri / Smt. ..... G. No. .....

I am forwarding herewith the Claim Bill submitted by the above Staff along with the following enclosures which are checked by me. (Please tick (✓) enclosed items)

CHECK LIST

S.No.	Details of Papers Enclosed	Checked	Received
1.	Form-D duly completed in all respects by the claimant and counter-signed by me	☐	☐
2.	Xerox copy of Membership Card of the claimant / Member	☐	☐
3.	Discharge Summary of the Hospital in original	☐	☐
4.	Original / Copy of Case Sheet duly attested by Hospital	☐	☐
5.	Original Printed Bill issued by the Hospital (Note : Surgeon's fee, Anesthetist's fee, Asst. Doctor's Fee, Treatment fee, if any should be included in the Hospital Bill. Bill issued on Hospital Letter Head will not be accepted)	☐	☐
6.	Prescriptions issued by Consulting Doctor, Hospital for Medicines purchased or Lab tests undergone	☐	☐
7.	Original Cash Bills / Receipts issued by Chemists or Hospital Dispensary and Clinical Laboratories duly attested by treating doctor on the reverse (Note : All cash bills should contain APGST No., CST No., date & Signature)	☐	☐
8.	Original Lab Reports, Scan Copies, X-Rays, ECG and similar Graphs	☐	☐
9.	Fee receipts in respect of Consulting Doctor / Family Doctor, if any and their specific recommendation for Hospitalization.	☐	☐
10.	Product Identification Sticker in respect of Implants for eyes or other parts of the body.	☐	☐

Please do the needful.

Received above papers

Branch Manager
The Visakhapatnam Co-operative Bank Ltd.

Claims Officer
The Visakhapatnam Co-operative Bank Ltd.