CLAIM INTIMATION
(To be filled and submitted to MDINDIA on admission of the patient in the Hospital)

Date: ____________

Name of Policyholder:____

Name of Patient:____Age:______yrs Sex: M / F

MDIndia ID number:___________________________Policy No.__________________________________

Name of Hospital:____

Address:____City:________________State:__________

Diagnosis:____Date of Admission: ______ / ______ /

Name of Treating Doctor:_____________________________Approximate Expenses: Rs.______________

Any other Relevant Information:____

Signature / Thumb Impression of Policyholder / Nominee
Name:____Contact No: _______________

MDINDIA HEALTH INSURANCE TPA PVT. LTD
IRDA License No. 005
H.O. S.No., -46//1, E-Space, A-2 Bldg., 3rd Floor Pune Nagar Road, Vadgaon Sheri, Pune - 411014
UAN Voice : 1860-233-4446 UAN Fax: 1860-233-4447 Tel: 020-25300000 Fax: 020-25300003

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