INPATIENT HOSPITALIZATION (IPD) MEDICAL CLAIM FORM

IGI General Insurance Limited

A. CLAIMS SUBMISSION PROCEDURE

To avoid any delays in processing of your claim, please ensure that:

1. All questions on the form are to be answered. Do not leave any blank spaces. Use block letters.
2. All original claims documents are to be attached.
3. Attached copy of medical card.
4. Complete the check list.

B. EMPLOYEE'S SECTION

1. Employee's Name & Date of Birth: ____________________
   (As shown on Enrollment Card Policy Listing)
2. Patient's Name & Date of Birth: ____________________
   (As shown on Enrollment Card Policy Listing)
3. Company Name: ____________________
4. Health Card Number ____________ Employee ID: ____________________
5. CNIC: ____________________
6. Mobile No.: ____________ Email Address: ____________________
7. Mailing Address: ____________________
8. Bank Name: ____________ Bank Account No.____________________

I hereby certify that all answers and all documents submitted with the Claim Form are complete and true. I hereby authorize any doctor, hospital, clinic or medical provider, any insurance company or any other company institution or any other person who has any record or information about me and I or any of my family members to provide IGI Life Insurance Limited with the complete information, including copies of their records with reference to any sickness or accident, any treatment, examination, advice or hospitalization. Any photocopy of this authorization shall be taken as the original copy.
I also authorize IGI Life Insurance Limited to share my or my family's information with third parties if needed for processing of this claim.

Employee's Signature: ____________________ Date: ____________________

C. EMPLOYER'S SECTION

1. Is this claim arising out of Patient's Occupation? Yes ☐ No ☐
2. Total Amount Claimed: ____________________
3. Employer's Representative Signature:____________________
4. Employer's Stamp: ____________________ Date: ____________________

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D. ATTENDING PHYSICIAN'S SECTION

1. Patient's Name & Date of Birth: ____
2. Presenting Complaints: ____
3. Duration of Complaints: ____
4. Diagnosis (Block Letters): ____
5. Date symptoms first appeared: ____
6. If the claim is resulting from pregnancy/ children,
   Please provide date of (LMP or E.D.D): ____
7. Details of Treatment (other than prescription): ____
8. Dates of any previous treatment in growth name of treating physician:
   ____
9. If further treatment or operative procedure anticipated? YES ☐ NO ☐
10. If "yes" Please provide full details & expected dates
   ____
   ____
11. Name of Operation: ____
12. Date performed: ____
13. Date of Admission: ______________________ Date of Discharge: __________________________________

   Physician's / Surgeon's Signature & Stamp: ____

   PMDC Number___________________________

   Date: ____________________________

CLAIMS CHECK LIST

KINDLY ATTACH THE FOLLOWING WITH YOUR CLAIM.
(NOTE: ORIGINAL DOCUMENTS REQUIRED) **(Please tick)**

DOCUMENTS	YES	NO (REASON)
1. Itemized Hospital Bill & Receipts		
2. Detailed Hospital Discharge Report.		
3. Itemized Laboratory & Radiology Bills.		
4. All Laboratory & Radiology Reports.		
5. Itemized Pharmacy Bills Along with Prescriptions		
6. Ultrasound, C.T. Scan, MRI Reports, etc.		
7. Others (If Any).		