OPD CLAIM FORM

(TO BE FILLED BY CLAIMANT EMPLOYEE)

1.	NAME OF COMPANY/ CLIENT:				
2.	NAME OF EMPLOYEE:				
3.	EMPLOYEE NUMBER:				
4.	IGI HEALTH CARD ID NUMBER:				
5.	NAME OF PATIENT:				
6.	RELATION WITH EMPLOYEE (mark the right choice)	SELF	SPOUSE	DAUGHTER	SON
7.	PERIOD FOR WHICH CLAIM IS MADE (MONTH)				
8	BANK NAME				
9.	BANK ACCOUNT NUMBER				

DETAILS OF CLAIMED AMOUNT:

SR. NO	EXPENSE DESCRIPTION	EMPLOYEE	SPOUSE	CHILDREN
1	CONSULTATION FEE			
2	MEDICINES			
3	DIAGNOSTIC TESTS			
4	PREVENTIVE VACCINATION			
5	DENTAL			
6	OPTICS			
7	OTHER			
	TOTAL			

DECLARATION:

We, the undersigned, do hereby declare that, to the best of our knowledge and belief, the foregoing particulars are true and correct. We authorize igi to obtain information from doctor/hospital/pharmacy/lab concerning the treatment for which claim is made.

_____ _____

Employee's Signature with date **Employer's Signature & Stamp**

CHECKLIST:

- Single form must be used against claim of multiple dependents
- Please ensure to attach the documents along with this claim form.
- Original invoices of the pharmacy /doctor /lab etc.
- Always keep scanned copies of complete claim form with all attached bills & prescription.