EKLAVYA STAFF HOSPITALISATION ASSISTANCE SCHEME
CLAIM FORM CUM CLAIM PROCESS SHEET

(Please give the following information correctly and completely to enable process your claim promptly.)

1. **Name (Eklavya Staff Member)**

2. **Name of the dependent (in respect of whom claim is made)**

3. **Nature of Disease contracted/Ailment suffered or injury sustained**

4. **Date on which injury was sustained/Disease Or ailment first detected**

5. **Name & Address of the Hospital/Nursing Home**

(a) Name :

(b) Full Address

(c) Qualification & Telephone No.

(d) Registration No.

4. **Particulars of the attending Medical Practitioner / Surgeon**

(a) Name :

(b) Full Address

(c) Qualification & Telephone No.

(d) Registration No.

7. **Date of Admission**

8. **Date of Discharge**

9. **Is the staff member or any of his/her dependents presently covered under any scheme like Personal Accident, Cancer Insurance, Mediclaim (Individual or Group), Health Insurance and the like. If Yes. please give particulars of each. If not, please write NOT APPLICABLE.**

SN	1	2	3
Name of Insurer			
Insurance Scheme			
Company			
Policy No.			
Period of cover			

In support of the above claim, I enclose the following documents ALL IN ORIGINAL.

SN	PARTICULARS	Tick √
1	Case file and medical prescriptions	
2	Bill, Receipt and Discharge certificate / card from the Hospital.	
3	Cash Memos from the Hospitals (s) / Chemists (s), as per prescriptions.	
4	Receipt and Pathological test reports from Pathologist supported by the note from the attending Medical Practitioner / Surgeon recommending such Pathological tests /pathological	
5	Surgeon's certificate stating nature of operation performed and Surgeons' bill and receipt.	
6	Attending Doctor's/ Consultant's/ Specialist's / Anaesthetist's bill and receipt, and certificate regarding diagnosis.	
7	Certificate from attending Medical Practitioner / Surgeon that the patient is fully cured.	

Summary of Expenses Incurred During Hospitalisation (for which original bills / receipts / cash Memos are enclosed.)

SN	PARTICULARS	AMOUNT CLAIMED Rs.	AMOUNT NOT PAYABLE Rs.	AMOUNT NET PAYABLE Rs.
	HOSPITALISATION			
1	Room rent and nursing for ___ days @ Rs.____/day = Rs. ICU rent and nursing for ___ days @ Rs. _____/day = Rs.			
2	Consultant's /Surgeon's / Anesthetist's / Specialist's Fees			
3	Diagnostics Tests			
4	Medicines & Drugs and allied supplies (syringe etc)			
5	Others			

	Sub-total Hospitalisation expenses			
	PRE / POST HOSPITALISATION			
6	Pre-hospitalisation expenses			
7	Post-hospitalisation expenses			
8	**Sub-total Pre-hospitalisation + Post-hospitalisation expenses**			
	GRAND TOTAL			

DECLARATION

I hereby warrant the truth of the foregoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppression or concealment of any fact, my right to claim reimbursement of the said expenses shall be absolutely forfeited. I further declare that, in respect of the above treatment, no benefits are availed or claimed under any other Medical Scheme or Insurance.

Place : **Signature of the Eklavya Member**

Date :

EKLAVYA STAFF HOSPITALISATION ASSISTANCE SCHEME

MEDICAL CERTIFICATE TO BE FILLED IN BY ATTENDING DOCTOR

1	**Name of the Patient:** **----------**	
2	**Age: --------- years**	
3	**Admission Date and Time**	
4	**Discharge Date and Time**	
5	**Name of Surgeon / Physician**	
6	**Diagnosis**	
7	**Date of first consultation with doctor**	
8	**Date of previous consultation before hospitalisation**	
9	**Nature of surgery / treatment given for the ailment**	
10	**Whether the hospital/nursing Home is registered. If yes, the Regn. No.**	
11	**Number of in-patient beds in the hospital/nursing home (including ICU)**	
12	**Whether the hospital/nursing home is is having fully equipped operation theatre of its own / qualified nurses round the clock / qualified nurses round the clock**	

Signature of the Doctor with Seal **Date :**

Seal of the Hospital / Nursing Home