Claim Intimation Form

Policy Information

Name of Insurance Company			
Policy Number			
Policy Start Date		Policy end date	
Name of Policy Holder			
Phone		Mobile Number	

Hospitalization Information

Name of Patient			
GID Number			
Age of Patient		Sex	Male / Female
Diagnosis			
Date & Time of Admission		Expected Date of Discharge	
Line Of Treatment			
Name of Hospital			
Address of Hospital			
City		State	
Contact No. of Hospital			
Name of Treating Doctor			
Address of Treating Doctor			
Contact No. of Treating Doctor		Mobile Number	
Name of Family Physician			
Address of Family Physician			
Contact No. of Family Physician		Mobile Number	
Estimated Expenses			
Any Other Relevant Information			
Additional Documents attached			
Intimation Submitted by	Insured / Patient / Relative / Agent		
Bed Number			

I hereby authorize Genins India Insurance TPA Ltd./ Insurance Company to obtain my medical record / information from Hospital / Nursing Home /Treating Medical professionals / family physician / Diagnostic centers /Medical shops necessary to process the claim.

Signature / Thumb Impression of Patient / Relative/
Policy Holder

Name

Date