

**ALANKIT HEALTHCARE TPA LTD.
2E/21, JHANDEWALAN EXTENSION,
NEW DELHI-110055**

CLAIM INTIMATION FORM

NAME OF THE INSURANCE COMPANY-

NAME OF THE INSURED

POLICY NO.

ALANKIT CARD NO.

NAME OF THE PATIENT

AGE

SEX

ADDRESS OF THE INSURED

CONTACT NO.

BANK DETAILS (NAME OF THE BANK AND BRANCH)

TYPE OF A/C (SAVINGS/CURRENT) AND A/C NO.

NAME OF THE HOSPITAL AND ADDRESS

HOSPITAL REGISTRATION NO./ FACILITIES AVAILABLE

DATE OF ADMISSION __/__/____ DATE OF DISCHARGE __/__/____

DIAGNOSIS

CONSULTANTS NAME AND CONTACT NO.

AMOUNT CLAIMED

DATE OF SUBMISSION OF THE CLAIM/ RECEIPT

TYPE OF CLAIM (CASHLESS/ REIMBURSEMENT) (MAIN/PRE-POST) QUERY REPLY
TYPE OF DOCUMENTS (ORIGINAL/PHOTOCOPY)

(DISCHARGE SUMMARY/HOSPITAL BILLS/ RECEIPT OF PAYMENT/FILMS/PRESCRIPTIONS/ MEDICINE BILLS)

SIGNATURE OF THE INSURED

FOR OFFICE USE

RECEIVED DATE __/__/____ RECEIVED BY HAND/BY COURIER/ FROM INSURANCE COMPANY

INWARD NO.