



Rothshield Healthcare TPA Services Limited

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CLAIM FORM

(Issuance of this form is not tantamount to liability by insurance company)

Name of Insurance Company : _____
 Policy No. : _____
 ID No. : _____
 Policy Period : From _____ to _____

1. Name of the insured _____	3. Name of the employee/ Proposor _____
2. Relation _____	4. Occupation _____
5. Age / D.O.B. _____	6. Phone / Mobile No. _____
7. Residential address _____	8. E-mail- ID _____

9. Nature of disease / illness contracted or injury suffered.
 10. Date of injury sustained / disease contracted _____
 11. Claim for Hospitalization Y N
 • Claim for Domiciliary Hospitalization Y N Date of completion of treatment _____
 • Date of Commencement of treatment _____
 12. Name & Address Hospital / Nursing Home / Clinic
 • Date of Admission : _____ Time _____
 • Date of Discharge : _____ Time _____
 13. Name & Address of Attending Medical practitioner
 • Qualification. : _____ Registration No. : _____
 • Telephone / Cell No. : _____
 14. No. of Beds. _____
 Registration of Hospital. : _____

15. Have you presently covered under any other type of insurance scheme? Like R.A. insurance, Cancer insurance medicine (Individual or group). Health insurance, if yes, state photocopies of previous insurance policies enclosed.
 16. Date of commencement of very first insurance for this insured person with continuous insurance cover:
 17. Is this the first claim under this policy Yes/ No
 If No. Please quote previous claim no. & details
 18. Total Amount Claims Rs. _____
 19. I have incurred on the treatment of disease illness/ accident & herewith as per schedule given below :

Sr. No.	Date	Bill No.	Particular	Amount Claim

- Pre authorization /First Admission Report
- Discharge Summary
- Hospitalization Bills with breakups
- Investigation Reports
- Consultation bills with Receipt
- If Surgery, Surgery bills with Receipt
- Medicine bills with prescriptions
- OT Pharmacy Bills
- Others

I hereby warrant the truth of the foregoing particular in every respect and I agree that if I have made or shall make any false or untrue Statement, suppression or concealment, my right to claim reimbursement of the said expenses shall be absolutely forfeited. I further declare that, in respect of the above treatment no benefit are admission under any other medical scheme or insurance.

I also consent and authorize ROTHSHIELD HEALTHCARE (TPA) SERVICES LTD. To seek medical information form any Hospital/ Medical Practitioner who has at any time attended on me. I authorize ROTHSHIELD HEALTHCARE (TPA) SERVICES LTD. To make payment of the claim admissible as per terms, conditions and limitations of the policy to the Hospital on my behalf for full & final settlement of Hospital bills.

I, also authorize ROTSHIELD HEALTHCARE (TPA) SERVICES LTD. Receive Payment from insurance company as reimbursement of Hospital bills incurred on my treatment.

Provider Representative	Policy Holder Patient
Name : Date: Signature :	Name : Date : Signature: