TPLInsurance

HEALTH CLAIM FORM

Company Name:_____ Employee's Name: _____

Health Card #:_____ Employee #:_____

CNIC #: _____Contact #: _____

Patient's Name: _____ Relation with Employee: _____

Gender: Male ☐ Female ☐ Age: _____Claim type: _____

Admission Date: _____ Discharge Date: _____ Amount Claimed: _____

Bank Name: _____ Bank Account #: _____

Following documents to be attached on official letter head of hospital, physician, surgeon, pharmacy, and laboratory.

- ☐ Original Itemized Bill (Room Charges, Lab & Radiology Charges, Consultation Charges, Anesthesia Charges, Surgeon Fee with details, Operation Theatre Charges, Medicine during hospitalization with breakdown.
- ☐ Clinical Summary
- ☐ Original Hospital Discharge
- ☐ Copy of Employee Health Card and CNIC
- ☐ Copy of Birth Certificate (if maternity case)

☐ I hereby confirm that the information provided and documents submitted are true and correct to the best of my knowledge. I hereby authorize TPL Insurance Limited to obtain / verify any information or reports pertaining to the claim from the hospitals, pharmacies, labs or doctors mentioned in the claim documents submitted.

Employee signature: _____ Date: _____ HR approval & stamp: _____

Doctor Name: _____ Hospital Name: _____

Contact #: _____ Address: _____

Admission Date: _____ Discharge Date: _____ Medical Record #: _____

Diagnosis: _____

☐ I hereby confirm that the information provided above are true and correct to the best of my knowledge.

Doctor's signature: _____ Date: _____ Hospital Sign & Stamp: _____

For Office Use Only

Policy #: _____Claim #: _____ Claim Receiving Date: _____

Amount Approved: _____ Deduction:_____ Approver's Signature:_____

Please send & address to:

Manager Health Claims
TPL Insurance Limited
19-B, Block-B, SMCHS,
Near Maulana Road, Karachi - 74900